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Programa de Doctorado en Psicología

PERCEPCIÓN DE LA VIOLENCIA DE GÉNERO Y SU INFLUENCIA EN LA VALORACIÓN DE RIESGO Y TOMA DE DECISIONES DIRIGIDAS A LA PROTECCIÓN DE POTENCIALES VÍCTIMAS

PERCEPTION OF INTIMATE PARTNER VIOLENCE AGAINST WOMEN AND ITS INFLUENCE ON RISK ASSESSMENT AND DECISION-MAKING AIMED AT PROTECTING POTENTIAL VICTIMS

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Resumen

La violencia de género (VG) constituye un grave problema de salud pública y una violación de los derechos humanos de las mujeres (Organización Mundial de la Salud; OMS, 2021). A nivel mundial se estima que casi un tercio de ellas ha sufrido violencia física o sexual en su relación de pareja (OMS, 2022). En España esta cifra se mantiene, siendo el 32,4% de mujeres las que indican haber sufrido algún tipo de violencia por parte de su pareja actual o pasada (Ministerio de Igualdad, 2020). Las consecuencias de la VG son devastadoras tanto para la salud física y mental de las víctimas –causando lesiones, dolores crónicos, trastornos de ansiedad, depresión, o estrés postraumático, entre otros– como para la sociedad en su conjunto suponiendo un alto coste económico y social (Campbell, 2002; López-Ossorio et al., 2018; OMS, 2021;2022; Valpied y Hegarty, 2015; Wang, 2016).

A pesar de ello, en el contexto español, el 66,9% de las mujeres víctimas de VG no busca ayuda formal mediante servicios legales o sanitarios, llamando al teléfono 016, solicitando casa de acogida o denunciando su situación (tan solo el 21,7% lo hace) (Ministerio de Igualdad, 2020). Sin embargo, a consecuencia de los problemas de salud derivados de la exposición a la VG, las mujeres acuden con frecuencia a los centros sanitarios (p.ej., atención primaria o urgencias) con motivos de consulta encubiertos, siendo fundamental una respuesta de detección e intervención adecuada por parte de las y los profesionales del ámbito sanitario (Campbell, 2002; Coll-Vinent et al., 2008; OMS, 2022; Ruiz-Pérez et al., 2004). Pero, las respuestas sanitarias ante la VG sólo reflejan el 7,8% del total de denuncias, indicando una posible falta de conciencia e implicación en ayudar a las víctimas desde su ámbito de trabajo, detectando y abordando la VG (Consejo General del Poder Judicial, 2023; Lorente, 2020). En este sentido, el apoyo a las víctimas es fundamental para disminuir la probabilidad de victimización y ayudarlas a salir de la relación violenta (Ministerio de Igualdad, 2020; OMS, 2022; Parker et al., 2020; Yamawaki et al., 2012). No obstante, todo parece apuntar a que sigue presente cierto clima de tolerancia hacia la VG donde, partiendo de un supuesto contexto de

igualdad en la sociedad española, se podría considerar que no existe tal discriminación hacia las mujeres y, por tanto, se intentaría justificar lo injustificable (p.ej.; ella podría haberlo evitado) e incluso negar la VG como tal, argumentando que la violencia es bidireccional, sufriéndola por igual hombres y mujeres. Todo ello, dificultaría que las víctimas rompan el silencio y que la sociedad en general responda activamente ante esta problemática (Expósito, 2022; Gracia, 2004).

Por ello, la presente tesis doctoral tiene como objetivo principal profundizar en la comprensión del proceso de toma de decisión respecto a las respuestas de ayuda o búsqueda de ayuda en casos de VG por parte de diferentes actores. Concretamente, explora el proceso de decidir dejar la relación violenta o buscar ayuda en víctimas de VG, así como la voluntad de intervención en casos de VG por parte de las y los profesionales sanitarios que las atienden. Para el desarrollo de la tesis doctoral se combinaron métodos cuantitativos y cualitativos, cumplimentando los y las participantes encuestas online y asistiendo a entrevistas grupales.

Esta tesis doctoral está formada por un total de cinco capítulos. En el **Capítulo 1** se realiza una introducción teórica sobre la violencia hacia las mujeres. Más concretamente, se profundiza en la conceptualización de la VG y sus consecuencias a nivel social e individual, así como en las teorías explicativas. Posteriormente, se centra en la normativa española para combatir la VG, describiendo la Ley 1/2004, de Medidas de Protección Integral contra la VG vigente en España para dar respuesta a esta problemática. Seguidamente se proporciona información respecto a la detección de la VG y, a continuación, se recogen las principales variables individuales y relacionales que suponen un obstáculo para la toma de decisión encaminada a la protección de las víctimas de VG por parte de las propias mujeres y de las y los profesionales del ámbito sanitario. Por último, se describen los objetivos generales y específicos de la tesis doctoral.

Los **Capítulos 2, 3,** y **4** conforman la parte empírica de esta tesis doctoral, en la que se recogen varios artículos científicos. Concretamente, en el **Capítulo 2**, con el objetivo de sintetizar y analizar la información disponible sobre cómo se percibe y se identifica la VG por parte de la sociedad en su conjunto, se realizaron dos estudios. El *Estudio 1* consistió en un análisis bibliométrico, sin límite temporal, de la documentación disponible sobre la temática en la base de datos Scopus. Los resultados mostraron un aumento en el interés de la producción científica –mayoritariamente de artículos originales–, sobre la percepción de gravedad de la VG y la identificación de las mujeres como víctimas. Igualmente, se constató un predominio de autoría única por país, siendo puntero Estados Unidos. Entre los estudios más destacados se encontraban los relacionados con: 1) la detección de la VG por parte del personal sanitario; 2) la valoración del riesgo de reincidencia mediante la percepción de las víctimas; y 3) las percepciones y actitudes de diferentes actores hacia la VG. En el *Estudio 2* se realizó una revisión sistemática y meta-análisis de la información disponible sobre la percepción de gravedad de la VG, así como de las variables actitudinales relacionadas con dicha percepción, analizando las diferencias en función del género. Se pudo observar cómo los hombres percibían la VG menos grave que las mujeres. Asimismo, se halló una relación negativa entre la percepción de gravedad de la VG y las actitudes favorables hacia la problemática como son el sexismo, la culpabilización de la víctima, la exoneración del agresor, la aceptación de mitos sobre violencia sexual y los roles de género tradicionales. Este estudio mostró la literatura disponible respecto a la percepción de gravedad de la VG, con qué variables se relaciona y en qué tipo de población se ha evaluado, observando que son casi inexistentes los estudios que se centran en la percepción de gravedad de la VG en poblaciones específicas como son las propias mujeres víctimas (n = 2) o las y los profesionales del ámbito sanitario que las atienden (n = 2).

En base a los resultados obtenidos en el **Capítulo 2** "Revisión bibliográfica", se planteó el estudio de la percepción de gravedad de la VG, así como su influencia en el proceso de toma

de decisión en población específica: 1) víctimas de VG; y 2) profesionales sanitarios. El **Capítulo 3** consta de cuatro estudios (*Estudio 3, 4, 5* y *6*) centrados en investigar el proceso de toma de decisión en víctimas de VG. Dado que se requería contar con un instrumento adecuado que permitiera detectar a las mujeres que han sufrido o sufren cualquier tipo de violencia física, psicológica, sexual o conductas de control por parte de su pareja o expareja, en el *Estudio 3* se validó y adaptó a la población española el instrumento de referencia de la OMS "World Health Organization's Violence Against Women Instrument" (OMS, 2005), el cual ha sido ampliamente utilizado en todo el mundo como instrumento de cribado. La validación y adaptación española del instrumento permitió mejorar la versión original, eliminando dobles preguntas e incluyendo la medición de la frecuencia de ocurrencia de la violencia. Se obtuvo una validez de la estructura interna del instrumento adecuada, con subescalas equivalentes a las del instrumento original, diferenciando entre violencia física, psicológica, sexual y conductas de control. Este trabajo ha sido esencial para disponer en España de un instrumento para la detección de las diferentes manifestaciones de la VG en diversos contextos –ámbito sanitario, educativo y de investigación– y para realizar comparaciones intra e inter-países.

En los *Estudios 4, 5* y *6* del **Capítulo 3** se exploraron las variables implicadas en el proceso de toma de decisión en mujeres víctimas de VG. Concretamente, el *Estudio 4* pretendió explorar las diferencias en la toma de decisión sobre la pareja según las mujeres informaran de conflictos de pareja o VG. Adicionalmente, también se estudió la percepción del riesgo de reincidencia de la VG por parte de las mujeres víctimas de este tipo de violencia. La toma de decisión se centró en el uso de las estrategias de *lealtad* y de *huida*, utilizando la adaptación española de la escala "Accommodation Among Romantic Couples Scale (Valor-Segura et al., 2020). Se seleccionaron estas estrategias porque la lealtad en situaciones de conflicto de pareja puede ser considerada como una estrategia constructiva, pero, en el caso de VG, puede tener consecuencias destructivas para las mujeres y mantenerlas expuestas a la violencia con las

consecuencias que ello conlleva (Overall et al., 2010). Asimismo, la estrategia de huida es de máximo interés para entender qué lleva a las mujeres víctimas de VG a romper o no con la relación violenta. Para discriminar entre aquellas mujeres víctimas de VG (vs. no) se les pidió que indicasen el conflicto más grave acontecido en su relación de pareja y, posteriormente cumplimentaron el instrumento para detectar la VG de la OMS (2005). En base a sus respuestas en este último instrumento, se clasificaron las mujeres en dos condiciones: 1) conflictos de pareja; y 2) VG. Finalmente, se testó un modelo explicativo sobre la asociación entre informar (vs. no) de VG y el uso de estrategias de lealtad y huida teniendo en cuenta el efecto mediador de la dependencia emocional y el compromiso con la relación, así como el efecto moderador del sexismo. En primer lugar, se encontró que las mujeres que informaron sufrir VG, tenían mayores niveles de sexismo benevolente y dependencia emocional y utilizaban más la estrategia de huida en comparación con aquellas mujeres que sólo presentaban conflictos de pareja. Seguidamente, el modelo explicativo mostró que, altos niveles de dependencia emocional y compromiso con la relación predecían un menor uso de la estrategia de huida en el grupo de las mujeres víctimas de VG, pero no en el grupo de conflicto de pareja. El modelo no arrojó resultados significativos para la estrategia de lealtad ni efecto moderador del sexismo benevolente. Por último, entre el 30-40% de las mujeres víctimas de VG no percibían riesgo de reincidencia por parte de su pareja en un futuro. Esta percepción se reducía considerablemente cuando se trataba de violencia física o sexual (vs. psicológica). Este estudio ha permitido ampliar la evidencia empírica previa y aporta hallazgos novedosos para comprender la complejidad que supone la toma de decisiones respecto a la relación de pareja, especialmente en mujeres víctimas de VG donde la dependencia emocional y el compromiso con la relación dificultan el uso de la estrategia de huida. Igualmente, los resultados obtenidos generaron nuevas preguntas de investigación en las que contemplar la posible influencia de la percepción de riesgo de las mujeres en la decisión de romper con la relación violenta.

Resumen

Al hilo del *Estudio 4*, se planteó el *Estudio 5* para indagar en las barreras psicológicas que encuentran las mujeres víctimas de VG para buscar ayuda. Para ello, se testó un modelo conceptual en el que esclarecer los efectos mediadores de la gravedad de la VG percibida y la valoración del riesgo para la vida, en la relación entre, la dependencia hacia la pareja y la búsqueda de ayuda, diferenciando según el tipo de violencia (física, psicológica o sexual). Los resultados confirmaron, para los tres tipos de VG (física, psicológica y sexual), que mayores niveles de dependencia hacia la pareja en mujeres víctimas de VG, se relacionaban con una menor percepción de gravedad de la VG, menor percepción del riesgo para la vida y, por tanto, menor probabilidad de buscar ayuda. Finalmente, con el objetivo de continuar indagando en las barreras que presentan las víctimas de VG para verbalizar su situación y buscar ayuda, en el *Estudio 6* se realizaron dos estudios combinando métodos cualitativos y cuantitativos. La primera parte del *Estudio 6* consistió en una entrevista a un grupo de mujeres víctimas de VG por parte de su expareja. Las participantes informaron sobre percepciones (p.ej., minimización de la situación), interpretaciones (p.ej., justificación del agresor) y sentimientos (p.ej., culpabilidad) como algunas de las principales barreras que encontraron para salir de la relación violenta. En base a estos hallazgos, el segundo estudio se centró en analizar las consecuencias de la exposición a la VG, evaluando en mujeres (víctimas vs. no víctimas de VG), las barreras informadas en el grupo focal por las víctimas mediante una encuesta online. Se compararon los resultados entre mujeres que informaron (vs. no) sufrir o haber sufrido VG por parte de su pareja o expareja. Las mujeres víctimas de VG obtuvieron puntuaciones más bajas en percepción de gravedad de la VG y atribución de responsabilidad al agresor, así como puntuaciones más altas en sentimientos de vergüenza y culpa que las mujeres que no habían sufrido VG. No se encontraron resultados significativos en la valoración del riesgo y miedo. Ambos trabajos ponen de relieve las consecuencias de la exposición a la VG para las víctimas y su toma de decisión.

Por otro lado, dada la relevancia del papel de los y las profesionales del ámbito sanitario en la detección e intervención en casos de VG, en el **Capítulo 4** "Profesionales del ámbito sanitario" de esta tesis doctoral se investigó acerca de las variables implicadas en su voluntad de intervención. El objetivo fue indagar en los obstáculos que encuentran las y los profesionales del ámbito sanitario para detectar y responder adecuadamente ante la VG. Para dicho fin se llevaron a cabo dos estudios (*Estudio 7* y *8*). El *Estudio 7* tuvo doble objetivo: 1) sintetizar la información disponible en los protocolos de atención a la VG desde el ámbito sanitario en España y analizarla de acuerdo con las directrices de la OMS; 2) conocer la perspectiva de las y los médicos de atención primaria sobre el uso y utilidad de dichos protocolos, así como acerca de los obstáculos que encuentran para detectar y responder adecuadamente ante casos de VG. Los resultados indicaron que los protocolos son insuficientes para abordar la VG desde su ámbito de trabajo. La mayoría de los y las profesionales de este ámbito desconocían su existencia y referían falta de formación en materia de VG y uso de los protocolos como principales obstáculos para ofrecer una respuesta de intervención. También, corroborando la información obtenida en la literatura previa, los y las participantes señalaron la falta de tiempo, sentimientos desagradables y factores culturales, educativos y políticos como impedimentos para responder activamente ante casos de VG. En el *Estudio 8* con el fin de conocer, de manera más precisa, qué variables están involucradas en la toma de decisiones en profesionales de la salud respecto a la VG, se examinó la relación entre las actitudes hacia la VG y la voluntad de intervención en casos de VG por parte de futuros profesionales del ámbito sanitario (estudiantes de medicina, psicología y enfermería), considerando la influencia de la gravedad percibida de la VG en esta relación. En el estudio se encontraron bajas puntuaciones en sexismo y aceptación de la VG, así como altas puntuaciones en percepción de gravedad de la VG y puntuaciones moderadas en voluntad de intervención en casos de VG. Asimismo, se testó un modelo conceptual que indica que a mayores actitudes sexistas, mayor aceptación de la VG, menor

percepción de la gravedad y, en consecuencia, menor voluntad de intervención en casos de VG. Este capítulo ofrece información de interés para entender tanto las herramientas de las que disponen los y las profesionales en atención primaria para responder ante casos de VG, como las variables actitudinales y perceptivas que influyen en su voluntad de intervención.

Finalmente, en el **Capítulo 5** se realiza una discusión general de los principales hallazgos obtenidos en los diferentes estudios que forman parte de esta tesis doctoral, así como de las limitaciones, futuras líneas de investigación e implicaciones para la investigación, la práctica y la política. También se incluye un apartado de conclusiones de los resultados obtenidos en la tesis doctoral.

Con la finalidad de cumplir con los requisitos para obtener la mención de doctorado internacional, en la tesis doctoral se presentan capítulos en español (**Capítulo 1** "Introducción" y **Capítulo 5** "Discusión general") y capítulos en inglés (**Capítulo 2** "Revisión bibliográfica", **Capítulo 3** "Víctimas de violencia de género", **Capítulo 4** "Profesionales del ámbito sanitario", y apartado de Conclusiones). Aunque todos los estudios empíricos incluidos siguen un hilo conductor a lo largo del desarrollo de la tesis doctoral, suponen artículos científicos independientes, presentando cada uno de ellos una introducción, metodología, resultados, discusión y referencias particulares. No obstante, dada la temática común de los artículos, muchas referencias son compartidas. Por ello, con la finalidad de economizar espacio y evitar la repetición de referencias, se incluye el apartado de Referencias al final del documento, agrupando todas las citas incluidas en los ocho estudios presentados en esta tesis doctoral. Todos los estudios están redactados con la idea de ser publicados en revistas científicas con lo que, es posible que cierta información resulte redundante. Los *Estudios 2, 5,* y *6* están escritos y enviados a revistas, encontrándose en proceso de revisión sin estar todavía publicados.

