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ORIGINALES

Mental health and risk of recidivism of violence in women and elderly victims of violence

Salud mental y riesgo de violencia en mujeres y adultos mayores víctimas de violencia

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ABSTRACT:

Objective: To determine the relationship between the risk (of continuity or aggravation) of violence and the mental health of women and older adult victims of intimate partner or family violence, respectively, whose cases were reported in a police station in Arequipa, Peru.
Methods: Descriptive, correlational and cross-sectional study. The sample consisted of 428 people. The risk (of continuity or aggravation) of violence was measured with specific "Risk Assessment Forms" for the study population, validated and used in Peru academically and legally. Mental health was assessed using the Self-Reporting Questionnaire SRQ. SPSS-IBM 24 was used for the analysis, using frequency and contingency tables, with the chi-square statistical test.
Results: An association was found between sociodemographic characteristics and mental health with the level of risk of violence, with sex, age, educational level, place of birth, marital status, economic income, occupation and family burden being statistically significant. No significant association was found between the assessment of risk of violence and the presence of at least one psychiatric disorder.
Conclusion: It is concluded that in female victims of intimate partner violence and older adult victims of family violence, the level of risk of continuity or aggravation of violence was higher in females, younger, with less independence and economic capacity, with less education or whose marital status was that of cohabitant. Mental health was not different according to the different levels of risk of violence, although 50% had possible psychiatric disorders, predominantly anxiety/depression and psychotic disorders.

Key words: Violence; violence against women and the elderly; mental health; risk assessment.

RESUMEN:

Objetivo: Determinar la relación entre el riesgo (de continuidad o agravamiento) de violencia y la salud mental de mujeres y adultos mayores víctimas de violencia de pareja o familiar, respectivamente, cuyos casos fueron denunciados en una comisaría de Arequipa, Perú.
Método: Estudio descriptivo, correlacional y transversal. La muestra fue de 428 personas. El riesgo (de continuidad o agravamiento) de violencia fue medido con “Fichas de Valoración de Riesgo” específicas para la población de estudio, validadas y utilizadas en el Perú académica y legalmente. La salud mental

se evaluó mediante el Cuestionario de Síntomas (Self-Reporting-Questionnaire SRQ). Para el análisis se empleó el SPSS-IBM 24, utilizando tablas de frecuencia y contingencia, siendo la prueba estadística chi-cuadrado.
Resultados: Se encontró asociación entre las características sociodemográficas y la salud mental con el nivel de riesgo de violencia, siendo el sexo, edad, grado de instrucción, lugar de nacimiento, estado civil, ingreso económico, ocupación y carga familiar, estadísticamente significativos. No se encontró una asociación significativa entre la valoración de riesgo de violencia y la presencia de al menos un trastorno psiquiátrico.
Conclusión: Se concluye que en mujeres víctimas de violencia de pareja y adultos mayores víctimas de violencia familiar, el nivel de riesgo de continuidad o agravamiento de la violencia era mayor en personas de sexo femenino, de menor edad, con menor independencia y capacidad económica, con menor grado de instrucción o cuyo estado civil era de conviviente. La salud mental no sería diferente según los diferentes niveles de riesgo de violencia, a pesar que el 50% tenía posibles trastornos psiquiátricos predominando la ansiedad/depresión y trastornos psicóticos.

Palabras clave: Violencia; violencia contra la mujer y adulto mayor; salud mental; valoración de riesgo.

INTRODUCTION

Preventing and responding to violence against women and older adults remains one of the key challenges for the humanitarian sector. The World Health Organization (WHO) is working to ensure health sector capacity meets the needs of women who have experienced violence by strengthening the knowledge and skills of providers and health service delivery. In 2016, the World Health Assembly endorsed the global action plan to strengthen the role of the health system in addressing interpersonal violence, particularly against women and girls.

WHO states that violence has significant harmful effects on women's mental health and well-being. Violence against women and older adults is a serious but preventable public health problem that is common throughout the world. According to WHO estimates, globally approximately one woman out of every 3 (35%) have experienced physical and/or sexual violence by an intimate partner or sexual violence by another person at some point in their lives, most of this by intimate partners.

In the midst of the 21st century, violence is still present in the global, national and local spheres. In recent years, there has been an increase in the levels of violence generated by multiple causes, such as social attitudes, cultural and gender inequality, intergenerational transmission of violence, lack of legal and human rights awareness, economic problems and personal problems such as infidelity or misunderstanding; in addition, some serious risk factors related to violence are alcoholism, substance abuse, and mental health problems, with women and members of the family group being vulnerable to violence of different types such as physical, psychological, sexual, economic or patrimonial violence [1-4]. Specifically in couple relationships, the most common type of violence against women is psychological violence, which occurs prior to physical violence and manifests itself early until it becomes chronic, which is why family and couple violence is a major social and cultural problema [5].

Family violence is considered a violation of the human rights and dignity of family members, where most of the time it occurs especially in women and the elderly[6]. Violence is really a mistreatment that erroneously becomes naturalized, or becomes a daily occurrence and is considered "normal behavior" while other people in society consider violence as a "family problem" that should be solved at home, however, it is

quite the opposite, since it is necessary to seek assistance due to the high risk of affecting mental health and therefore the biopsychosocial balance, even in some cases it requires legal interventions [3,6].

Most women who have been victims of violence come to health centers in search of care to break their silence about the violence they experience at home; this is why the first level of health care is where the health professional has the opportunity to recognize some form of violence and be the women's refuge [7]. However, lately, the problems that affect the mental health of victims of violence are not usually identified in any emergency service or in medical reports of the first level of care or in other cases, the response or follow-up provided to an event of violence is not always the most appropriate and complete [8, 9].

For this reason, it is necessary to improve the health and political sector in order to overcome those factors that make it difficult for a woman not to report acts of violence and therefore access adequate care, such as: shame, fear, prejudice, social pressure and bureaucratic procedures in the corresponding entities [10]. In recent years, the health system has undergone important modifications aimed at strengthening Comprehensive Health Care, giving priority to primary care in the promotion and prevention of diseases, since in different situations victims of violence contact health personnel for help as the first or perhaps the only professional [11]. It is important to emphasize that the first level of care connects the health system with the individual, the family and the community, being of vital importance that health professionals are prepared to provide comprehensive care[4].

For this reason it is of vital importance to train them so that they can provide comprehensive care that involves early detection and follow-up until recovery is achieved, hence the importance of implementing care programs and home visits focused on women at risk of violence, which help prevent major consequences in the mental health of the victim such as anxiety, depression, alcoholism, sleeping difficulties, post-traumatic stress disorder and suicide attempts [2, 11-14].

This study aims to explore the relationship between different types of violence, such as physical, psychological, sexual and economic and patrimonial violence, and the mental health of the victim, since cultural diversity and economic gaps increase the vulnerability of this population. The information of this study allows to evaluate and/or propose an educational program, which should be worked as prevention and promotion in primary health care in violence and in this way, the preventive actions could be better focused on women and older adults, and that, added to other studies. In addition, it is important to highlight that violence against women continues to be very frequent in Ecuador, Bolivia, Paraguay and Peru; according to some statistics, in Peru alone, 7 out of 10 women are victims of violence by their partners [15], which is why social research should be conducted on the subject of violence, in terms of prevention and change of attitude and behavior. According to the Ministry of Health, in Peru during 2017, for mental health, 52 611 people were attended on an outpatient basis, both victims of family violence and patients suffering from various mental disorders, specifically 18 387 people were victims of family violence [16]. In Arequipa, the complaints received for family violence recorded in 2019 by the Ministry of the Interior, refer that they reported about 20 496 acts of violence; in physical violence were 8 369 and in psychological violence 10 308 [17].

Therefore, it was proposed to determine the relationship between the risk of violence, whether physical, psychological, sexual, economic or patrimonial, and mental health in women victims of intimate partner violence and elderly victims of domestic violence, whose police report had been registered and who live in the district of Cerro Colorado in the Province of Arequipa, Arequipa, Peru in 2018. In addition, sociodemographic characteristics associated with the risk of violence will be identified.

METHODS

An observational, descriptive, correlational design, cross-sectional, cross-sectional study was conducted during 2018 in the district of Cerro Colorado, the district with the largest population in the city of Arequipa, Peru.