Cabe destacar que, la presente tesis doctoral pretende estudiar el papel de algunas de las variables implicadas en el proceso de toma de decisión para combatir la VG teniendo en

cuenta la perspectiva tanto de las víctimas como de los y las profesionales del ámbito sanitario que las atienden. Para ello, además de ampliar la información respecto a hallazgos obtenidos en investigaciones previas, esta tesis explora la percepción de gravedad y valoración del riesgo como variables clave para entender el proceso de toma de decisión, aportando datos novedosos para el avance científico sobre esta problemática. En este sentido, es escasa la investigación que relaciona estas variables con la toma de decisión teniendo en cuenta la propia valoración de las personas que están expuestas o son testigos de la VG. Partiendo de la premisa de que, para actuar ante un problema es necesario percibirlo como tal y valorar adecuadamente el riesgo que implica, esta tesis doctoral pretende estudiar la relación de estas variables con la búsqueda de ayuda y voluntad de intervención teniendo en cuenta a su vez, la influencia de otras variables —como creencias sexistas, actitudes hacia la VG o dependencia hacia la pareja— en dichas percepciones y valoraciones. Los hallazgos obtenidos permitirán establecer programas de prevención que aumenten la conciencia sobre esta problemática y favorezcan las respuestas de ayuda y búsqueda de ayuda ante situaciones de VG, así como programas de intervención específicos con víctimas que les permitan realizar una valoración ajustada de su situación, salvaguardando así su integridad y la de sus hijas e hijos.

Overview

Intimate partner violence against women (IPVAW) is a serious public health problem and a violation of women's human rights (World Health Organization; OMS, 2021). Globally, it is estimated that almost one-third of women have suffered physical or sexual violence in their relationship (WHO, 2022). This number remains in Spain, with 32.4% of women indicating that they have suffered some type of violence from their current or past partner (Spanish Ministry of Equality, 2020). The consequences of IPVAW are devastating for both the physical and mental health of the victims—causing injuries, chronic pain, anxiety disorders, depression, or posttraumatic stress disorder, among others—and for society as a whole, entailing a high economic and social cost (Campbell, 2002; López-Ossorio et al., 2018; Valpied y Hegarty, 2015; Wang, 2016; WHO, 2021; 2022).

Despite this, in the Spanish context, 66.9% of women victims of IPVAW do not seek formal help through legal or healthcare services, by calling 016, by requesting a shelter, or by reporting their situation (only 21.7% do so) (Spanish Ministry of Equality, 2020). However, because of health problems resulting from exposure to IPVAW, women frequently present to health care facilities (e.g., primary care or emergency rooms) with covert reasons for consultation, and adequate detection and intervention responses from health care professionals are essential (Campbell, 2002; Coll-Vinent et al., 2008; Ruiz-Pérez et al., 2004; WHO, 2022). However, health care responses to IPVAW only reflect 7.8% of the total number of complaints, indicating a possible lack of awareness and involvement in helping victims in their work environment, as well as detecting and addressing IPVAW (Consejo General del Poder Judicial, 2023; Lorente, 2020). In this sense, victim support is essential to reduce the likelihood of victimization and help victims leave a violent relationship (Parker et al., 2020; Spanish Ministry of Equality, 2020; WHO, 2022; Yamawaki et al., 2012). However, everything seems to indicate that there is still a certain climate of tolerance toward IPVAW where, based on a supposed context of equality in Spanish society, it could be considered that there is no such

discrimination against women; therefore, an attempt should be made to justify the unjustifiable (e.g., she could have avoided it) and even deny IPVAW as such, arguing that violence is two-way (i.e., men and women suffer equally from it). All this would make it difficult for the victims to break the silence and for society in general to respond actively to this problem (Expósito, 2022; Gracia, 2004).

Hence, the main objective of this doctoral thesis is to deepen the understanding of the decision-making process regarding the responses to help or offer help-seeking in cases of IPVAW by various actors. Specifically, it explores the process of deciding to leave the violent relationship or to seek help in victims of IPVAW, as well as the willingness to intervene in cases of IPVAW on the part of the health care professionals who attend them. For the development of the doctoral thesis, we combined quantitative and qualitative methods, with participants completing online surveys and attending group interviews.

This doctoral thesis consists of a total of five chapters. **Chapter 1** provides a theoretical introduction to violence against women. More specifically, we delve into the conceptualization of IPVAW and its consequences at the social and individual level, as well as explanatory theories. In response to this problem, we focus on Spanish regulations to combat IPVAW, describing Law 1/2004, on comprehensive protection measures against IPVAW enforced in Spain. Next, we provide information on the detection of IPVAW, followed by the main individual and relational variables that are an obstacle to decision-making aimed at protecting the victims of IPVAW by the women themselves and by health care professionals. Finally, we describe the general and specific objectives of the doctoral thesis.

Chapters 2, 3, and **4** make up the empirical part of this doctoral thesis, in which several scientific articles are collected. Specifically, in **Chapter 2**, with the aim of synthesizing and analyzing the available information on how IPVAW is perceived and identified by society, two studies were conducted. *Study 1* consisted of a bibliometric analysis, with no time limit, of the

available documentation on the subject in the Scopus database. The results showed an increase in the interest of scientific production—mainly original articles—on the perception of the seriousness of IPVAW and the identification of women as victims. There was also a predominance of single authorship by country, with the United States leading the way. Among the most prominent studies were those related to 1) the detection of IPVAW by health care personnel; 2) the assessment of the risk of recidivism through the perception of victims; and 3) the perceptions and attitudes of different actors toward IPVAW. In *Study 2*, we performed a systematic review and meta-analysis of the available information on the perception of IPVAW's severity, as well as of the attitudinal variables related to this perception, analyzing the differences according to gender. We observed how men perceived IPVAW less severely than women. In addition, we found a negative relationship between the perception of the seriousness of IPVAW and favorable attitudes toward the problem such as sexism, guilt of the victim, exoneration of the aggressor, acceptance of myths about sexual violence, and traditional gender roles. This study showed the available literature regarding the perception of IPVAW's severity, with which variables it is related, and in which type of population it has been evaluated, noting that studies focusing on the perception of IPVAW's severity in specific populations such as women victims themselves (n = 2) or health care providers (n = 2) are almost nonexistent.

Based on the results obtained in **Chapter 2** "Bibliographic review", we proposed the study of the perception of IPVAW's severity, as well as its influence on the decision-making process in specific population: 1) victims of IPVAW; and 2) health care professionals. **Chapter 3** consists of four studies (*Studies 3, 4, 5,* and *6*) focused on investigating the decision-making process in victims of IPVAW. Given the need for a suitable instrument to detect women who have suffered or are suffering any type of physical, psychological, or sexual violence or controlling behaviors by their partner or ex-partner, *Study 3* validated and adapted to the

Spanish population the World Health Organization (WHO) reference instrument, WHO's Violence Against Women Instrument (WHO, 2005), which has been widely used throughout the world as a screening instrument. The Spanish validation and adaptation of the instrument improved the original version, eliminating double questions and including the measurement of the frequency of occurrence of violence. The validity of the internal structure of the instrument was obtained, with subscales equivalent to those of the original instrument, differentiating between physical, psychological, sexual, and controlling behaviors. This work has been essential to provide Spain with an instrument for the detection of the different manifestations of IPVAW in different contexts—health, education, and research—and to make intra- and intercountry comparisons.

Studies 4, 5, and *6* in **Chapter 3** explored the variables involved in the decision-making process in women victims of IPVAW. Specifically, *Study 4* sought to explore differences in partner decision-making according to whether women reported couple conflict or IPVAW. Additionally, we also studied the perceived risk of IPVAW recidivism by women victims of IPVAW. Decision-making focused on the use of loyalty and exit strategies, using the Spanish adaptation of the Accommodation Among Romantic Couples Scale (Valor-Segura et al., 2020). We selected these strategies because loyalty in situations of couple conflict can be considered a constructive strategy, but, in the case of IPVAW, it can have destructive consequences for women and continue to expose them to violence with its attendant consequences (Overall et al., 2010). Likewise, the flight strategy is of utmost interest to understand what leads women victims of IPVAW to separate (or not) from the violent relationship. Likewise, the flight strategy is of utmost interest to understand what leads women victims of IPVAW to separate (or not) from the violent relationship. To discriminate between those women who were victims of IPVAW (vs. not), they were asked to indicate the most serious conflict in their relationship and then completed the WHO (2005) IPVAW screening instrument. Based on their responses

in the latter instrument, women were classified into two conditions: 1) couple conflict and 2) IPVAW. Finally, an explanatory model was tested on the association between reporting (vs. not reporting) IPVAW and the use of loyalty and flight strategies considering the mediating effect of emotional dependence and commitment to the relationship, as well as the moderating effect of sexism. First, we found that women who reported experiencing IPVAW had higher levels of benevolent sexism and emotional dependence and used more of the flight strategy compared to those women who only had relationship conflict. Next, the explanatory model showed that higher levels of emotional dependence and commitment to the relationship predicted lower use of the flight strategy in the women IPVAW victim group but not in the couple conflict group. The model did not yield significant results for the loyalty strategy or moderating effect of benevolent sexism. Finally, between 30 and 40% of women victims of IPVAW did not perceive a risk of recidivism by their partner in the future. This perception was considerably reduced when physical or sexual (vs. psychological) violence was involved. This study has allowed us to expand on previous empirical evidence and provides novel findings to understand the complexity of decision-making regarding the relationship, especially in women victims of IPVAW where emotional dependence and commitment to the relationship make it difficult to use the exit strategy. Likewise, the results obtained generated new research questions through which to contemplate the possible influence of women's perception of risk on the decision to break away from the violent relationship.

Building on *Study 4*, *Study 5* was designed to investigate the psychological barriers encountered by women victims of IPVAW in seeking help. To this end, we tested a conceptual model to elucidate the mediating effects of perceived IPVAW severity and life-risk assessment on the relationship between partner dependence and help-seeking, differentiating by type of violence (physical, psychological, or sexual). The results confirmed, for the three types of IPVAW (physical, psychological, and sexual), that higher levels of dependence on the partner

in women victims of IPVAW were related to a lower perception of IPVAW's severity, lower perception of risk to life, and, therefore, lower probability of seeking help. Finally, with the aim of further investigating the barriers that IPVAW victims present to verbalizing their situation and seeking help, two studies combining qualitative and quantitative methods were conducted in *Study 6*. The first part of *Study 6* consisted of an interview with a group of women who were victims of IPVAW by their ex-partner. Participants reported perceptions (e.g., minimization of the situation), interpretations (e.g., justification of the aggressor), and feelings (e.g., guilt) as some of the main barriers they encountered to leaving the violent relationship. Based on these findings, the second study focused on analyzing the consequences of exposure to IPVAW by assessing in women (victims vs. nonvictims of IPVAW) the barriers reported in the focus group by victims through an online survey. We compared results between women who reported (vs. not) suffering or having suffered IPVAW by their partner or ex-partner. Women victims of IPVAW had lower scores on the perceived severity of IPVAW and attribution of responsibility to the perpetrator, as well as higher scores on feelings of shame and guilt than women who had not experienced IPVAW. No significant results were found for risk assessment and fear. Both papers highlight the consequences of exposure to IPVAW for victims and their decision-making.

On the other hand, given the relevance of the role of health care professionals in the detection and intervention in IPVAW cases, in **Chapter 4** of this doctoral thesis "Health care professionals", we investigated the variables involved in their willingness to intervene. The objective was to investigate the obstacles faced by health care professionals to detect and respond adequately to IPVAW. To this end, we carried out two studies (*Studies 7* and *8*). The aim of *Study 7* was twofold: 1) to synthesize the information available in the protocols for IPVAW care in the Spanish healthcare setting and analyze it in accordance with WHO guidelines; and 2) to learn the perspective of primary care physicians on the use and usefulness

of these protocols, as well as on the obstacles they encounter in detecting and responding adequately to cases of IPVAW. The results indicated that the protocols are insufficient to address IPVAW in their field of work. Most of the professionals in this field were unaware of their existence and referred to a lack of training in IPVAW and the use of protocols as the main obstacles to offering an intervention response. Also, corroborating information obtained from previous literature, participants pointed to lack of time, unpleasant feelings, and cultural, educational, and political factors as impediments to actively responding to cases of IPVAW. *Study 8*, with the aim of learning more precisely what variables are involved in decision-making in health care professionals regarding IPVAW, examined the relationship between attitudes toward IPVAW and future health care professionals' (medical, psychology, and nursing students') willingness to intervene in cases of IPVAW, considering the influence of the perceived severity of IPVAW on this relationship. The study found low scores on sexism and acceptance of IPVAW, as well as high scores on the perceived severity of IPVAW and moderate scores on the willingness to intervene in cases of IPVAW. In addition, a conceptual model was tested indicating that when sexist attitudes are higher, the acceptance of IPVAW was greater, the perception of severity was lower, and, consequently, the willingness to intervene in IPVAW cases was lower. This chapter provides information of interest for understanding both the tools available to primary care professionals to respond to cases of IPVAW and the attitudinal and perceptual variables that influence their willingness to intervene.

Finally, **Chapter 5** provides a general discussion of the main findings obtained in the various studies that are part of this doctoral thesis, as well as the limitations, future lines of research, and implications for research, practice, and policy. It also includes a conclusionary section of the results obtained in the doctoral thesis.

To meet the requirements for obtaining the international doctoral degree, the doctoral thesis presents chapters in Spanish (**Chapter 1** "Introduction" and **Chapter 5** "General discussion") and chapters in English (**Chapter 2** "Bibliographic review", **Chapter 3** "Victims of IPVAW", **Chapter 4** "Health care professionals", and Conclusions). Although all of the empirical studies included follow a common thread throughout the development of the doctoral thesis, they are independent scientific articles, each presenting an introduction, methodology, results, discussion, and specific references. However, given the common theme of the articles, we shared many references. Therefore, to save space and avoid repeating references, we included a References section at the end of the document grouping all of the citations included in the eight studies presented in this doctoral thesis. All of the studies are written with the idea of being published in scientific journals, so it is possible that some information may be redundant. *Studies 2, 5*, and *6* have been written and submitted to journals and are in the process of being reviewed but have not yet been published.

It should be noted that this doctoral thesis aims to study the role of some of the variables involved in the decision-making process to combat IPVAW, as the perspective of both the victims and health care professionals who care for them. To this end, in addition to expanding the information on findings obtained in previous research, this thesis explores the perception of severity and risk assessment as key variables to understand the decision-making process, providing new data for scientific progress on this problem. In this sense, little research has been done that relates these variables to decision-making considering the assessment of people who are exposed to or witness IPVAW. Based on the premise that, in order to act on a problem, it is necessary to perceive it as such and adequately assess the risk involved, this doctoral thesis aims to study the relationship of these variables with help-seeking and the willingness to intervene, bearing in mind the influence of other variables, such as sexist beliefs, attitudes toward IPVAW, and dependence on the partner, on these perceptions and assessments. The

findings obtained will make it possible to establish prevention programs that increase awareness of this problem and favor help-seeking responses to situations of IPVAW, as well as specific intervention programs with victims that allow them to make an accurate assessment of their situation, thus safeguarding their integrity and that of their children.

CAPÍTULO 1: Introducción

CHAPTER 1: Introduction

El día en que una mujer pueda amar no en su debilidad sino en su fuerza, no escapar de sí misma sino encontrarse, no humillarse sino afirmarse, ese día el amor será para ella como para el hombre: fuente de vida y no de peligro mortal.

(Simone de Beauvoir)

1. Violencia contra las mujeres

En 1993, la Asamblea General de la Organización de Naciones Unidas (ONU) emite la declaración sobre la eliminación de la violencia contra la mujer, en la que la reconoce como "todo acto de violencia basado en la pertenencia al sexo femenino que tenga o pueda tener como resultado un daño o sufrimiento físico, sexual o psicológico para la mujer, así como las amenazas de tales actos, la coacción o la privación arbitraria de la libertad, tanto si se producen en la vida pública como en la vida privada" (ONU, 1993). Concretamente, en el Convenio de Estambul, se contempla la violencia contra las mujeres como un delito que puede manifestarse de múltiples formas como son la violencia física, psicológica y sexual, incluida la violación; la mutilación genital femenina, el matrimonio forzado, el acoso, el aborto o esterilización forzada, la explotación sexual y trata, así como feminicidio, infanticidio femenino, violencia política o violencia económica, entre otras (Boletín Oficial del Estado, 2011). La violencia contra las mujeres es uno de los principales obstáculos para alcanzar los objetivos de igualdad real y efectiva, desarrollo y paz, impidiendo el disfrute de los derechos humanos y libertades fundamentales (Ministerio de Derechos Sociales y Agenda 2030, 2021; ONU, 1995).

Todas las violencias contra las mujeres repercuten gravemente en su desarrollo como seres humanos y están reconocidas como un problema de salud pública que genera pérdidas, en ocasiones irreparables, en las esferas biológica, psicológica y social de las mujeres (OMS; 1996; 2022; ONU, 1993). En particular, una de cada dos mujeres en España refiere haber sufrido algún tipo de violencia, desde una mirada lasciva a una violación (Ministerio de Igualdad, 2020). Entre las diferentes violencias que sufren las mujeres, la mayor parte es perpetrada por sus parejas o exparejas, quienes, como máxima expresión de la violencia, pueden llegar incluso a asesinarlas (United Nations Office on Drogs and Crime, 2021). Para las mujeres, entender que su pareja, quien supuestamente dice que las ama, es capaz de someterlas y hacerles daño intencionadamente, no es tarea sencilla debido a las referencias de

una cultura androcéntrica. Por ello, la presente tesis doctoral se centra en el estudio de la VG en España en el contexto de las relaciones de pareja.