The study population was defined as: female victims of intimate partner violence, older adults (> 65 years) victims of family violence, over 18 years of age and current residents of the Cerro Colorado district. Being a victim of violence was defined as those identified as "victims" in a police report made at a police station in the Cerro Colorado district in 2018. Thus, the sample frame was determined by requesting the available information on reports of violence at the district's "Comisaría PNP Zamácola". The size of the sample frame was 1780 people. Using this value as a reference, a sample size calculation was made for finite populations (> 30) considering an expected prevalence of 50%, a confidence level of 95% and a sampling error of 6%, resulting in a sample size of approximately 428 people. Cases were selected by systematic random sampling.

The sociodemographic characteristics studied were sex, age, educational level (illiterate, primary, secondary, technical, higher), place of birth, marital status (single, married, cohabiting, divorced, widowed), income (less than minimum wage, minimum wage, greater than minimum wage), occupation (housewife, self-employed, dependent worker, student) and family burden (i.e., persons economically dependent on the aggressor: none, one to two persons, three or more).

For the assessment of the risk of continuity or aggravation of violence, the following instruments were used: "Risk Assessment Form for Women Victims of Intimate Partner Violence" and the "Risk Assessment Form for Elderly Victims of Domestic Violence". The purpose of these instruments is to detect and measure the risks to which a victim is exposed with respect to the denounced person, either on the continuity or aggravation of the violence [18]. These forms are available in the Regulation of Law No. 30364 (18) (Law to Prevent, Punish and Eradicate Violence against Women and Family Members), which also details the standardized application procedures. The Ficha de Valoración de Riesgo en Mujeres Víctimas de Violencia de Pareja, consists of 19 items and is applied to assess the risk in women older than 14 years affected by violence by their partner or ex-partner (spouses, ex-spouses, cohabitants, ex-cohabitants, boyfriends/girlfriends, ex-boyfriends, boyfriends/girlfriends, lovers, ex-lovers). It includes the sections "History of physical, psychological and sexual violence" (items 1 to 7), "Threats" (items 8 and 9), "Extreme control towards the partner or ex-partner" (items 10 to 14), and "Aggravating circumstances" (items 15 to 19). Each item has a score assigned to it depending on the response. These scores are added together to obtain the final score that will be categorized as mild (0-12), moderate (13-21) or severe (22-44) risk [18]. The Ficha de

Valoración de Riesgo en Personas Adultas Mayores Víctimas de Violencia Familiar consists of 26 items and is applied to older adults who are victims of violence by a member of their family group (it does not include intimate partner violence). It includes the sections "Vulnerability (Independence and economic autonomy)" (items 1 to 9), "Dysfunctional Family Dynamics" (items 10 to 16) and "Characteristics of violence" (items 17 to 26). Each item has a score assigned to it depending on the response. These scores are summed to obtain the final score that will be categorized as mild (0-17), moderate (18-29) or severe risk (30-43) [18].

Mental health was assessed using the Self-Reporting Questionnaire (SRQ), designed by the World Health Organization to screen for psychiatric disorders, especially for developing countries, in order to identify those probable cases of mental disorders that could benefit from a more detailed evaluation and treatment by a mental health specialist [19]. It consists of 30 questions, the first 20 questions correspond to those symptoms that imply a lesser severity (those that are frequent in depressive and anxiety disorders); questions 21 to 24 correspond to symptoms of greater severity and when answered affirmatively probably indicate the existence of a psychotic disorder; question 25 inquires about the existence of a seizure disorder and questions 26 to 30 refer to alcohol drinking habits and have been added to the original questionnaire, to obtain information about this disorder. Each positive response to an item is scored with 1 and negative responses with 0. The total score is obtained by adding the positive responses, according to each category with its items. Thus, 9 points in items 1 to 20 would indicate anxiety/depression; 1 point in items 21 to 24 would indicate psychotic disorder, 1 point in item 25 would indicate convulsive disorder, 1 point in items 26 to 30 would indicate alcoholism [19]. This instrument has been extensively validated by Veliz, J. [20] for intra- and interobserver reliability, as well as construct validity and internal consistency, with a cronbach's alpha of 0.88. Mental health was finally dichotomized as "Without possible disorders" (in the case of no items) and "With possible disorders" (in the case of at least one item).

For data collection, training was provided to apply the instruments in a standardized manner to the research team and collaborators, made up of 7 people, including nursing and education professionals and nursing students. This team has previous experience in conducting home visits and interviews. A pilot study was then conducted in a similar population in another police station in the district to verify the understanding of the data collection form. Subsequently, information on reported cases of violence in 2018 in a police station in the district, including data on telephone number and address of the victim of violence, was appropriately requested. Potential participants were then telephoned to verify their home address, and to coordinate a home visit. In very few cases, the participants selected for the call did not participate in the study (less than 10), either because they could not be contacted by telephone, they could not be found by home address, or because they did not want the home visit to be carried out; in these situations, systematic sampling was continued until the calculated sample size was completed. During the home visit, informed consent was obtained, the inclusion criteria were verified and then all the data collection instruments were applied to the victim of violence in a standardized manner and following the application guidelines [18,19]. All participants who underwent the home visit accepted and signed the informed consent form.

Regarding ethical considerations, participation in the study was voluntary, with informed consent, and also complied with the provisions of the Helsinki declaration and responsible conduct in research.

The data were analyzed with the SPSS - IBM 24 program, where frequency and contingency tables were created, as well as statistical tests such as chi-square for the comparison of categorical variables (without an interest in the ordinal nature of the variable risk of violence), considering a value of $p < 0.05$ as statistically significant.

RESULTS

A total of 428 people were studied, their characteristics are presented in **Table 1**.

Table 1: SOCIODEMOGRAPHIC CHARACTERISTICS OF THE STUDY POPULATION

Characteristics	N	%
Sex		
Female	398	93
Male	30	7
Age		
18 to 25 years old	38	8.9
26 to 40 years old	174	40.7
41 to 60 years old	168	39.3
61 to 80 years old	48	11.2
Level of education		
Illiterate	12	2.8
Primary school	87	20.3
High school	218	50.9
Technical	60	14
Higher	51	11.9
Place of birth		
Arequipa	251	58.6
Puno	105	24.6
Cusco	51	11.9
Other*	21	4.9
Marital Status		
Single	130	30.4
Married	111	25.9
Cohabiting	139	32.5
Divorced	42	9.8
Widowed	6	1.4

Economic income		
Less than minimum wage	142	33.2
Minimum wage	156	36.4
More than minimum wage	130	30.4
Occupation		
Homemaker	169	39.5
Self-employed	165	38.6
Dependent worker	78	18.2
Student	16	3.7
Family burden		
None	61	14.3
One to two persons	271	63.3
Three or more	96	22.4
Total	428	100

*Moquegua, Lima, Tacna and Pasco

From the results obtained, it can be observed that the majority of the population is between the ages of 26 to 40 years, representing 40.7%, followed by 41 to 60 years, with 39.3%; the female sex is predominant with 93%; the highest educational level with 50.9% was secondary school, and as for the place of origin, it is important to note that there is a significant population from Puno (24%) due to the high migration registered in recent years; however, a higher percentage (58.6%) was found in the Arequipa region. In addition, the results show that most of the population has the following marital status: cohabitant, with 32.5%, followed by single, with 30.4%. Regarding marital status, the majority are cohabitants with 32.5%; in addition, 36.4% have a minimum salary, which is s/. 930.00. More than half of them are employed or self-employed, and only 3.7% are studying. Finally, 63.3% have a family burden of one to two people.

In total, 222 (51.9%) persons were identified as having a positive psychiatric disorder. Table 2 shows the different patterns of presentation of these disorders.

Table 2: SCREENING FOR MENTAL HEALTH DISORDERS IN VICTIMS OF VIOLENCE

Classification	N	%
Anxiety/Depression	72	32.4
Psychotic Disorder	39	17.6
Anxiety/Depression + Psychotic Disorder	39	17.6
Anxiety/Depression + Psychotic + Seizure Disorder	18	8.1
Anxiety/Depression + Psychotic + Alcoholism	18	8.1
Psychotic + Psychotic + T. Convulsive + Alcoholism	18	8.1
Alcoholism + Psychotic T.	6	2.7
Anxiety/Depression + Alcoholism	6	2.7

Seizure Disorder	3	1.4
Psychotic + Seizure disorder	3	1.4
Total	222	100

From the data obtained, it can be seen that 32.4% of the study population could present anxiety/depression and 17.6% could present some psychotic disorder. Likewise, 17.6% could present anxiety/depression plus some psychotic disorder.