1.1. Violencia de género

En España, la VG implica cualquier comportamiento intencional que cause daño físico (p.ej., empujones o palizas), sexual (p.ej., tocamientos o violación) o psicológico (p.ej., insultos o humillaciones), así como a comportamientos de control (p.ej., aislamiento o vigilancia) hacia las mujeres por parte de la pareja o expareja (Devries et al., 2013; OMS, 2022). No se trata de una violencia determinada por el contexto en el que se produce (p.ej., ámbito doméstico), sino que se trata de una violencia construida sobre referencias socioculturales de desigualdad y relaciones de poder de los hombres sobre las mujeres quienes, podrían asumir la violencia como una opción para corregir o castigar a aquellas mujeres con las que establecen una relación de pareja y que no se ajustan al modelo social establecido y determinado por la cultura patriarcal (Lorente et al., 2022).

Esta violencia, ejercida del hombre hacia la mujer, conlleva serias consecuencias tanto para las mujeres que la sufren como para la sociedad en general (López-Osorio et al., 2018; OMS, 2022). Concretamente, las víctimas de VG presentan múltiples problemas de salud física (p.ej., fracturas o dolor crónico), mental (p.ej., ansiedad o depresión), sexual y reproductiva (p.ej., embarazos no deseados) e incluso consecuencias fatales (p.ej., homicidio o suicidio) (Campbell, 2002; Ellsberg et al., 2008; OMS, 2022; Sans y Sellarés, 2010; Sarasua el al., 2007; Wang, 2016). Del mismo modo, para dar respuesta a la VG se necesitan recursos en justicia, sanidad, servicios sociales y educación, entre otros, lo que supone un elevado coste social y económico con efecto dominó en toda la sociedad (Ministerio de la Presidencia, Relaciones con las Cortes e Igualdad, 2016; OMS, 2021). En particular, el coste anual de la VG en la Unión Europea supone 366.000 millones de euros y en España 30.000 millones, de los que el 56% están destinados a abordar los problemas de salud que esta violencia ocasiona a las mujeres

(Instituto Europeo para la Igualdad de Género, 2021). Concretamente, las víctimas de VG presentan peor salud en general que las mujeres que no están expuestas a este tipo de violencia y acuden con frecuencia a los centros sanitarios con motivos de consulta encubiertos y síntomas de difícil filtraje (Campbell, 2002; Coll-Vinent et al., 2008; OMS, 2022; Ruiz-Pérez et al., 2004; Sans y Sellarés, 2010). En este sentido, las y los profesionales del ámbito sanitario son un recurso referente para que las víctimas revelen su situación, siendo su papel fundamental en la detección y respuesta de ayuda ante la VG (Fernández, 2015; Garcia-Moreno et al., 2014; Ruiz-Pérez et al., 2004). Por ello, uno de los principales objetivos de esta tesis doctoral fue el estudio de las variables relacionadas con la respuesta de los y las profesionales del ámbito sanitario ante casos de VG.

1.1.1. Teorías explicativas

Múltiples marcos teóricos han intentado explicar el origen y mantenimiento de la VG, desde la inclusión de teorías, hoy obsoletas, centradas en la explicación unicausal de la VG a partir de factores individuales del agresor o de la víctima, hasta teorías socioculturales que apuntan a que la violencia tiene un origen multicausal derivado de las estructuras sociales, culturales, políticas e ideológicas. Teniendo en cuenta la complejidad que supone la VG, se requiere su consideración a partir de modelos multicausales. Todos ellos explican la VG desde el contexto general de las desigualdades de poder entre hombres y mujeres tanto a nivel individual como grupal, nacional y mundial (Bosch y Ferrer, 2019). Algunos de los modelos explicativos multicausales existentes son: 1) teoría del aprendizaje social (Bandura, 1987); 2) modelo ecológico (Bronfenbrenner, 2002); 3) teoría de los recursos (Goode, 1971); o 4) teorías feministas (Barnett et al., 2018; Bograd, 1988; Disch y Hawkesworth, 2016; Dobash y Dobash, 1979; West y Zimmerman, 1987).

Concretamente, esta tesis doctoral se apoya en el feminismo para comprender el papel del patriarcado y las desigualdades entre hombres y mujeres en el origen y mantenimiento de

la VG (Barnett et al., 2018). A partir de las teorías feministas se ha contribuido a conceptualizar e investigar la VG (Disch y Hawkesworth, 2016), entendiéndola como un fenómeno funcional del sistema patriarcal que mantiene el orden establecido mediante la construcción social y la desigualdad de poder que conducen al privilegio de los hombres y a la opresión de las mujeres (Bograd, 1988; Delegación del Gobierno para la Violencia de Género, 2019; Dobash y Dobash, 1979; West y Zimmerman, 1987). Por tanto, la VG no es un problema individual o familiar, ni un comportamiento puntual o patológico, es una manifestación del sistema, un reflejo de las normas sociales que toleran la VG y la dominancia de los hombres sobre las mujeres (Expósito, 2022; Ferrer y Bosch, 2005).

En este sentido, la VG se diferencia de otro tipo de violencias por la presencia de los componentes estructurales, de control y aislamiento que se manifiestan en un contexto de cultura patriarcal que permite aflorar estos componentes, definiendo una forma de organización sociocultural en el que las mujeres son sometidas como objeto de control y dominio por parte de los hombres (Cantera, 2007; European Institute for Gender Inequality, 2020; Expósito, 2022; Lorente, 2020). El componente estructural de la VG es una consecuencia de los elementos culturales y de organización social que conllevan efectos negativos sobre las oportunidades de supervivencia y bienestar, identidad o libertad de las mujeres, colocándolas en una situación de vulnerabilidad (Galtung, 1996; Lorente, 2020; Montesanti, 2015). En el caso de la VG, las políticas sanitarias, económicas, educativas y sociales serían un ejemplo de violencia estructural que contribuye a la desigualdad de género en la relación de pareja (OMS, 2002; 2019). Asimismo, el control asimétrico sobre la mujer por el mero hecho de serlo –qué hace, dónde va, con quién– constituye un factor de riesgo para el homicidio cuando el agresor percibe la pérdida de control sobre la mujer, a quien considera de su dominio y su propiedad. Mediante este control, el agresor consigue aislar a la mujer de su entorno (p.ej., familia o

amistades), reduciendo las posibilidades de que la víctima encuentre apoyo en otras personas y favoreciendo la cronificación e invisibilización de la violencia (Lorente, 2022).

1.1.2. Normativa

La VG ha pasado de ser un problema perteneciente al ámbito privado "cuestiones de pareja", a un problema público y de responsabilidad social. Un problema social es cuando una parte significativa de la sociedad percibe y define el problema como tal, en este caso la VG, y pone en marcha acciones para abordarlo (Bosch y Ferrer, 2000; Expósito, 2022). Concretamente, la normativa disponible a nivel internacional, europeo y estatal refleja parte de los avances en el reconocimiento y abordaje de la VG como un problema social que afecta a las mujeres a nivel mundial. Sin embargo, esto no es suficiente y se requiere un compromiso unánime en el que las mujeres tengan acceso a los mismos derechos y libertades en cualquier parte del mundo pues, todavía encontramos 49 países en los que no existen leyes que protejan a las mujeres frente a la VG (Naciones Unidas, 2023).

En España, donde se enmarca la presente tesis doctoral, contamos con la Ley Orgánica 1/2004, de 28 de diciembre, de Medidas de Protección Integral contra la Violencia de Género, como la principal normativa desarrollada en materia de VG. En ella se define la VG como la violencia que se ejerce sobre las mujeres por el mero hecho de serlo, manifestando el símbolo más brutal de desigualdad en la sociedad española. Esta ley garantiza los derechos y libertades de todas las mujeres y pretende dar respuesta a las recomendaciones de organismos internacionales. Para ello, proporciona una respuesta integral a la VG que abarca tanto aspectos preventivos, educativos, sociales, asistenciales y de atención posterior a la víctima, como la normativa civil que incide en el ámbito familiar o de convivencia.

Asimismo, la Ley Orgánica 1/2004 propone planes de sensibilización y formación en el ámbito sanitario para la detección precoz y lucha contra la VG, planteando la puesta en marcha de protocolos de atención a la VG desde sanidad. En consecuencia, en España se han

desarrollado protocolos nacionales y autonómicos como herramientas fundamentales para dar respuesta a la VG desde la perspectiva sanitaria. Estos protocolos deberían definir y sistematizar las actuaciones de detección e intervención desde los centros sanitarios, resultando prácticos y útiles para que los y las profesionales del ámbito sanitario puedan ejecutarlos (Fernández et al., 2015). Sin embargo, la disponibilidad de herramientas adecuadas para dar respuesta a la VG desde este ámbito puede no ser suficiente, requiriendo que las y los profesionales conozcan dichas herramientas y las pongan en práctica. En esta línea, uno de los objetivos de esta tesis doctoral fue examinar la homogeneidad y cumplimiento de las directrices propuestas por la OMS de los protocolos disponibles en España y por comunidades autónomas, así como la opinión de las y los profesionales del ámbito sanitario respecto a dichos protocolos, indagando asimismo en los obstáculos que pueden encontrar para responder adecuadamente ante la VG. Los resultados obtenidos proporcionarán información de relevancia para establecer intervenciones específicas que aborden los obstáculos para adoptar una actitud proactiva ante la VG desde el ámbito sanitario, abordando realmente la problemática desde su aplicación práctica y no meramente teórica.

1.1.3. Prevalencia

La VG es omnipresente y devastadora. Se estima que afecta a una de cada tres mujeres en el mundo, constituyendo un problema de salud pública que requiere una respuesta social urgente (OMS, 2022). Una revisión sistemática reciente (Sardinha el al., 2022) recogió datos de prevalencia de 161 países y concluyó que, en torno al 27% de mujeres de 15 años en adelante había sufrido violencia física y sexual a lo largo de su vida, con inicio en edades tempranas (24%). Asimismo, se observó una amplia variabilidad en cuanto a la prevalencia entre países (16-49 %), situándose Europa central, Asia central y Europa occidental con las menores tasas mundiales de prevalencia (16%, 18% y 20% respectivamente). En cuanto a la Unión Europea, las cifras revelaron alrededor de un 22% de prevalencia de violencia física o sexual, así como

un 43% de violencia psicológica en mujeres de 28 países distintos (European Union Agency for Fundamental Rights, FRA, 2014). Concretamente, en España, un 32,4% de mujeres informa de haber sufrido VG (física, sexual o psicológica) a lo largo de su vida y un 10,8% en los últimos 12 meses (Ministerio de Igualdad, 2020). Estos datos son preocupantes ya que, además de las serias consecuencias que conlleva la VG para la salud e integridad de las mujeres, desde 2003 en España se han registrado más de 1.200 asesinatos de mujeres a manos de sus parejas o exparejas. Estas cifras, que por desgracia siguen en aumento, sólo representan la punta del iceberg de la problemática, la máxima expresión de la VG que siempre viene precedida de manifestaciones previas, en ocasiones sutiles y normalizadas que requieren de una identificación y respuesta precoz por parte de la sociedad en su conjunto.

La variabilidad en la prevalencia de la VG entre países puede ser explicada por múltiples factores, como el uso de diferentes terminologías o el tipo de metodología empleada para detectarla (Garcia-Moreno et al., 2006; Nybergh et al., 2013). En este sentido, a pesar de que la VG está reconocida mundialmente, no todos los países utilizan la misma nomenclatura para referirse a este tipo de violencia. Algunos de los términos empleados son “violencia doméstica”, “violencia intrafamiliar”, “violencia interpersonal”, “violencia bidireccional”, “violencia machista” o “violencia en la pareja”, entre otros. Esto puede dar lugar a confundir la VG con otro tipo de violencias con orígenes y motivaciones distintas, invisibilizando los elementos socioculturales que conforman las raíces de la VG y atribuyen roles y espacios a cada sexo para construir su identidad y desarrollo en la sociedad (Lorente et al., 2022). Igualmente, a nivel mundial encontramos múltiples y variados instrumentos para detectar la VG. En particular, en España, aunque se encuentran disponibles adaptaciones de instrumentos norteamericanos para detectar la VG, no se cuenta con un instrumento de cribado universal en mujeres españolas que permita detectar si sufren violencia física, psicológica, sexual o

conductas de control por parte de su pareja o expareja (Escuela Andaluza de Salud Pública, 2005).

Por lo tanto, será conveniente disponer de un instrumento universal que permita establecer comparaciones y evaluar la VG al unísono. Para ello, entre los objetivos de la presente tesis doctoral, se adaptó y validó en una muestra de mujeres españolas el instrumento de referencia de la OMS para identificar la VG física, sexual, psicológica o conductas de control.

1.2. Detección de la violencia de género

Gran parte de la identificación de la VG depende de la información que se obtenga de las personas implicadas con los sesgos y distorsiones que ello conlleva (Escuela Andaluza de Salud Pública, 2005). En este sentido, la mayoría de las mujeres sufren la violencia en silencio y tardan una media de ocho años en verbalizar o denunciar su situación, a pesar de las graves consecuencias que ésta implica para su salud (Ministerio de Igualdad, 2020; Satyen et al., 2019; Wang, 2016). Este silencio dificulta la identificación de la VG, así como la consecuente respuesta de ayuda por parte del entorno. No obstante, a raíz de las afectaciones en la salud que conlleva la VG, algunas mujeres acuden con frecuencia a los servicios de atención sanitaria, los cuales son espacios privilegiados para la detección de la VG pues, a la mayoría de ellas no les importaría ser preguntadas rutinariamente por si sufren VG e identifican a los y las profesionales de este ámbito como referentes para revelar su situación (FRA, 2014; Garcia-Moreno et al., 2014; Ministerio de Igualdad, 2020).

En este sentido, la OMS (2005), entidad referente en materia de VG, desarrolló un instrumento de cribado universal en 10 países para detectar la violencia física, psicológica, sexual o conductas de control que las mujeres sufren por parte de su pareja o expareja. Este instrumento ha sido ampliamente utilizado, permitiendo establecer la prevalencia de la VG en diferentes partes del mundo. Sin embargo, en España, el instrumento de la OMS no ha sido

validado ni adaptado constituyendo esto uno de los objetivos de esta tesis doctoral. La validación y adaptación de este instrumento en mujeres españolas podrá aplicarse en diferentes contextos –sanitario, educativo, investigación– y permitirá obtener prevalencias y realizar comparaciones intra y entre países, asegurando a la vez unas propiedades psicométricas adecuadas.

1.3. Obstáculos para la toma de decisiones encaminadas a la protección de las víctimas de violencia de género

Dejar una relación de pareja es una decisión complicada a la que muchas personas pueden enfrentarse a lo largo de su vida (Garrido-Macías et al., 2017). Aunque a priori pudiera parecer lógico pensar que, la vulneración de los derechos y libertades como persona por parte de la pareja son motivos más que suficientes para romper con la relación violenta sin titubear, la realidad es muy diferente. Cuando las mujeres están expuestas a la VG, quedan atrapadas en ella y encuentran muchas dificultades para terminar con la relación tanto por las consecuencias de la VG en sí misma como por los factores externos que la normalizan. En particular, en España el 22,1% de las víctimas de VG no contaron su situación a nadie, sufriendo la violencia en silencio; y el 77,4% de ellas no denunció a su agresor y, en menor medida, cuando se trataba de su pareja actual (5,4% vs. 25% su pareja pasada), entre los principales motivos para no hacerlo se encuentra el hecho de que resolvían la situación por sí mismas o no consideraban la VG suficientemente grave (Ministerio de Igualdad, 2020). Asimismo, un 12,1% de las víctimas de VG se acogieron a la dispensa de la obligación a declarar entre 2013-2022, es decir, tomaron la decisión de renunciar a seguir adelante con el proceso de denuncia interpuesto por ellas mismas o por otras personas (p.ej., profesional de atención primaria o familiar) (Consejo General del Poder Judicial, 2022). Estos datos reflejan la complejidad que rodea a la VG, siendo necesario ofrecer a las mujeres los recursos y el apoyo necesarios para facilitarles la toma de decisión encaminada a su protección y bienestar.

En esta línea, han surgido diferentes explicaciones teóricas para tratar de comprender por qué las mujeres víctimas de VG se mantienen en la relación violenta como son la teoría de la indefensión aprendida (Seligman, 1975), la teoría del ciclo de la violencia (Walker, 1979), la teoría de costes-beneficios (Pfouts, 1978), la teoría de la unión traumática (Dutton y Painter, 1995), la teoría de la inversión (Rusbult, 1986), o la teoría de la trampa psicológica (Strube, 1988), entre otras. Concretamente, parecería que las normas sociales y culturales que se manifiestan mediante un clima de tolerancia y aceptación de la VG, así como la dependencia emocional, el compromiso con la relación, la presencia de distorsiones cognitivas (p.ej., minimización de la gravedad) o las emociones como la culpa, el miedo o la vergüenza, entre otras, constituyen factores de riesgo que pueden influir en la decisión de romper con la relación de VG o buscar ayuda (Bell y Naugle, 2005; Fanslow y Robinson, 2010; Ferrer-Pérez et al., 2020; Garrido-Macías et al., 2017; Gracia et al., 2020; Herrera y Expósito, 2009; Le y Agnew, 2003; Le et al., 2010; Ministerio de Igualdad, 2020; Nicholson y Lutz, 2017; Overall et al., 2010; Tan et al., 2018; Valor-Segura et al., 2014). Por ello y, dada la asociación con la permanencia en la VG (Amor et al., 2006), esta tesis doctoral examina la influencia de determinados factores cognitivos y emocionales en la toma de decisión de las mujeres respecto a la relación de pareja violenta.

A su vez, entre las víctimas de VG que deciden revelar su situación, el 10,4% lo hacen en los servicios sanitarios ya que, confían en los y las profesionales de atención primaria para abordar la problemática (Garcia et al., 2008; Garcia-Moreno et al., 2014; Ministerio de Igualdad, 2020). En este contexto, los centros de salud son lugares idóneos para la prevención, detección precoz y abordaje de la VG, siendo el rol de las y los profesionales de atención primaria crucial para ello (Fernández, 2015; Ruiz-Pérez et al., 2004). Sin embargo, la respuesta a la VG desde este ámbito todavía es insuficiente pues, más del 70% de los casos de VG no son visibilizados en los servicios de salud, y tan solo el 7,8% de las denuncias provienen de

este ámbito (Consejo General del Poder Judicial, 2023; Martínez-García et al., 2021; Siendones et al., 2002), requiriendo mayor implicación para combatir la VG.

Por tanto, es necesario profundizar en los obstáculos que encuentran, tanto las víctimas de VG como los y las profesionales del ámbito sanitario que las atienden, para tomar decisiones que protejan a las mujeres de las diferentes formas de violencia por parte de su pareja o expareja. Esto permitirá entender el proceso de toma de decisión de romper con la situación de violencia, teniendo en cuenta el procesamiento emocional y racional que conlleva dicha tarea. Por un lado, el estado emocional que presenta la persona puede influir en la percepción del riesgo de la situación e intención activa de dar una respuesta de evitación o aproximación (Damasio, 1998; Forgas, 1995; Lempert y Phelps, 2015). Por otro lado, la toma de decisión puede predecirse mediante un proceso racional y deliberativo que tiene en cuenta la intención de realización de la conducta (Fishbein y Ajzen, 1975; 2010). En este sentido, la racionalización podría enmarcarse en un contexto social determinado en el que, la VG podría aceptarse en determinadas circunstancias que llevarían a normalizarla y, por tanto, romper con esa normalización podría suponer un acto irracional en sí mismo. Ambos factores, cognitivos y emocionales se exploran en la presente tesis doctoral con el objetivo de estudiar su papel en la respuesta ante la VG.

1.3.1. Sexismo y actitudes hacia la violencia de género

El contexto de igualdad presente en España puede hacer pensar que la sociedad en la que vivimos ya no discrimina a las mujeres, entendiendo la VG como un hecho puntual o excepcional. Sin embargo, la realidad es que las mujeres continúan siendo estereotipadas según los mandatos de género, favoreciendo un clima de tolerancia hacia la violencia, justificando lo injustificable y obstaculizando el proceso de las víctimas para salir de la VG (Expósito, 2022). Estas creencias y actitudes respecto a cómo deben comportarse en las relaciones de pareja los hombres y las mujeres de acuerdo con el género, hacen referencia al sexismo y suponen una

discriminación hacia las mujeres resultado de una cultura androcéntrica que impregna a toda la sociedad (Expósito et al., 1998). En concreto, la teoría del sexismo ambivalente (Glick y Fiske, 1996), señala el sexismo como un constructo multidimensional que puede manifestarse de manera hostil o benévola. El sexismo hostil es más explícito e implica actitudes negativas hacia las mujeres, a las que considera inferiores a los hombres (p.ej., "Las mujeres se ofenden muy fácilmente"). El sexismo benévolo puede ser incluso más perjudicial que el hostil porque sigue justificando el poder estructural del hombre, pero enmascarando la realidad mediante actitudes positivas hacia las mujeres (p.ej., "Muchas mujeres se caracterizan por la pureza que pocos hombres poseen"), recompensándolas por adoptar roles tradicionales y fomentando la desigualdad de género (Glick y Fiske, 2001). En este sentido, el sexismo es ambivalente por la coexistencia de la antipatía sexista hacia las mujeres y los sentimientos positivos hacia ellas (Glick y Fiske, 1996).

El sexismo justifica una serie de ideas respecto a las relaciones de pareja basadas en el mantenimiento del poder y en la distinción positiva de los hombres frente a las mujeres (Durán et al., 2014; Expósito y Herrera, 2009; Glick y Fiske, 1996; 2001; Juarros-Basterretxea et al., 2019). Concretamente, cuando las mujeres están envueltas en relaciones de VG, el sexismo contribuye a la justificación de la violencia, constituyendo un factor de riesgo para continuar con la relación (Expósito et al., 2010; 2022). Asimismo, las actitudes sexistas pueden legitimar y mantener las diferencias de estatus y poder entre hombres y mujeres, tendiendo a culpabilizar a la víctima y justificar al agresor (Berkel et al., 2004; Expósito, 2022; Ferrer et al., 2006; Herrera y Expósito, 2009; Pradas y Perles, 2012). En particular, las actitudes sexistas disminuyen la voluntad de intervención en casos de VG por parte del entorno, así como la probabilidad de que las víctimas denuncien su situación (Harris et al., 2005; Martínez-Fernández et al., 2018). Además, el sexismo no permite ver la problemática que supone la VG pues, influye en la percepción de su gravedad, minimizándola (Anderson y Bushman, 2002;

Martín-Fernández et al., 2018; Sánchez-Hernández et al., 2020; Yamawaki et al., 2009). En base a esto, es necesario continuar investigando el papel del sexismo, tanto en la percepción de gravedad de la VG como en la respuesta ante la misma. Por ello, la presente tesis doctoral contempla el sexismo como variable de interés para comprender el proceso de toma de decisión tanto en víctimas como en los y las profesionales del ámbito sanitario que las atienden.

Del mismo modo, las actitudes que aprueban o fomentan la VG (p.ej., justificación), revelan las normas sociales relativas a la aceptación o no de la violencia hacia las mujeres en la pareja, favoreciendo un clima de tolerancia y percepción de normalidad que impacta en la respuesta de las víctimas y de las y los profesionales ante esta problemática (Ferrer et al., 2020; Flood y Pease, 2009; Gracia y Tomás, 2014; Gracia et al., 2020; Herrera et al., 2014; Kuijpers et al., 2021; Waltermaurer, 2012). Las personas que muestran actitudes más tolerantes hacia la violencia, responsabilizando a la víctima y no al agresor de esta, es más probable que no actúen para poner fin a la VG (Cinquegrana et al., 2017; Gracia y Herrero, 2006; Gracia et al., 2018; León et al., 2022; West y Wandrei, 2002). En particular, la exposición de las mujeres a la VG podría generarles una incongruencia interna que las llevaría, o bien a dejar la relación violenta, o bien a modificar la interpretación de su situación, por ejemplo, mediante la minimización de la atribución de responsabilidad que le otorga al agresor (Grawe, 2004). Esta manera errónea de interpretar la VG implica la justificación de la misma (Gracia et al., 2018; West y Wandrei, 2002), pudiendo ser considerada una distorsión cognitiva (Loinaz, 2014). En este caso, las mujeres que no han sufrido VG podrían hacer una interpretación más ajustada de la realidad ya que no se encontrarían en una situación de incongruencia entre lo que es (p.ej., violencia) y lo que esperan que sea (p.ej., buen trato).

Esta tesis doctoral pretende ahondar en el impacto que tiene la VG en la interpretación que hacen las mujeres de la situación y su influencia en la toma de decisiones pues, una interpretación desajustada de la realidad podría dificultar la adopción de comportamientos

encaminados a romper con la relación violenta. Los hallazgos obtenidos contribuirán al entendimiento de los efectos transformativos que la VG provoca en las mujeres y las implicaciones que ello conlleva para sus vidas.

1.3.2. Percepción de gravedad y valoración del riesgo

Para combatir la VG no es suficiente con reconocerla como una condición social perjudicial para las mujeres, sino que debe ser comprendida como una situación indeseable tanto para las víctimas como para la sociedad en su conjunto (Expósito, 2022). Sin embargo, en España, tan sólo un 2,7% de la población considera la VG como uno de los principales problemas sociales (Centro de Investigaciones Sociológicas; CIS, 2023), lo que podría repercutir en su implicación para erradicarla. En este sentido, la percepción de gravedad y riesgo que implica la VG serán determinantes para valorarla como un problema social y actuar en consecuencia.

Concretamente, la percepción de gravedad hace referencia a las creencias que tienen las personas acerca de la magnitud o importancia de una amenaza (Riddle y Di, 2020; Witte, 1994). En casos de VG, la percepción de gravedad es fundamental para predecir los comportamientos de búsqueda de ayuda o denuncia de la situación (Kuijpers et al., 2021). Estudios previos señalan que, cuanto más grave se percibe la VG, más probabilidad hay de intervenir activamente ante tales situaciones violentas (Gracia et al., 2008; 2009; León et al., 2022; Sylaska y Walter, 2014). Para percibir tal gravedad será necesario identificar la VG en toda su magnitud, teniendo en cuenta incluso las señales más sutiles de violencia. En este caso, el sexismo, la aceptación de la violencia y la culpabilización a las víctimas podrían dificultar la percepción de gravedad, minimizándola (Herrera y Expósito, 2009; Lelaurain et al., 2018; Sánchez-Fernández et al., 2020; Vidal-Fernández y Megías, 2014).

Por su parte, la valoración del riesgo indica las creencias individuales sobre la probabilidad de que ocurra una amenaza (Riddle y Di, 2020; Witte, 1994). De acuerdo con

Brewer et al. (2004), una percepción de riesgo alto ante determinadas situaciones debería impulsar el comportamiento dirigido a disminuirlo. No obstante, esta valoración es variable y específica según la situación, pudiendo llegar a ser subestimada e influir en la toma de decisión (Andrés-Pueyo y Echeburúa, 2010; Riddle, 2020). En el caso de las mujeres víctimas de VG será fundamental una valoración del riesgo ajustada a la realidad, sin embargo, muchas de ellas no perciben el riesgo adecuadamente. En particular, Campbell et al. (2003) hallaron que, la mitad de las mujeres asesinadas por sus parejas o exparejas no se consideraban en riesgo de muerte. Esta distorsión en la valoración del riesgo puede ser muy peligroso para ellas, resultando incluso en consecuencias fatales como la muerte.

Por ello y, dada la responsabilidad social que implica la VG, se han desarrollado instrumentos de evaluación para que las y los profesionales puedan determinar el riesgo en el que se encuentra la mujer y tomar medidas de gestión e intervención acordes a dicho riesgo (Ministerio del Interior, 2018; Nicholls y Pritchard, 2013). Específicamente, en España se cuenta con un sistema de seguimiento integral de los casos de VG (VioGén) que incluye, entre otros indicadores de riesgo, la valoración que las propias víctimas hacen del riesgo de su situación (Ministerio del Interior, 2018), lo cual será fundamental para que tomen medidas encaminadas a su protección. No obstante, desde nuestro conocimiento, son escasas las investigaciones previas focalizadas en estudiar la valoración del riesgo para la vida que las víctimas realizan de la VG que sufren y las implicaciones de dicha valoración en la decisión de buscar ayuda.

Con la finalidad de dar respuesta a estas cuestiones, esta tesis doctoral se centra tanto en la percepción de gravedad como en la valoración del riesgo para aproximarse al entendimiento de algunos obstáculos que las víctimas y los y las profesionales del ámbito sanitario encuentran para enfrentar la VG. Los novedosos hallazgos obtenidos pueden ser

fundamentales para el desarrollo de programas de prevención e intervención específicos que favorezcan las respuestas de búsqueda de ayuda e intervención ante la VG.

1.3.3. Emociones

En situaciones conflictivas o demandantes como es la VG, las personas necesitan tomar decisiones encaminadas a su protección y no supongan un riesgo para su integridad. Estas decisiones pueden estar influenciadas por las emociones, las cuales, afectarían a la percepción de la situación, así como a la respuesta de evitación o aproximación ante el problema (Forgas, 1995; Lempert y Phelps, 2015). Concretamente, las emociones como la culpa, la vergüenza y el miedo son frecuentes entre las mujeres que sufren VG y suponen un obstáculo para que informen de su situación o busquen ayuda (FRA, 2014; Ministerio de Igualdad, 2020).

Por un lado, la *vergüenza* genera malestar y confusión en las víctimas de VG, impidiendo la acción y, por otro, la *culpa*, justifica las conductas negativas del agresor y mantiene a la mujer en la violencia. Ambas emociones, aumentan la probabilidad de continuar en la relación abusiva y limitan la búsqueda de ayuda (Ministerio de Igualdad, 2020; Puente-Martínez et al., 2016). A su vez, la presencia de estas emociones podría llevar a las víctimas a infravalorar la gravedad de la situación y a justificar el comportamiento del agresor, buscando una explicación a situaciones de violencia difíciles de comprender (Herrera y Expósito, 2009; Valor-Segura et al., 2014). Por lo que se refiere al miedo, parecería ser una emoción que permite a las mujeres alejarse del peligro que supone la VG. Sin embargo, cuando la violencia se mantiene en el tiempo puede tener un efecto paralizador, favoreciendo la permanencia en la relación mediante el uso de estrategias como la negación, la normalización de la situación o el perdón al agresor, exponiendo a las mujeres a nuevos comportamientos violentos hacia ellas (Fanslow y Robinson, 2010; Puente-Martínez et al., 2016). Para indagar en el impacto de la VG en las emociones de las mujeres, así como en las percepciones e interpretaciones, en esta

tesis, se explora la vergüenza, la culpa y el miedo que supone la VG para las mujeres, analizando las diferencias según sean víctimas o no de esta violencia.

1.3.4. Dependencia emocional y compromiso con la relación

La dependencia emocional implica la necesidad afectiva de amor y apoyo por parte de la pareja, influyendo en las respuestas cognitivas, emocionales y de autocontrol de la persona (Rusbult, y van Lange, 2003; Valor-Segura et al., 2014). Las mujeres que mantienen relaciones de VG parecerían presentar mayor dependencia emocional hacia sus parejas en comparación con aquellas mujeres no expuestas a situaciones de violencia (Tan et al., 2018). Asimismo, la alta dependencia emocional hacia la pareja favorecería la tolerancia al maltrato y el mantenimiento en la relación violenta (Rusbult y van Lange, 2003; Tan et al., 2018; Valor-Segura et al., 2014; Yamawaki et al., 2012) puesto que, las personas más dependientes, tenderían a perdonar a sus parejas con mayor facilidad que las personas con menores niveles de dependencia (Beltrán-Morillas et al., 2019). Esto puede suponer un riesgo para las mujeres ya que, dicha necesidad afectiva hace que tiendan a pensar que no pueden vivir sin su pareja, idealizándola y soportando situaciones de violencia con tal de preservar la relación que tanto anhelan (Bornstein, 2006; Tan et al., 2018).

Del mismo modo, el compromiso con la relación es un predictor significativo para que las mujeres se mantengan en una relación de pareja (Arriaga y Agnew, 2001; Bell y Naugle, 2005; Le y Agnew, 2003). En concreto, mayores niveles de compromiso con la relación se han asociado al uso de estrategias constructivas que favorecen la estabilidad de la pareja (Arriaga et al., 2016; 2018; Overall y Girme, 2014; Rusbult, el al., 1986). Sin embargo, cuando las mujeres mantienen relaciones abusivas o violentas, un alto compromiso con la relación implicaría un factor de riesgo para continuar expuestas a la violencia. Las mujeres más comprometidas con la relación pueden mostrar actitudes más tolerantes hacia la VG, tendiendo a sobreestimar las consecuencias negativas que tendría dejar la relación y favoreciendo el

mantenimiento en la misma (Arriaga et al., 2013; 2016; 2018; Weiser y Weigel, 2014). En este sentido, parecería que, las mujeres expuestas a la VG se muestran más comprometidas con la relación que las mujeres que mantienen relaciones de pareja no violentas, priorizando la relación de pareja a su interés personal, perdonando los actos violentos y restándoles importancia (Arriaga, 1997; Gordon et al., 2004; Hanley y O'Neil, 1997; Weiser y Weigel, 2014).

En definitiva, tanto la dependencia emocional hacia la pareja como el compromiso con la relación son factores clave para entender por qué las personas permanecen en las relaciones sentimentales y, más concretamente, ayudar a explicar la dificultad que encuentran las mujeres para romper con las relaciones de VG (Arriaga, 1997; Garrido-Macías et al., 2017; Gordon et al., 2004; Rusbult y Martz, 1995; Valor-Segura et al., 2014). De acuerdo con Arriaga y Capezza (2011), la dependencia emocional y el compromiso con la relación podrían reducir la percepción de gravedad de las transgresiones de la pareja, favoreciendo que las mujeres pasaran por alto la situación de violencia. Por ello, a pesar de que la literatura previa muestra la influencia de la dependencia emocional y el compromiso con la relación en la toma de decisión, en esta tesis doctoral se pretende examinar cómo se relacionan ambas variables y qué impacto tienen en la toma de decisión de las mujeres respecto a dejar o continuar con la pareja.

Objetivo general y objetivos específicos de la tesis doctoral

En base a la justificación teórica recogida en el **Capítulo 1** "Introducción" y, dada la importancia de continuar investigando en los aspectos que dificultan la toma de decisión encaminada a dar respuesta a la grave problemática que supone la VG en todos los niveles, esta tesis doctoral tuvo como objetivo principal obtener evidencia empírica respecto a las variables implicadas en el proceso de toma de decisión en situaciones de VG por parte de las víctimas y de las y los profesionales del ámbito sanitario que las atienden.