Table 3 shows the association between sociodemographic characteristics and mental health with the level of risk of violence, where sex, age, educational level, place of birth, marital status, economic income, occupation and family burden were statistically significant. No significant association was found between the assessment of risk of violence and the possible presence of at least one psychiatric disorder.

Table 3: FACTORS ASSOCIATED WITH VIOLENCE RISK ASSESSMENT

Characteristics	**Violence Risk Assessment**						**p-value**
	Mild		**Moderate**		**Severe**		
	N	**%**	**N**	**%**	**N**	**%**	
Sex							
Female	153	38.4	162	40.7	83	20.9	**0.001**
Male	21	70	9	30	0	0	
Age							
From 18 to 25 years	9	23.7	12	31.6	17	44.7	
From 26 to 40 years old	66	37.9	81	46.6	27	15.5	**0.000**
From 41 to 60 years	75	44.6	69	41.1	24	14.3	
61 to 80 years of age	24	50	9	18.8	15	31.3	
Level of education							
Illiterate	3	25	6	50	3	25	
Primary school	30	34.5	27	31	30	34.5	
High school	84	38.5	96	44	38	17.4	**0.003**
Technical	30	50	24	40	6	10	
Higher	27	52.9	18	35.3	6	11.8	
Place of birth							
Arequipa	90	35.9	111	44.2	50	19.9	
Puno	60	57.1	30	28.6	15	14.3	**0.000**
Cusco	21	41.2	15	29.4	15	29.4	
Others*	3	14.3	15	71.4	3	14.3	

Marital Status							
Single	57	43.8	48	36.9	25	19.2	
Married	57	51.4	42	37.8	12	10.8	
Cohabiting partner	42	30.2	60	43.2	37	26.6	**0.001**
Divorced	12	28.6	21	50	9	21.4	
Widowed	6	100	0	0	0	0	
Income							
Less than the minimum wage	42	29.6	57	40.1	43	30.3	
Minimum Wage	45	28.8	84	53.8	27	17.3	**0.000**
Más del sueldo mínimo	87	66.9	30	23.1	13	10	
Occupation							
Housewife	45	26.6	87	51.5	37	21.9	
Self-employed	81	49.1	51	30.9	33	20	
Dependent Worker	42	53.8	30	38.5	6	7.7	**0.000**
Student	6	37.5	3	18.8	7	43.8	
Family Burden							
None	30	49.2	15	24.6	16	26.2	
One to two persons	120	44.3	111	41	40	14.8	**0.000**
Three or more	24	25	45	46.9	27	28.1	
Mental health							
With possible disorders	87	50	93	54.4	42	50.6	0.694
Without possible disorders	87	50	78	45.6	41	49.4	
Total	174	40.7	171	40	83	19.4	

*Moquegua, Lima, Tacna and Pasco

DISCUSSION

The main results of the study were that: the risk of moderate to severe violence was approximately 60%, the prevalence of possible psychiatric disorders was 50%, the most frequent being anxiety/depression (~30%), psychotic disorders (18%) and the combination of both (18%). Associations were found between sex, age, educational level, place of birth, marital status, income, occupation, and family burden with the risk of violence; however, no relationship was found with the mental health of the victims.

This study reflects the high frequency of potential mental disorders in the population of victims of violence. One out of every two people who have suffered violence and have reported it present these problems. This should draw attention to the need to provide mental health care in a timely manner. In addition, it is important to consider that the

study only included victims who have made a report and agreed to participate in the study, which probably underestimates the real frequency of these disorders, considering that those with significant mental disorders or those who presented a greater risk of violence would not have participated in the study. Thus, future studies should take this information into consideration for a better selection and recruitment of the sample, and even make comparisons with a population that does not suffer these types of violence.