Con la finalidad de alcanzar el objetivo general de la tesis doctoral, ésta se dividió en tres objetivos específicos: 1) conocer el estado del arte con relación a la percepción de gravedad de la VG y variables relacionadas; 2) examinar las variables implicadas en la decisión de dejar la relación o buscar ayuda en víctimas de VG; y 3) explorar las variables implicadas en la voluntad de intervención en casos de VG por parte de los y las profesionales del ámbito sanitario que las atienden. Estos objetivos específicos se recogen en el **Capítulo 2** "Revisión bibliográfica", **Capítulo 3** "Víctimas de violencia de género" y **Capítulo 4** "Profesionales del ámbito sanitario" de la presente tesis doctoral, todos ellos conectados con el objetivo general planteado.

Para dar respuesta a los objetivos propuestos en esta tesis, se llevaron a cabo ocho estudios empíricos. Los *Estudios 1* y *2* forman parte del **Capítulo 2** "Revisión bibliográfica" y permiten fijar el punto de partida de la tesis doctoral ya que recogen información bibliométrica para conocer qué hay publicado sobre la percepción de gravedad de la VG e identificación como víctimas, además de sintetizar y analizar las variables relacionadas con la percepción de gravedad de la VG por parte de la sociedad en su conjunto. A partir de la información obtenida en este capítulo y teniendo en cuenta las particularidades de cada muestra (víctimas de VG vs. profesionales del ámbito sanitario), se abordan de manera independiente el **Capítulo 3** "Víctimas de violencia de género" y el **Capítulo 4** "Profesionales del ámbito sanitario" para indagar en el papel de determinadas variables en la toma de decisión de actuación ante situaciones de VG.

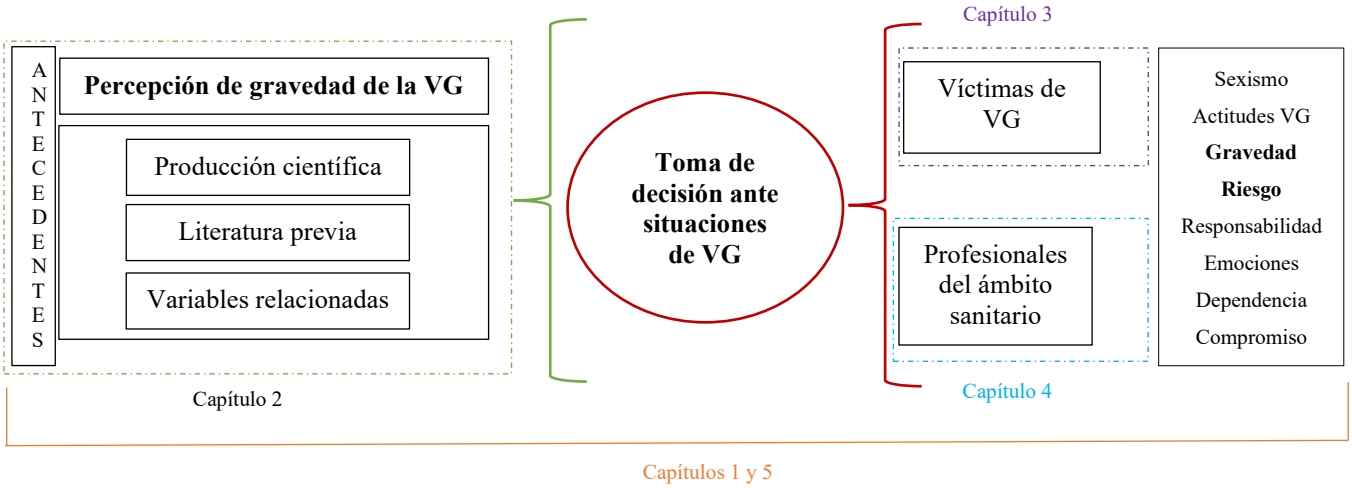
En particular, el **Capítulo 3** "Víctimas de violencia de género" se compone de cuatro estudios empíricos con mujeres de población general (n = 747) y víctimas de VG (n = 1.152). El *Estudio 3*, en base a la dificultad que supone identificar a las víctimas de VG, se adapta y valida el instrumento de la OMS (2005) para detectar la violencia física, psicológica, sexual, o conductas de control en mujeres de población española. El *Estudio 4*, trata de establecer

diferencias en la toma de decisión respecto a finalizar la relación de pareja según las mujeres informen de conflictos de pareja o de situaciones de VG. Seguidamente, con una muestra específica de mujeres que informan sufrir VG, el *Estudio 5* pretende explorar las barreras que encuentran las mujeres para buscar ayuda y revelar la VG. Al hilo del *Estudio 5* y con la finalidad de cubrir el objetivo específico 2 "examinar las variables implicadas en la decisión de dejar la relación o buscar ayuda en víctimas de VG", en el *Estudio 6* se plantea explorar qué barreras presentan las víctimas de VG para romper con la relación violenta y si estas barreras están presentes del mismo modo en mujeres que no informan de VG. Mediante estos cuatro estudios se cubre el objetivo específico planteado, contribuyendo a la comprensión de la VG con hallazgos novedosos.

En cuanto al objetivo específico 3 "explorar las variables implicadas en la voluntad de intervención en casos de VG por parte de los y las profesionales del ámbito sanitario que las atienden", se llevaron a cabo los *Estudios 7* y *8*. En primera instancia, el *Estudio 7* permite sintetizar y analizar la información respecto a los instrumentos que los y las profesionales del ámbito sanitario tienen disponible para dar respuesta a la VG. A su vez, mediante entrevistas grupales, se explora la opinión de las y los profesionales del ámbito sanitario sobre dichos instrumentos, así como acerca de los obstáculos que encuentran para responder de manera proactiva y adecuada ante casos de VG. Con el *Estudio 8* se cierra este capítulo examinando el papel que determinadas variables (sexismo, aceptación de la VG y gravedad percibida de la VG) ejercen en la voluntad de intervención por parte de futuros y futuras profesionales del ámbito sanitario. De esta manera, se obtiene una visión general de las variables implicadas en el proceso de toma de decisión por parte de las víctimas de VG y las y los profesionales del ámbito sanitario que las atienden, enfatizando en el papel de la percepción de la gravedad y valoración del riesgo como variables de interés principal dada su relevancia y la escasa literatura previa disponible (véase la Figura 1).

Figura 1

Esquema del planteamiento de la tesis doctoral



ESTUDIOS EMPÍRICOS

EMPIRICAL STUDIES

CAPÍTULO 2: Revisión bibliográfica

CHAPTER 2: Bibliographic review

Sólo se ve lo que se mira, y sólo se mira lo que se tiene en la mente

(Alphonse Bertillon)

Estudio 1

Study 1

Perception and Detection of Gender Violence, and Identification as Victims: A Bibliometric Study

Percepción y Detección de Violencia de Género e Identificación como Víctimas: Un Estudio Bibliométrico

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Abstract

This bibliometric study seeks to know and analyze the available scientific activity on the perception and detection of gender violence as well as in the identification as victims. An unlimited search was conducted in the Scopus database, finding 2,152 documents. Subsequently, the results were screened by reducing the documentary noise. The results were obtained from 1984-2020 and the final 974 documents were analysed from 465 documentary sources, 160 journals, 2,758 authors, 159 institutions, and 79 countries. The results show an increase in production in recent years, highlighting the publication of original articles. Likewise, the single authorship per country predominates, being the United States the leading country. The main objectives of the most cited documents are detection of gender violence by health care personnel, assessment of the risk of recidivism through the perception of the victims, as well as the study of perceptions and attitudes of different actors towards gender-violence.

Keywords: perception, detection, identification, gender violence, scientific production

Resumen

El presente estudio bibliométrico tuvo como objetivo conocer y analizar la actividad científica disponible sobre percepción y detección de violencia de género (VG) e identificación como víctimas. Se realizó una búsqueda sin límite temporal en la base de datos Scopus hallando 2.152 documentos. Para reducir el ruido documental de la búsqueda, se cribaron los resultados y se analizaron 974 documentos finales procedentes de 465 fuentes documentales, 160 revistas, 2.758 autores/as, 159 instituciones y 79 países. Los resultados muestran un aumento en la producción en los últimos años, destacando la publicación de artículos originales. Asimismo, predomina la autoría única por país, siendo Estados Unidos el país puntero. Entre los objetivos de los documentos más citados se encuentra la detección de VG por el personal sanitario, la valoración del riesgo de reincidencia mediante la percepción de las víctimas, así como el estudio de percepciones y actitudes de diferentes actores hacia la VG.

Palabras clave: percepción, detección, identificación, violencia de género, producción científica, bibliometría

Perception and Detection of Gender Violence, and Identification as Victims: A Bibliometric Study

Gender violence is defined as any act of violence against women that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of freedom occurring in both public and private life (United Nations, 1993). Likewise, gender violence poses a major global public health problem that can affect any woman. The number of victims of gender violence is alarming: around 38% of female homicides are due to spousal violence, and 35% of women have suffered physical or sexual violence by their partner or other men throughout their life (World Health Organization, 2016). Because of their exposure to abuse, female victims of gender violence show higher scores on psychopathological variables associated with emotional distress such as anxiety, depression, low self-esteem, and maladjustment, as compared to non-victimized women (Sarasua et al., 2007). In this regard, health professionals play an essential role in identifying and helping women victims of gender violence. Adequate awareness and training on the subject are essential for recognizing the possible indicators of gender violence (Shearer et al., 2006).

Likewise, gender violence can be identified with greater or lesser difficulty depending on how it manifests. People recognize violent behaviours more easily when related to manifest violence like physical or sexual violence than when it is a subtle violence like psychological violence (Novo et al., 2016). In the same way, some variables such as sexist beliefs (Herrera et al., 2014; Yamawaki et al., 2009), culture (Shiu-Thornton et al., 2005), tolerant attitudes towards the control and devaluation of women (Government Delegation for Gender Violence, 2014), or interpretation of a violent situation (Herrera & Expósito, 2009), can influence the identification and perception of violence by minimizing its severity.

Sometimes, despite having objective indicators of abuse and acknowledging having suffered violent behaviour, some women are unable to perceive it or identify themselves as victims of gender violence (Hamby & Gray-Little, 2000; Instituto de la Mujer, 2006). In this regard, Campbell et al. (2003) found that half of the victims killed by gender violence did not consider themselves to be at risk of death. This presents a problem because the victim's perception of the violent situation is a fundamental axis for predicting the recidivism risk of gender violence (Cattaneo et al., 2007; Heckert & Gondolf, 2004a) and for their protection. In contrast, women who have not been victims of gender violence might distance themselves and blame battered women for the violent situation in which they are in, due to the fear that the same situation will happen to them at some point in their own lives (Yamawaki et al., 2009).

Hence, to adequately address violence against women due to gender inequalities, it is necessary to become aware of gender violence as a social problem that should not be underestimated. In this line, exploring and analysing the available findings on how gender violence is perceived and identified will be relevant for scientific advancement.

For this, bibliometric studies are useful because they allow relevant information on a topic of interest to be obtained, structured, and quantified by highlighting keywords, the most relevant authors, the main sources of publication, collaborations between countries, and other types of data (Aria & Cuccurullo, 2017; Holden et al., 2005). Publications are analysed through bibliometric indicators, taking into account the number of articles and the number of citations they receive (Dorta-González & Dorta-González, 2010), which facilitates the selection of impactful journals in which to publish. For researchers, knowing the means through which to disseminate their scientific works is a priority because the journals in which they publish can guarantee their work's impact and visibility (González-Sala et al., 2017). In the same way, the bibliometric methodology is fundamental for evaluating scientific production and determining the progress of research in scientific fields such as psychology (López & Osca-Lluch, 2009).

At present, although some bibliometric works on gender exist (Arias et al., 2016; Morais et al., 2016; Söderlund & Madison, 2015), no studies have analysed the scientific production available on the perception and detection of gender violence or on identifying abused women. Therefore, the objective of this study was to quantify and analyse the available scientific activity regarding the perception and detection of gender violence by the general population, battered women, and the professionals who care for them as well as regarding identification as victims of gender violence. The secondary objectives were to (a) analyse the evolution of scientific production on the topics; (b) determine the keywords most frequently used by the authors; (c) determine the scientific activity and impact of the main journals and institutions; (d) study the most productive authors on the search topic as well as the research collaboration network among countries; and (e) identify the most cited works on the topic of interest.

Method

Materials and Units of Analysis

A bibliographic search was carried out in the international and multidisciplinary database Scopus (Elsevier) because it includes many indexed journals and is one of the most commonly used databases for conducting bibliometric studies (Osca-Lluch et al., 2013). Scopus provides the Scimago Journal & Country Rank (SJR), a bibliometric indicator that measures a scientific journal's impact or prestige. This indicator is calculated using the citations received by the journals in a 3-year period (González-Pereira et al., 2010).

The Web of Science (WoS) database owned by Clarivate Analytics is adequate for this type of study. However, Scopus was considered more appropriate for several reasons. Firstly, Scopus allows for more exhaustive analysis of international scientific activity and collects journals from more countries. It also includes a larger number of scientific sources (more than 15,000 journals, compared to the 9,000 that WoS offers) and citable documents. Finally,

Scopus has greater thematic coverage in the areas of science, technology, and medicine, as well as in the social sciences, with which we are concerned in this study (Bosman et al., 2006).

Design and Procedure

This research was a quantitative study with an ex post facto bibliometric historiography design (Montero & León, 2007). In February 2020, a search was carried out on the Scopus database introducing the following formula: ("self-perception" OR perception OR recognition OR identification OR detect) AND ("gender violence" OR "gender-based violence" OR "dating violence" OR "partner violence" OR "victims of gender violence" OR "violence against women") AND (women OR men OR student OR police OR "health professional"). The search was filtered by title, abstract, and keywords. All of the documents available from Scopus were included without being limited by subject area or temporality, obtaining 2,152 results. Subsequently, these documents were manually reviewed by title and summary to reduce the document noise, and 974 final documents were exported in BibTeX format for subsequent statistical management.

Data Analysis

The data were analysed with the statistical analysis program R (R Core Team, 2018). Specifically, the Bibliometrix package was used (Aria & Cuccurullo, 2017). The results were analysed quantitatively, taking into account the development in the field; the contributions by year and journal; the most prolific authors, institutions, and coauthors; the most frequent keywords; and interactions by country.

Results

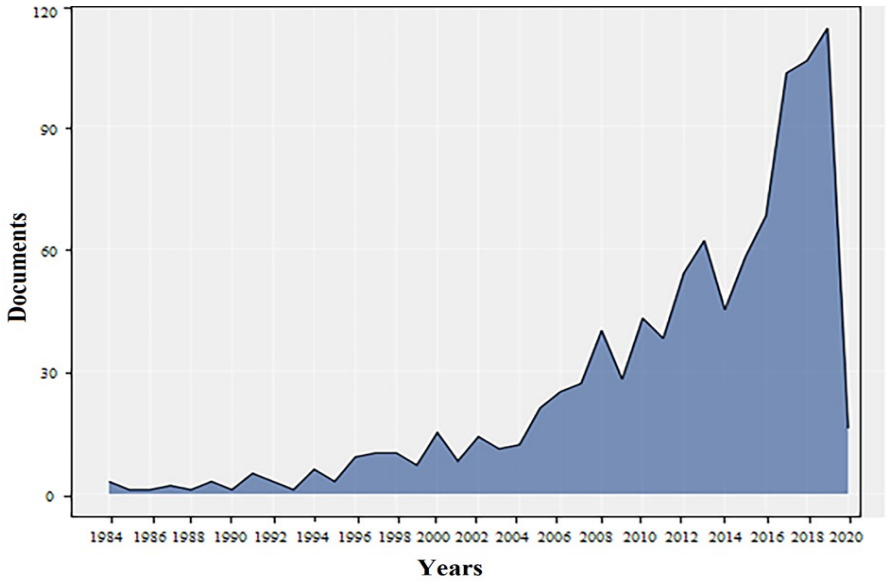
The 974 final analysed documents were published between 1984 and 2020, of which 162 had single authorship, 853 were original articles, 58 were review articles, 33 were press articles, 13 were book chapters, seven were conference documents, six were notes, three were books, and one was an editorial. Most of the documents were published in English (n = 904),

and the rest were in Spanish (*n* = 46), Portuguese (*n* = 31), French (*n* = 10), German (*n* = 2), Italian (*n* = 1), Croatian (*n* = 1), Hebrew (*n* = 1), Japanese (*n* = 1), Russian (*n* = 1), and Turkish (*n* = 1). Likewise, 465 documentary sources were identified, as were 2,758 authors (150 single authors), 1,598 keywords per author, 160 journals, 159 institutions, and 79 countries. The average number of citations per document was 15.19, the average number of authors per document was 2.83, the average number of co-authors per document was 3.37, the average number of documents per author was 0.35, and the collaboration index among authors was 3.21.

Annual scientific production on the topic increased gradually ever since the publication of the first studies in 1984, with an annual growth rate of 4.76%. Since 2004, the publication of scientific documentation on the perception and detection of gender violence has increased significantly, reaching a peak in 2019 with the publication of 114 articles (Figure 1). Among the annual evolution of the types of documentation produced, the publication of original articles stood out (87.58%) every year (Figure 2).

Figure 1

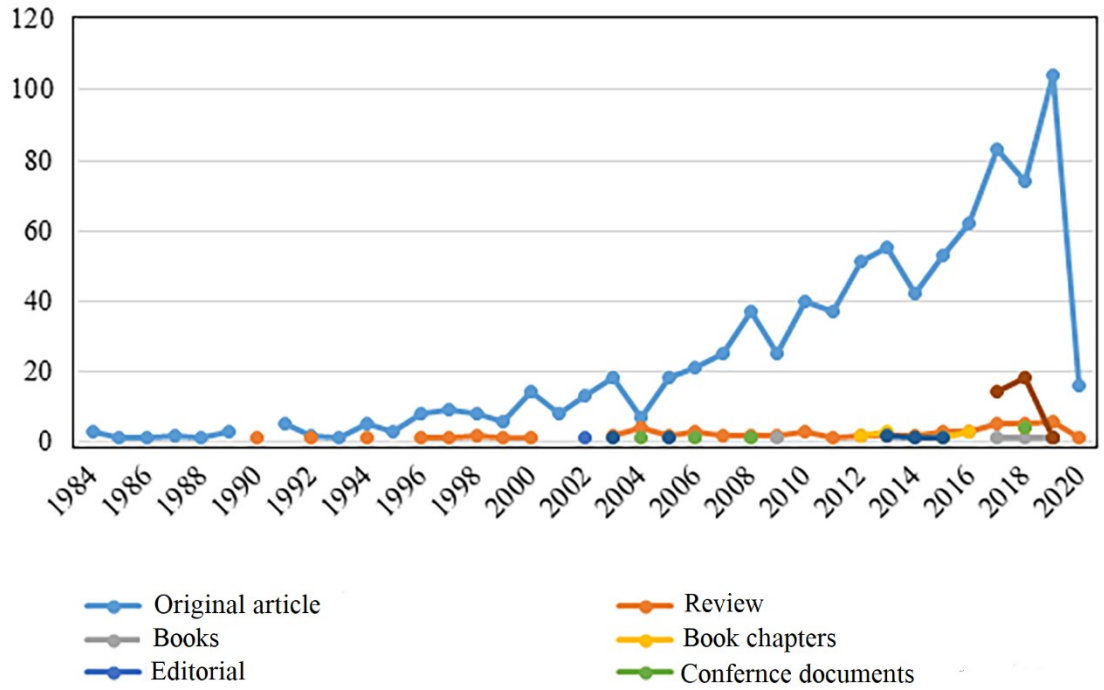
Annual Scientific Production[1]



[1] The results analyzed for 2020 only include the months of January and February.

Figure 2

Annual Evolution of Published Documents



The documents were distributed mainly in the thematic areas of social sciences (*n* = 395), medicine (*n* = 393), and psychology (*n* = 324). The *Journal of Interpersonal Violence* stood out with the publication of 138 articles, followed to a lesser extent by *Violence Against Women* (*n* = 50), *Violence and Victims* (*n* = 33), and the *Journal of Family Violence* (*n* = 22). Table 1 shows the 20 most productive journals on this topic, half of them being published in the United States (U.S.) and the rest in the United Kingdom (*n* = 7), the Netherlands (*n* = 2), and Brazil (*n* = 1). All are between the first and third quartiles.

Table 1

The 20 Journals with the Most Publications

Journal	Area	Country	Number of articles	SJR-index	H-index topic	H-index journal	Quartile
Journal of Interpersonal Violence	Psychology	U.S.	138	1.17	21	93	1º
Violence Against Women	Social sciences	U.S.	50	0.9	22	83	1º

Violence and Victims	Medicine Social sciences	U.S.	33	0.57	13	76	1º
Journal of Family Violence	Psychology Social sciences	U.S.	22	0.61	10	69	1º
Health Care for Women International	Health professions	United Kingdom	13	0.40	7	47	3º
Journal of Aggression, Maltreatment and Trauma	Health professions	U.S.	10	0.47	3	40	2º
Psychology of Violence	Psychology Social sciences	U.S.	10	1.63	6	30	1º
Plos One	Agriculture and biological sciences Biochemistry, genetics and molecular biology Medicine	U.S.	9	1.1	5	268	1º
Issues in Mental Health Nursing	Nursing	United Kingdom	8	0.35	5	53	2º
Journal of Clinical Nursing	Nursing Medicine	United Kingdom	8	0.77	4	87	1º
Social Science and Medicine	Arts and humanities Medicine Social sciences	United Kingdom	8	2.03	7	273	1º
Aggression and Violent Behavior	Medicine Psychology	United Kingdom	7	1.09	4	90	1º
Culture Health and Sexuality	Medicine Social sciences	United Kingdom	7	1.12	5	53	1º
Midwifery	Nursing Medicine	U.S.	7	0.82	4	58	1º
Sex Roles	Psychology Social sciences	U.S.	7	1.08	7	101	1º
BMC Women's Health Issues	Medicine	United Kingdom	6	0.89	3	40	1º
Women's Health Issues	Nursing Medicine Social sciences	Netherlands	6	0.90	5	53	1º
American Journal of Preventive Medicine	Medicine	Netherlands	5	2.68	4	193	1º

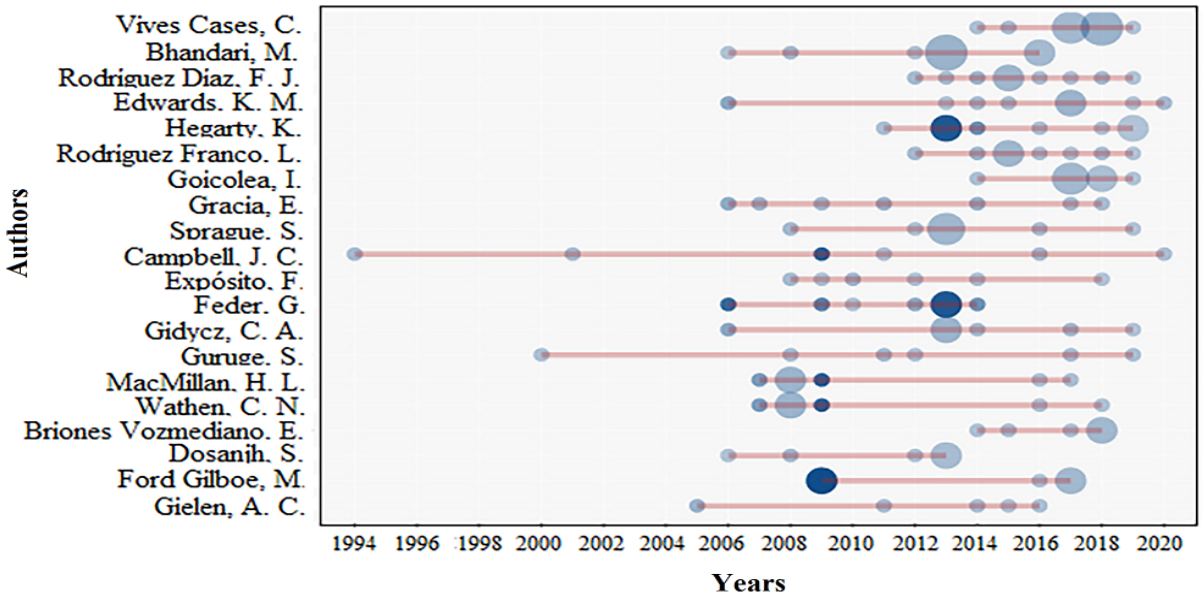
Sciencia e Saude Colectiva	Medicine	U.S.	5	0.53	2	39	2º
Feminist Criminology	Social sciences	U.S.	5	0.50	2	29	2º

Note. Index *h* topic = *h* number of articles published with at least *h* citations each on perception and detection of gender violence and identification as a victim published by the journal; Index *h* journal = *h* number of articles published with at least *h* citations each on any topic published by the journal.

Figure 3 shows the 20 main authors of scientific productions on the search topic, as well as the evolution of their research activity over the years on the perception and detection of gender violence and on identification as a victim. Among the main keywords used by all of the documents' authors, the use of the terms "intimate partner violence", "domestic violence", "violence against women", and "dating violence" stood out, occurring 260, 202, 76, and 58 times, respectively. Less frequently used were the terms "perceptions" (*n* = 11), "gender roles" (*n* = 10), "social norms" (*n* = 9), "victims" (*n* = 8), and "assessment" (*n* = 7), among others (Figure 4).

Figure 3

Production Over Time of the 20 Main Authors



Note. Larger circles indicate more publications. Darker shades of blue show higher number of citations per year. The length of the lines shows the production time interval, and the position of the circles indicates the years of publication. The results for 2020 only include the months of January and February.

Figure 4

The 50 Most Used Keywords

Note. The size of the word indicates the frequency of occurrence. The larger the size, the more times it was used.

On the other hand, all 20 institutions with the most published works were universities. In first place was McMaster University, with 30 articles and located in Canada, followed by the University of Toronto (*n* = 19), the University of California (*n* = 18), the University of North Carolina (*n* = 18), and the University of Michigan (*n*=16) located in the United States. The rest of institutions are located in the United States, Spain, Canada, and Israel.

Likewise, of the 79 countries producing works on the topic, 10 countries reported more than 10 documents, and the United States stood out notably with 305 documents and 6,717 citations. A majority of papers were published by a single country (87.28%), compared to a minority of papers published in collaboration with other countries (12.72%; Table 2). The collaboration network among countries can be seen in Figure 6.

Figure 5

The 20 Institutions with the Highest Scientific Production

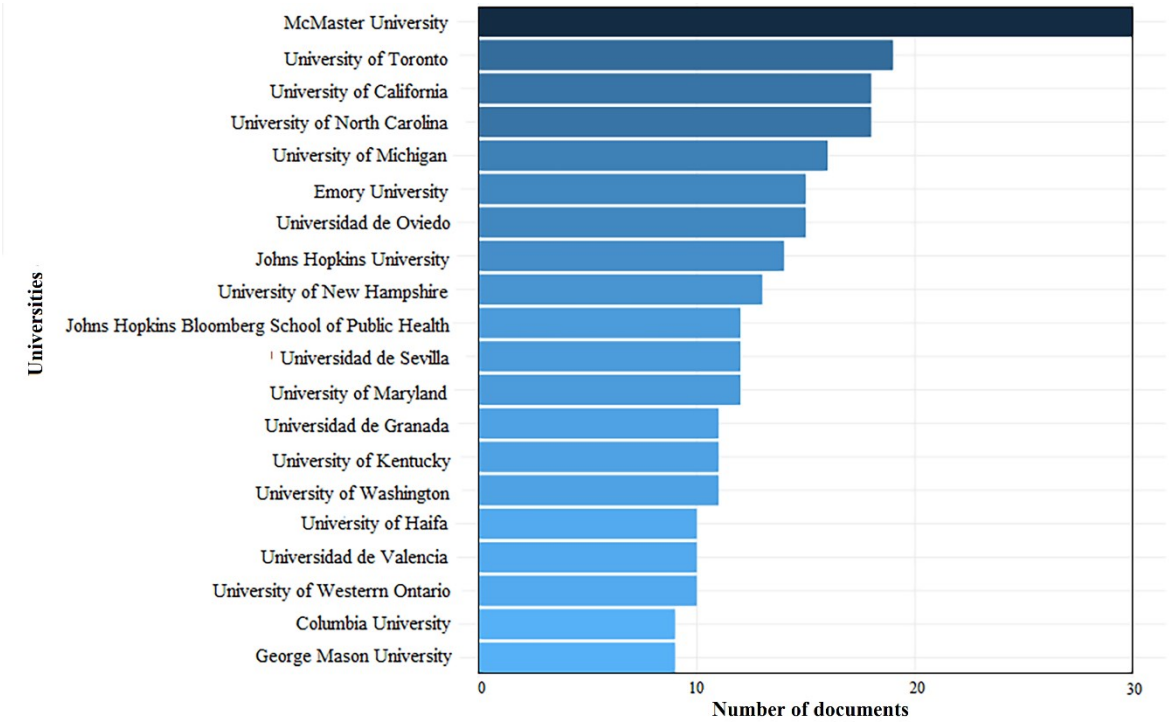


Table 2

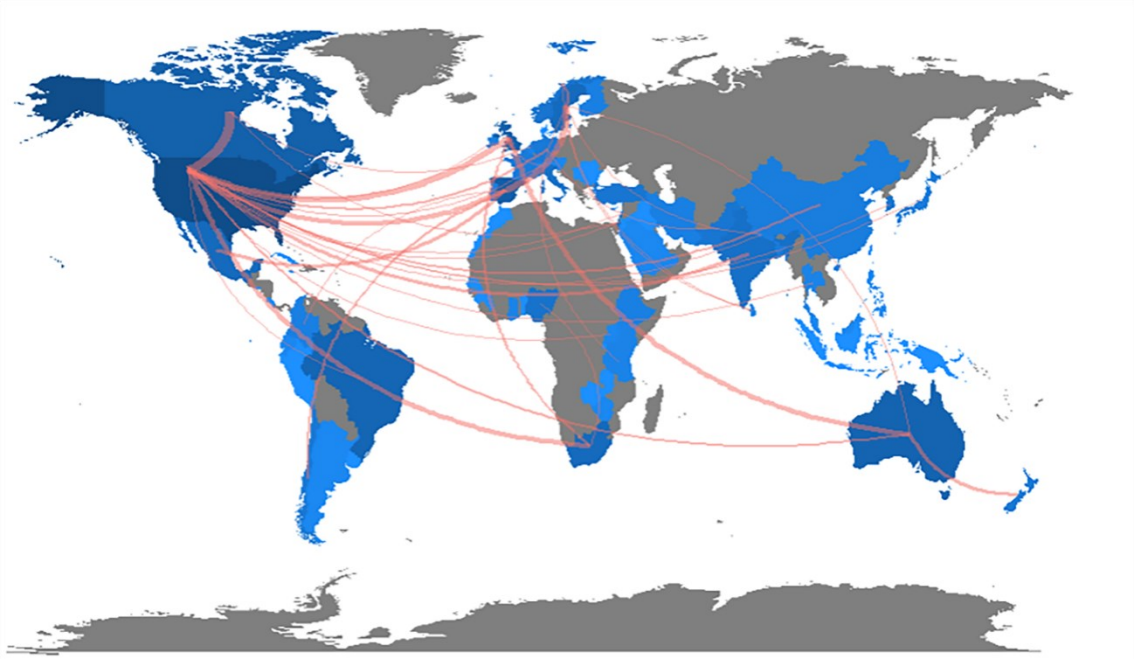
The Most Productive Countries

Country	Number of documents	UP	MP	Number of citations	Average of citations per document
U.S.	305	279	26	6.717	22.02
Spain	53	41	12	486	9.17
Canada	51	40	11	1.308	25.65
Brazil	33	32	1	237	7.18
United Kingdom	27	22	5	743	57.52
Australia	27	24	3	677	25.07
Israel	19	16	3	187	9.84
Mexico	19	16	3	125	6.56
South Africa	13	10	3	313	24.08
Sweden	11	7	4	152	13.82

Note. UP = Number of unique publications per country; MP = Number of documents of multiple-country publications.

Figure 6

Collaboration Network among Countries



Note. The darker shades of blue indicate higher production. The lines indicate the collaborations among countries, and their thickness indicated the frequency of these collaborations, being higher when the line is thicker.

Finally, among the documents analysed, the 25 articles with more than 100 citations were considered (Table 3). Among the three most cited articles, the article "Accuracy of 3 Brief Screening Questions for Detecting Partner Violence in the Emergency Department" (Feldhaus et al., 1997), published in the *Journal of the American Medical Association*, stood out for being the most cited, with 393 citations. In second place, with 316 citations, was a meta-analysis study entitled "Women Exposed to Intimate Partner Violence: Expectations and Experiences When They Encounter Health Care Professionals: A Meta-Analysis of Qualitative Studies" (Feder et al., 2006), which was published in the journal *Archives of Internal Medicine*. In third place was the article "Stop Blaming the Victim: A Meta-analysis on Rape Myths" was published in 2010 in the *Journal of Interpersonal Violence* and had more than 290 citations.

Of the documents, 72% were empirical studies. Some of them focused on detecting and responding to gender violence (Feldhaus et al., 1997; Gutmanis et al., 2007; Waalen et al.,

2000), as well as on perceptions and attitudes towards gender violence (Kim & Motsei, 2002) among health professionals. Among them, the most cited article was "Accuracy of 3 Brief Screening Questions for Detecting Partner Violence in the Emergency Department" (Feldhaus et al., 1997), whose main objective was to validate a brief three-question instrument for detecting physical violence and women's perception of their safety.

Other empirical studies focused on exploring the perceptions and attitudes towards gender violence by female victims, perpetrators and/or students (Arias & Pape, 1999; Avery-Leaf et al., 1997; Banyard & Moynihan, 2011; Dobash et al., 1998; Fabiano et al., 2003; Fanslow & Robinson, 2010; Glass et al., 2001; Heckert & Gondolf, 2004b; Hegarty et al., 2013; Johnson et al., 1995; Torres, 1991; Rose et al., 2000; Wolf et al., 2003). Among the studies focusing on victims' perceptions of gender violence, the article "Battered Women's Perceptions of Risk Versus Risk Factors and Instruments in Predicting Repeat Reassault" (Heckert & Gondolf, 2004b) explored the prediction of gender violence recidivism using the victim's perceived risk as compared to the use of risk-assessment instruments. The results showed better prediction by the victim in a sample of 499 women.