Although no association was found between mental health and the risk of violence, this would indicate that there is no difference between the levels of risk of violence in terms of the presence of mental disorders, i.e., once the victim makes the complaint there are already mental health problems, so that it is enough to reach that point to develop the possible disorder. Thus, future studies should include as a comparator a population that does not suffer violence in order to better demonstrate this possible relationship. On the other hand, it was shown that sociodemographic characteristics are associated with the level of risk of violence, indicating that these are risk modifiers and therefore should be taken into account to identify and act in a preventive-promotional manner. Women presented a higher level of risk of violence compared to men, similar to other studies such as Aye W.T. et al. [2], who found that exposure to any form of domestic violence in married people is significantly higher in women than in men and also found that the most common violence was emotional, followed by physical and sexual violence occurring in both sexes.

Younger people (between 18 and 25 years), presented a higher risk of severe violence unlike other studies such as the one conducted by Sandoval-Jurado L. and others [3] found that in Cancun the average age of the study population was 35 years while in a study by Aye W. T. et al. T. et al.[2] found that the prevalence of violence in Myanmar predominated between 40 and 49 years of age. This could probably be due to the fact that the population, being from different places, receives a different education, resulting in a different level of maturity to cope with any type and degree of violence. Likewise, people with a lower level of education presented a higher risk of severe to moderate violence, while those with a higher level of education presented mainly a risk of mild violence, similar to other studies such as the one conducted by García MJ. and Matud P. [21] found that specifically in Spanish women with a lower level of education suffered more psychological violence; meanwhile Orrego S. et al.[22] in their study of men and women found that violence predominated in people whose level of education was secondary school; it can be inferred that the level of education has a great influence on people's knowledge of how to deal with violence, since violence was lower in people with higher levels of education.

Cohabiting persons presented a higher risk of severe violence similar to other studies such as the one conducted by Sandoval-Jurado L. et al.[3] where they found that the risk of violence predominates in people with free union, on the other hand in the study of Aye W.T. et al. 3% were exposed to domestic violence whether physical, sexual or emotional, 21% of them were exposed to all three forms of violence at the same time; and in the research of Orrego S. et al.[22] they found that married or in union people predominate different types of violence, from this it is probably inferred that the partner could be a potential aggressor.

In addition, if the occupation was student, the risk was almost double in relation to housewives or self-employed women, evidence of the high vulnerability of these

people. In the case of people with no family burden, the risk of violence was lower in comparison to other categories, while other studies such as the one developed by Garcia MJ. and Matud P. [21] found that Spanish women suffer more psychological violence in those who have more children.

At a general level, Aye W.T. et al. [2] report a high prevalence of different types of domestic violence in both women and married men whose age ranges from 18 to 49 years, finding that there is an association between exposure to domestic violence and mental distress. Guzmán C. et al. [13] conclude that adult women working in a health center in Mexico have an elevated risk of depression associated with intimate partner violence. Garcia MJ. and Matud P. [21] indicate that the results found are evidence that intimate partner violence, and even more so in the psychological area, is an important threat to the mental health of the women affected. Orrego S. et al. [22] mention that it is important to take into account other traumatic events such as interpersonal and intrafamilial violence, among the factors that can affect the mental health of those who have suffered violence. All agree that it is vitally important to develop a model of care or implement strategies that develop protective factors and thus avoid or at least help to reduce the different forms of violence both to women and to the various members of the family group.

The limitations of the study include the fact that the population was only circumscribed to a single area of the Arequipa region, so these data could not be generalized to the entire Arequipa region or to other different realities. However, these results show the problems of a sector of the population and should therefore encourage the development of future studies with a broader scope. Similarly, mental health was measured through a questionnaire for rapid screening of common psychiatric disorders, so a high false positive rate is possible. Future studies should incorporate psychiatric evaluation to establish a better diagnosis of these disorders.

CONCLUSIONS

It is concluded that in female victims of intimate partner violence and older adult victims of family violence, the level of risk of violence was higher in females, younger, less independent and less economically capable, as well as less educated or whose marital status was that of cohabitant. Mental health was not different according to the different levels of risk of violence, although the prevalence of possible psychiatric disorders was approximately 50%, with a predominance of anxiety/depression and psychotic disorders. It is important to work on preventive-promotional activities with emphasis on sociodemographic characteristics considered as risk conditions in order to plan operative strategies to reduce, raise awareness and achieve changes in behavior and attitudes related to violence and in probable risks of having mental health diseases.

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