Half of the empirical studies analysed were conducted with women victims of gender violence (Arias & Pape, 1999; Dobash et al., 1998; Fanslow & Robinson, 2010; Felhaus et al., 1997; Glass et al., 2001; Heckert & Gondolf, 2004b; Hegarty et al., 2013; Rose et al., 2000; Torres, 1991; Wolf et al., 2003). The rest of them were carried out with aggressors (Dobash et al., 1998), health professionals (Gutmanis et al., 2007; Hegarty et al., 2013; Kim & Motsei, 2002; MacMillan et al., 2009), the general population (Glass et al., 2001), and students (Avery-Leaf et al., 1997; Banyard & Moynihan, 2011; Fabiano el al., 2003; Johnson et al., 1995).

On the other hand, 28% of the documents were theoretical studies aimed at synthesizing and analysing the available information about (a) the perceptions among victims of gender violence on the healthcare they received (Feder et al., 2006); (b) the social perception and

acceptance of myths about sexual aggression against women (Suarez & Gadalla, 2010); (c) the relationship between risk perception and sexual victimization among women (Gidycz et al., 2006); (d) the perceptions of gender violence, taking into account cultural norms and individual characteristics (Langhinrichsen-Rohling, 2010); (e) the diagnosis, process, and identification of gender violence (Walker, 1989); (f) health professionals' perceptions regarding the perceived barriers to detecting and acting on gender violence as well as the effects of interventions to increase these professionals' perceptions of and capacity to detect cases of gender violence (Waalen et al., 2000); (g) the relationship between perceptions and attitudes towards gender violence and its influence on individual and societal responses (Flood & Pease, 2009); and (h) the fulfilment of criteria for detecting gender violence in healthcare (Feder et al., 2009).

The results show a wide temporal range in the study of the topic (1989–2013), as well as a notable interest in the scientific production of studies on how different actors (victims, aggressors, health professionals, and/or students) perceive gender violence. However, among the main articles, there were no specific studies on women's identification as victims of gender violence.

Table 3

The 25 Most Cited Documents

Authors	Year	Title	Source	Number of cites	Number of cites per year
Feldhaus, K., Koziol-McLain, J., Amsbury, H., Lowenstein, S., & Abbott, J.	1997	Accuracy of 3 Brief Screening Questions for Detecting Partner Violence in the Emergency Department	*J Am Med Assoc, 277*(17), 1357-1361	393	17.08
Feder, G., Hutson, M., Ramsay, J., & Taket, A.	2006	Women Exposed Intimate Partner Violence: Expectations and Experiences When They Encounter Health Care Professionals: A Meta-Analysis of Qualitative	*Arch Intern Med, 166*, 22-37	316	22.57
Suarez, E. & Gadalla, T.	2010	Stop Blaming the Victim: A Meta-Analysis on Rape Myths	*J Interpers Violence,*	292	29.20

			25(11), 2010-2035		
Waalen, J., Goodwin, M., Spitz, A., Petersen, R., & Saltzman, L.	2000	Screening for Intimate Partner Violence by Health Care Providers: Barriers and Intervention	*Am J Prev Med, 19*(4), 230-237	284	14.20
MacMillan, H. et al.	2009	Screening for Intimate Partner Violence in Health Care Settings: A Randomized Trial	*J Am Med Assoc, 302*(5), 493-501	279	25.36
Flood, M. & Pease, B.	2009	Factors Influencing Attitudes to Violence Against Women	*Trauma Violence Abuse, 10*(2), 125-142	239	21.73
Arias, I. & Pape, K.	1999	Psychological Abuse: Implications for Adjustment and Commitment to Leave Violent Partners	*Violence Victims, 14*(1), 55-67	206	9.81
Fabiano, P., Perkins, H., Berkowitz, A., Linkenbach, J., & Stark, C.	2003	Engaging Men as Social Justice Allies in Ending Violence Against Women: Evidence for a Social Norms Approach	*J Am Coll Health Assoc, 52*(3), 105-112	204	12.00
Avery-Leaf, S., Cascardi, M., O'leary, D., & Cano, M.	1997	Efficacy of a Dating Violence Prevention Program on Attitudes Justifying Aggression	*J Adolesc Health, 21*(1), 11-17	200	8.69
Feder, G. et al.	2009	How Far Does Screening Women for Domestic (Partner) Violence in Different Heatlh-Care Settings Meet Criteria for a Screening Programme? Systematic Review of Nine UK National Screenning Committee Criteria.	*Health Technol Assess, 13*(16), 137-347	182	16.54
Langhinrichsen-Rohling, J.	2010	Controversies Involving Gender and Intimate Partner Violence in the United States	*Sex Roles, 62*(3-4), 179-193.	175	17.50
Dobash, R., Dobash, R., Cavanagh, K., & Lewis, R.	1998	Separate and Intersecting Realities: A Comparison of Men's and Women's Accounts of Violence Against Women	*Violence Against Woman, 4*(4), 382-414	150	6.82
Walker, L.	1989	Psychology and Violence Against Women	*Am Psychol, 13*(4), 611-632	149	4.80
Torres, S.	1991	A Comparison of Wife Abuse between Two Cultures: Perceptions, Attitudes, Nature, and Extent	*Issues Ment Health Nurs, 12*(1), 113-131	138	4.76
Gutmanis, I., Beynon, C., Tutty, L., Wathen, C., & MacMillan, H.	2007	Factors Influencing Identification of and Response to Intimate Partner violence: A survey of Physicians and Nurses	*BMC Public Health, 7*(12)	126	9.69
Kim, J. & Motsei, M.	2002	"Women Enjoy Punishment": Attitudes and Experiences of	*Soc Sci Med, 54*(8), 1243-1254	121	6.72

Hegarty, K. et al.	2013	Gender-Based Violence Among PHC Nurses in Rural South Africa Screening and Counselling in Primare Care Setting for Women Who Have Experienced Intimate Partner Violence (Weave): A Cluster Randomised Controlled Trial	*The Lancet, 382*(9888), 249-258	120	17.14
Banyard, V. & Moynihan, M.	2011	Variation in Bystander Behaviour Related to Sexual and Intimate Partner Violence Prevention: Correlates in a Sample of College Students	*Psychol Violence, 1*(4), 287-301	117	13.00
Fanslow, J. & Robinson, E.	2010	Help-seeking Behaviors and Reasons for Help RSeking Reported by a Representative Sample of Women Victims of Intimate Partner Violence in New Zeland	*J Interpers Violence, 25*(5), 929-951	115	11.50
Wolf, M. Ly, U., Hobart, M., & Kernic, M.	2003	Barriers to Seeking Police Help for Intimate Partner Violence	*J Fam Violence, 18,* 121-129	115	6.76
Johnson, J., Adams, M., Ashburn, L., & Reed, W.	1995	Differential Gender Effects of Exposure to Rap Music on African American Adolescents' Acceptance of Teen Dating Violence	*Sex Roles, 33,* 597-605	112	4.48
Rose, L., Campbell, J., & Kub, J.	2000	The Role of Social Support and Family Relationships in Women Responses to Battering	*Health Care Woman Int, 21*(1), 27-39	108	5.40
Heckert, D. & Gondolf, E.	2004	Battered Women's Perceptions of Risk versus Risk Factors and Instruments in Predicting Repeat Reassault	*J Interpers Violence, 19*(7), 778-780	107	6.69
Glass, N., Dearwater, S., & Campbell, J.	2001	Intimate Partner Violence Screening and Intervention: Data from Eleven Pennsylvania and California Community Hospital Emergency Departments	*J Emerg Nurs, 27*(2), 141-149	107	5.63
Gidycz, C., McNamara, J., & Edwards, K.	2006	Women's Risk Perception and Sexual Victimization: A Review of the Literature	*Aggression Violent Behav, 11*(5), 441-456	101	7.21

Note. J Am Med Assoc = Journal of the American Medical Association; Arch Inter Med = Archives in Internal Medicine; J Interpers Violence = Journal of Interpersonal Violence; Am J Prev Med = American Journal of Preventive Medicine; Trauma Violence Abuse = Trauma, Violence, & Abuse; Violence Victims = Violence and Victims; J Am Coll Health Assoc = Journal of American College Health Association; J Adolesc Health = Journal of Adolescent Health; Health Technol Assess = Health Technology Assessment; Am Psychol = American Psychologist Journal; Issues Ment Health Nurs = Issues in Mental Health Nursing; Soc Sci Med = Social Science & Medicine; Psychol Violence = Psychology of Violence; J Fam Violence = Journal of Family Violence; Health Care Woman Int = Health Care for Women International; J Emerg Nurs = Journal of Emergency Nursing; Aggression Violent Behav = Aggression and Violent Behavior.

Discussion

The present study was aimed at covering the lack of bibliometric studies that involved collecting and analysing the available scientific works on the perception and detection of gender violence as well as on identification as victims. The data obtained allow easy access to this information and clarifies it, favouring the approach used.

The increase in scientific production over time denotes a social change in interest and understanding of the problem. The most cited works focus on the perceptions and attitudes towards gender violence by victims, aggressors, health personnel, and students as well as on the detection of gender violence in health care.

Regarding studies focusing on victims of gender violence, Heckert and Gondolf (2004b) highlighted the importance of women's perceptions of recidivism of gender violence. They pointed out that this perception is a significant predictor of future victimization, even during the 15 months following the assessment. Likewise, Cattaneo et al. (2007) agreed on the importance of assessing the victim's perception of the violent situation, as a key aspect in predicting recidivism and preserving their safety. In this respect, Fanslow and Robinson (2010) indicated that one of the main reasons why victims of gender violence do not seek help is because they normalize the situation or do not perceive it as serious. Doing so could be dangerous because if the woman is incapable of perceiving violence in her relationship with her partner and making an interpretation adjusted to reality, then it will be difficult for her to assess the risk to her personal integrity and to make self-protection decisions. Therefore, as Andrés-Pueyo and Echeburúa (2010) pointed out, predicting the appearance of future violent behaviour allows one to assess risk and make graduated and re-evaluated decisions with respect to the prognosis. Continuing research along these lines is fundamental because it is necessary to become aware of a problem's existence, magnitude, and severity in order to confront it.

On the other hand, as some of the main studies showed, health professionals are essential in detecting gender violence. According to Taft et al. (2013), battered women tend to have worse general health, problems in pregnancy, and more premature deaths than women who do not suffer gender violence do. Similarly, battered women visit the doctor up to three times more often than other women do; thus, health centres should be encouraged to evaluate warning signs of gender violence among their patients (Campbell, 2002). To this end, according to previous studies (Shearer et al., 2006), health professionals' training and ability to perceive signs of gender violence will be essential to take action against this problem.

Regarding the main authors, Jacqueline Campbell stood out for her continuity and persistence in studying the topic over time, starting with her first publications in 1994 and maintaining her scientific production to the present day. Likewise, the rest of the authors contributed significantly to the advancement of knowledge on perceiving and detecting gender violence as well as identification as victims. In this line, we should note the importance of collaboration among authors, as well as among institutions, because a higher rate of international collaboration could be related to scientific publications having greater impact and visibility (Alonso-Arroyo et al., 2005). The results show a low level of international cooperation, with the majority of countries presenting single authorship. However, the high numbers of countries (n = 79), institutions (n = 159), and professionals (n = 2,758) involved in scientific production on the topic denote an interest amongst researchers worldwide and favours progress in the field of gender violence.

Finally, to identify the studies of interest, the authors mainly used terms related to gender violence, violence towards partners, and domestic violence ("intimate partner violence", "violence against women", "dating violence", or "domestic violence"). Although gender violence is recognised worldwide, not all countries have the same legislation or use the

same nomenclature to refer to violence against women. In order to obtain results with more precision, the search formula did not include the term “domestic violence”.

Regarding the limitations of the study, the results obtained should be interpreted with caution because the chosen methodology did not take into account the grey literature and could have excluded certain works related to the topic that may provide information of interest. However, this limitation was minimized by the wide coverage of journals and the number of documents available on Scopus. Likewise, Valderrama-Zurián and colleagues (2015) pointed out the need for greater rigour in the registration of accessible documents in Scopus because duplicate documents sometimes appear. This could affect the interpretation of the results obtained in bibliometric studies. Taking into account this limitation, articles resulting from the search were manually screened to ensure the lack of duplicates.

Conclusion

The findings allow one to see the current state of the topic of study with respect to scientific production, as well as its dispersion over time. The structuring and analysis of the results provide a starting point for future research and contribute to advancing the scientific knowledge on gender violence. In this line, it will be convenient to explore the governmental commitments adopted by each country at the national and international levels for preventing and approaching gender violence, as well as other related variables that allow one to understand the differences regarding the interest in studying this topic within each country. In the same way, theoretical studies that review and synthesize the available literature in this regard will be essential to determine what elements are influencing the identification of gender violence.

Hence, future research should continue to explore how different actors perceive gender violence because this constitutes the first step for effectively addressing the problem. The ability to identify even the most subtle signs of violence will be essential to prevent fatal consequences and adopt appropriate safety behaviors for the victim.

Estudio 2

Study 2

How Severity of Intimate Partner Violence is Perceived and Related to Attitudinal Variables? A Systematic Review and Meta-Analysis

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Abstract

Intimate partner violence against women (IPVAW) is a global public health problem where multiple factors, such as the perceptions and attitudes towards IPVAW, should be considered to properly address this issue. This systematic review and meta-analysis synthesized the information available about perceived severity of IPVAW by different actors, analyzed the relationship between attitudes toward IPVAW and perceived severity of IPVAW, and examined gender differences in perceived severity of IPVAW. A systematic search was conducted using Web of Science, Scopus, and ProQuest. Studies were included if (a) provide information about perceived severity of IPVAW (physical, psychological, or sexual violence); (b) the relationship between perception of severity of IPVAW and attitudes toward IPVAW was analysed empirically; (c) the languages of publication were English or Spanish; and (d) they were not theoretical studies or reviews. A total of 27 studies were included in systematic review and 12 in the meta-analysis. The results showed that men perceived IPVAW as less severe than women. Likewise, a negative relationship was found between perceived IPVAW severity and favorable attitudes toward IPVAW such as sexist views, victim blaming, excusing the perpetrator, rape myths acceptance, and traditional gender roles. These findings highlight some of the potential factors to focus on IPVAW prevention programs, and it offers a starting point for further research on barriers to the perception of IPVAW severity.

Keywords: intimate partner violence against women, perceived severity, minimization, attitudes, systematic review, meta-analysis

How Severity of Intimate Partner Violence is Perceived and Related to Attitudinal Variables? A Systematic Review and Meta-Analysis

Intimate partner violence (IPV) is one of the most common forms of violence against women (World Health Organization; WHO, 2021). Intimate partner violence against women (IPVAW) can include any physical, psychological, or sexual abuse, as well as controlling behaviors by a current or former intimate male partner (WHO, 2021). IPVAW is a global public health concern of epidemic proportions, with nearly one-third of the global population of women having experienced some form of IPVAW in their lifetime (WHO, 2013; 2021). Consequently, women who have been victims of IPV show adverse physical and mental health symptoms, such as fractures, chronic pain, hematomas, gastrointestinal problems, depression, anxiety, low self-esteem, and an inability to adapt (Blanco et al., 2004; Sarasua et al., 2007; Wang, 2016). Due to the prevalence and consequences of IPVAW victimization, examining variables to target for intervention and prevention efforts are needed.

IPVAW is a social problem where public response to IPVAW can have an important influence on victims, perpetrators, and society (Flood & Pease, 2009; Gracia et al., 2020; López-Ossorio et al., 2018). Specifically, attitudes towards IPVAW are related to IPVAW perpetration and play an important role in the responses to IPVAW by victims and perpetrators (Pease, & Flood, 2016; Wang, 2016). For example, women with favourable attitudes toward traditional gender roles were less likely to report IPVAW victimization (Harris et al., 2005). Likewise, attitudes that justify IPVAW, such as peer approval of IPVAW during dating in adolescence were related to IPV perpetration in adulthood (Eriksson, & Mazerolle, 2015). Attitudes toward IPVAW are also related to the social perception of the severity of IPVAW (Herrera & Expósito, 2009; Vidal-Fernández & Megías, 2014). In turn, perceived severity of IPVAW is associated to individuals' willingness to intervene in cases of IPVAW (Martín-Fernández et al., 2018). This suggests that addressing perceived severity of and attitudes

towards IPVAW could be an effective strategy to prevent IPVAW (Badenes-Sastre, & Expósito, 2021; Currier, & Carlson, 2009). Thus, in this study we examine the relationship between attitudes of acceptance of IPVAW and the perceived severity of IPVAW through a systematic review and meta-analysis.

Theoretical Framework

This study was guided by feminist theory. A tenant of feminist theory is the exploration of gender relations focusing on the social construction of gender, and how this leads to privilege and oppression (West & Zimmerman, 1987). When examining IPVAW, there is a focus on gender and oppression created by IPVAW victimization. Particularly, one factor that contributes to IPVAW are gender norms and attitudes, such as acceptance or justification of violence against women, which also impacts public and professional responses to IPVAW (Ferrer et al., 2020). A tenant of feminist theory is to dismantle the different forms of IPVAW legitimization in society, as well as understanding social perceptions and attitudes toward this problem (De Miguel, 2005). Based on feminist theory, exploring the influence attitudes towards IPVAW on perceived severity of IPVAW is important. Additionally, knowing how IPVAW is perceived is essential to predict help-seeking and reporting behaviors in the case of experiencing or witnessing partner violence (Kuijpers et al., 2021).

Gender differences in the perception of IPV have been found, with men showing lower perception of IPV severity than women (Kuijpers et al., 2021). In this regard, according to previous research, the normalization of violence against women could be influenced by attitudes towards victims, aggressors, and different forms of violence towards women (Herrera et al., 2014). For example, gender inequality supposes the assumption of stereotyped social and cultural roles according to sex and/or gender (European Institute for Gender Inequality, 2020) and it is a factor that contributes to IPVAW (Gracia et al., 2019), linking to tendency to perpetrate violence towards a partner and/or to be victimized by a partner, as well as greater

attitudes of tolerance towards aggression (Fitzpatrick et al., 2004). Hence, it will be essential to explore the influence of attitudes toward IPVAW on the perception of severity of IPVAW, because if IPVAW is not perceived, it will be an obstacle to its approach.

Perception of Severity and Attitudes towards IPVAW

Research examining the perception of IPVAW has increased significantly in recent years (Badenes-Sastre & Expósito, 2021). Perceived severity of IPV refers to people's beliefs about the magnitude or significance of the threat of IPV (Riddle & Di, 2020; Witte, 1994). The perception of IPVAW could vary depending on the type of violence, with physical or sexual violence potentially being perceived as more severe (Novo et al., 2016), and forms of violence such as threats or non-severe physical aggression being more tolerated than other forms of violence (Gracia & Herrero, 2006). Similarly, attitudes towards IPVAW, such as the acceptability of IPVAW, sexist beliefs, and blaming the victim are negatively related to the perception of the severity of IPVAW (Lelaurain et al., 2018a; Sánchez-Fernández et al., 2020). Recently, a systematic review about IPVAW in the European Union (Gracia et al., 2020) identified 20 labels to define attitudes towards IPVAW such as legitimization (e.g., victim blaming or justification), acceptability (e.g., tolerance or permissive attitudes), intervention (e.g., willingness or helping), and perceived severity (e.g., minimization or recognition), revealing associations between gender and attitudes toward IPVAW. Particularly, the study showed less acceptance and justification of IPVAW by women, as well as a higher perception of severity of IPVAW and willingness to intervene in cases of IPVAW than men. Similarly, Flood and Pease (2009), also pointed out that in general, men show more favorable attitudes towards IPVAW and perceive less severe IPVAW than women.

According to Ming and colleagues (2020) multiple factors, such as perceptions and attitudes toward IPV, should be considered when looking at methods to minimize and prevent IPVAW. Therefore, it is essential to explore how the severity of IPVAW is perceived by

different actors (Badenes-Sastre, & Expósito, 2021). Specially, victims of IPVAW usually take an average of more than eight years to verbalize their situation or filing a complaint (Spanish Ministry of Equality, 2020), suffering in silence because they may normalize the abuse and do not perceive the situation as severe (Fanslow & Robinson, 2010; Wang, 2016). It has a strong impact on the health of women who are victims of IPV, as it increases mortality risk by 40% (Chandan et al., 2020). Likewise, public, professionals', and victims' perceptions of IPVAW are influenced by their attitudes towards IPVAW (Gracia et al., 2018). Therefore, the perception of severity of IPVAW, as well as attitudes towards IPVAW are important variables to examine in order to address IPVAW. In this line, Gracia and colleagues (2020) conducted a systematic review about attitudes toward IPVAW during 2000-2018 in the European Union, including eight studies about perceived severity of IPVAW. However, no specific systematic review, without country limits, about perceived severity of IPVAW and its relation with attitudinal variables has been carried out. Additionally, no meta-analysis has been conducted to examine the relationship using all available quantitative data. Thus, it will be essential to examine how the severity of IPVAW is perceived, as well as how it is related to attitudes of acceptance of IPVAW. The present study aims to address this gap because it will promote further understanding of how the problem is perceived by different actors and what variables influence that perception, contributing to a more specific and effective approach to prevention and intervention efforts to reduce IPVAW. Additionally, conducting a meta-analysis and systematic review can highlight gaps in the current literature that may be beneficial to examine in future research.

The Present Research

The present systematic review and meta-analysis was conducted to synthesize the information available about perceived severity of IPVAW by the general population, perpetrators, victims of IPVAW, and professionals who work with victims of IPVAW.

Perceptions of IPVAW severity is an important construct to examine, as it may influence help-seeking behaviors by victims, public response to IPVAW, and can be utilized in education and prevention efforts (Fanslow & Robinson, 2010; Gracia et al., 2009). This study analyzed the relationship between attitudes towards IPVAW and perceived severity of IPVAW using a meta-analysis. Additionally, this study examined if there are significant differences between men and women on their perceived severity of IPVAW. In this respect, we hypothesized that people who present more favorable attitudes towards IPVAW will perceive its severity less than people with less favorable attitudes towards IPVAW (Hypothesis 1). Furthermore, we expected that men will perceive IPVAW as less severe than women (Hypothesis 2).

Method

This systematic review was performed according to the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) guidelines (Moher et al., 2009), and relevant methodological references (Perestelo-Pérez, 2013; Rubio-Aparicio et al., 2018). We registered the study in the International Prospective Register of Systematic Reviews (PROSPERO; registration number CRD42020215561). Likewise, to obtain effect sizes from relevant studies on attitudinal variables related to perceived severity of IPVAW, this study followed typical meta-analytic procedures (Borenstein et al., 2009; Card, 2012).

Search Strategy

We performed a comprehensive database search using Web of Science (including SciELO Citation Index, Russian Science Citation Index, MEDLINE, KCI-Korean Journal Database, Derwent Innovations Index, Current Contents Connect, BIOSIS Previews, BIOSIS Citation Index, and Collection Principal de Web of Science), Scopus, and ProQuest (including Health & Medical Collection, Nursing & Allied Health Database, ProQuest Dissertations & Theses Global, PsycARTICLES, PsycEXTRA, Psychology Database, PsycINFO, PsycTESTS, Education Collection, International Bibliography of the Social Science, and Social Science

Database). The search was conducted in November 2020, without limited temporality. The Boolean search terms that were used in order to locate studies within these databases that included terms related to perception of severity of IPVAW ("percept* sever*","perceive* sever*", "percept* serious*", "perceive* serious*", "percept* gravit*", "perceive* gravit*", and minimiz*), attitudes toward IPV (tolera*, accept*, approv*, jutif*, attitud*, opinion*, sexism*, attribut*, blam*, stereotyp*, and reject*), relationship between perception of severity of IPVAW and attitudes toward IPVAW (predictor OR correlate* OR relation* OR associat*), and IPVAW ("intimate partner violence against wom*" OR "violence against wom*" OR "gender violence" OR "gender-based violence" OR violence OR aggression OR abuse OR "domestic violence" OR maltreatment OR batter OR "dating relation*" OR "dating violence" OR "partner violence" OR "spouse abuse"). The database search was accompanied by a manual screening of references included in previous reviews on this topic.

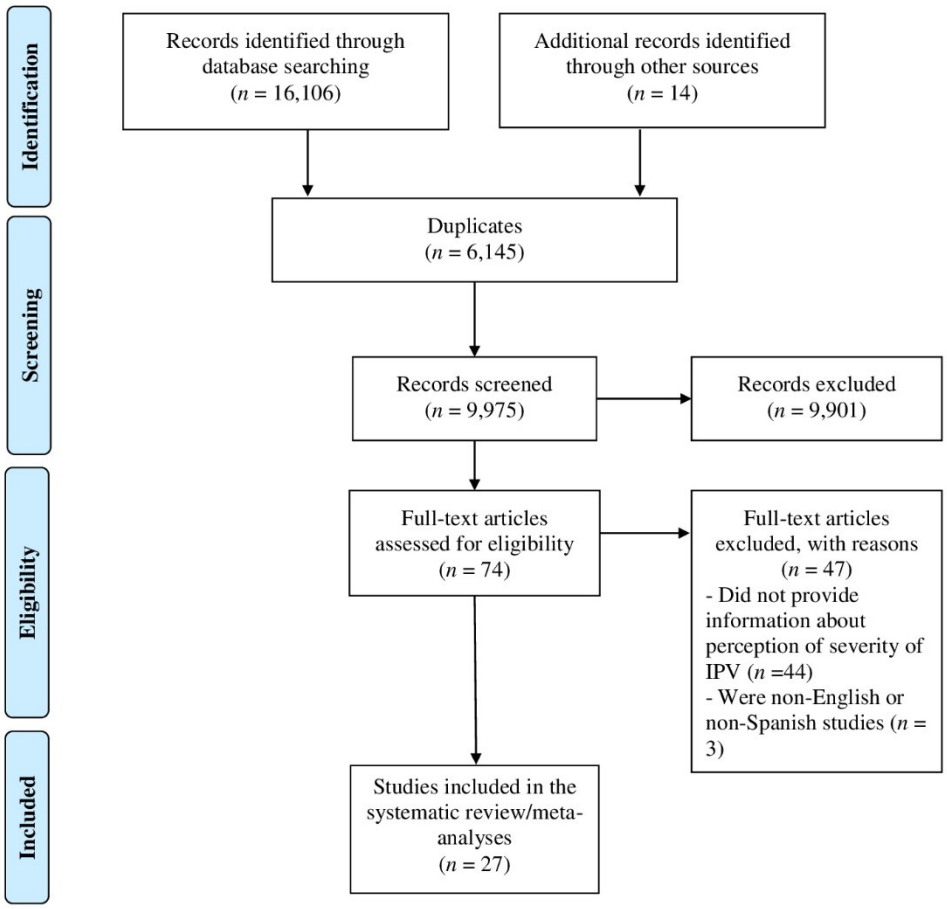
Studies Selection

Studies were included if they met the following inclusion criteria: (a) provide information about perceived severity of IPVAW (physical, psychological, or sexual violence); (b) the relationship between perception of severity of IPVAW and attitudes toward IPVAW was analysed empirically; (c) the languages of publication were English or Spanish; and (d) they were not theoretical studies or reviews. Conversely, we excluded studies that: (a) did not provide information about perception of severity of IPVAW; (b) were letters to the editor, reviews, or meta-analysis; and (c) were non-English or non-Spanish languages studies.

The database search initially revealed 16,106 studies, of which 6,145 were duplicates, and the manual search yielded 14 additional studies, resulting in a total of 9,975 studies. During the first step screening, 9,901 studies were excluded by title and abstract, and 74 studies were retained for full text screening. Finally, 27 studies were included in the systematic review and 12 in the meta-analysis (see the selection process PRISMA flow in Figure 1).

Figure 1

Selection Process PRISMA Flow Diagram



Data Extraction and Analysis

Two researchers (M.B. and M.A.) independently selected studies based on inclusion and exclusion criteria. Disagreements between researchers were solved by discussion and when required, through a consensus with a third researcher (C.S.). The screening was conducted in two phases. First, we selected articles by title and abstract to verify compliance with the inclusion criteria. Second, when the summary could not provide all require information, we selected definitive studies by full text. Once the articles meeting the inclusion criteria were selected, the researchers performed data extraction following a previously developed coding protocol. Specifically, extracted data included authors, year of publication, study population and demographic characteristics, assessment instruments, statistical analysis, type of violence,

perception of severity of IPVAW, attitudinal variables toward IPVAW, and main results. Inter-coder reliability was appropriate, obtaining 97.9% of agreement on systematic review studies, and 97.4% of agreement on meta-analysis studies.

Studies were included in the meta-analysis if they provided statistical information needed to calculate at least one bivariate effect size. Data extracted from the studies were entered and analyzed using Comprehensive Meta-Analysis Software 3.0 (Borenstein et al., 2014). First, using a random-effects approach (Borenstein et al., 2010) the aggregate correlation between perceived severity of IPVAW and approving attitudes towards IPVAW (including high levels of ambivalent sexism, hostile sexism, benevolent sexism, domestic violence myth acceptance, rape myth acceptance, victim blaming attitudes, agreement with traditional gender roles, and attitudes that excuse the perpetrator's actions) was calculated. The study was used as the unit of analysis, so that only one effect size was included per study. Therefore, if one study examined multiple attitudes towards IPVAW and provided multiple effect sizes, we calculated an aggregate effect size for that study so only one effect size was included per study in the analysis. Next, to ensure our finding was robust against potential publication bias, which refers to the phenomenon that insignificant findings often go unpublished, a Classic Fail-Safe *N* was calculated. A Classic Fail-Safe *N* (Rosenthal, 1979) provides the number of insignificant studies it would take to nullify the result to become statistically insignificant at a $p > .05$ level. Lastly, using the subgroup of gender as the unit of analysis and using women as the control group, a Hedges *g* statistic was calculated to determine if there was a significant difference between men and women on perceived severity of IPVAW.

Results

Systematic Review Results

Main studies characteristics of the 27 studies included, are collected in Table 1. The years of publication of the studies included ranged from 1992 to 2020, with 29.63% of the studies published in the last five years of the review.

Sample Characteristics

The total sample consisted of 37,290 participants (*n* = 32,234 general population (2,273 women; 1,347 men; 5 transgender; and 28,609 not differentiated by gender; *n* = 146 adolescents; *n* = 1427 students; *n* = 158 victims of IPVAW; *n* = 129 perpetrators; *n* = 350 Latin American immigrants; *n* = 143 police officers; *n* = 449 psychologists; *n* = 800 lawyers; and *n* = 110 participants over 65 years old). The overall gender distribution was 14.85% women, 8.42% men, 0.01% transgender, and 76.72% not differentiated by gender. Likewise, the nationality of samples recruited varied. Ten studies included samples from the United States, nine from Spain, two from France, two from Australia, one from Russia, one from Israel, one from Canada, and one from both Japan and United States.

Table 1

Characteristics of Studies Included

Authors and year	Sample	Type of violence	Variables evaluated	Evaluation instruments	Main findings regarding perceived severity of IPVAW
*Adams-Clark & Chrisler (2018)	152 men 253 women 5 transgenders	Sexual violence	- Minimization of rape - Victim blaming -Social desirability	- Rape vignettes describing a rape situation - 17 items adapted to previous research to assess perceptions of rape (7-point Likert response) - Four items from the Sex-Role Stereotypical Victim Blame Scale (Monson et al., 2000) to assess victim blaming - Four items from the Rape-Supportive Attributions Scale (Monson et al., 2000) to assess rape minimization - Marlowe–Crowne Social Desirability Scale (Crowne & Marlowe, 1960) to assess social desirability	Significant effects of gender and type of sexual act on victim blaming, and rape minimization. Men endorsed more victim blaming and more rape minimization than did women. Participants who read a vignette involving penile–vaginal intercourse scored significantly lower on rape minimization than did those who read a vignette involving digital sex on perpetrator, digital sex on victim, oral sex on perpetrator, and oral sex on victim.
Burke (2015)	585 women	Physical, psychological, and sexual violence	-Perceived severity of IPVAW	- Ad hoc questionnaire with 5 items to assess perceived severity of IPVAW	IPVAW in Appalachia will be seen as an issue of concern by the women participating across the counties being investigated. Women who experienced IPVAW perceived it more severe than women who did not experience IPVAW.
Cantera et al. (2009)	313 women (180 Euskera and 133 Spain)	Psychological violence	- Perceived severity of IPVAW	- VEC scale (Cantera, Estébanez, & Vázquez, 2009) to assess the perception of IPVAW (Euskera and Spain versions)	Euskera version: 48% of women did not perceived the behaviors presented as psychological violence; 29% perceived medium severity; and 23% perceived high severity. Spain version: 43% of women did not perceived the behaviors presented as psychological violence; 29% perceived medium severity; and 28% perceived high severity.

Delgado & Gutiérrez (2013)	110 participants over 65 years (42 men and 68 women)	Psychological and sexual violence	- Perceived severity of IPVAW	- VEC scale (Cantera, Estébanez, & Vázquez, 2009) to assess the perception of IPVAW	Low recognition ability for most dimensions, with significant differences by gender: in all dimensions perception is higher in women than in men. The effect of marital status indicates a lower ability of perception when people have a partner. Age only correlates negatively with the perception of violence when threats appear.
*Delgado & Mergenthaler (2011)	289 students (176 men and 113 women)	Psychological violence	- Perceived severity of IPVAW	- VEC scale (Cantera, Estébanez, & Vázquez, 2009) to assess the perception of IPVAW	Women perceived more severity in acts related to psychological violence than men. Men perceived more severity in acts related to physical and sexual violence than women. Perceived severity increases in higher educational courses.
Diakonova-Curtis (2013)	122 men 153 women	Sexual violence	- Comprehension and perception of rape - Crime evaluation - Behavior and personal character blame - Perceptions of how each character was dressed, how much alcohol each might have consumed at dinner, and how much the woman might have fought to get away from the man	- Three vignettes for assessing people's perception of marital, date and stranger rapes - 20 items ad hoc to assess comprehension of the vignette (three items), perceived severity of sexual assault scenarios (three items; 5-point Likert response), perceptions of sexual assault and tapped into common rape and domestic violence myths (eight items; 5-point Likert response), the consideration of the scenario as a crime (one item; yes/no), and about what the participants imagined of the scenario (five items; write answers) - Attitudes toward women scale (Spence & Helmreich, 1972)	The husband was blamed and held responsible the least, his actions were perceived as the most justified, and the incident was deemed the least serious, compared to the date or stranger scenarios. The stranger was blamed and held responsible the most, his actions were perceived as the least justified and the incident was deemed the most serious, compared to the husband or the date. The woman was blamed, held responsible and punished more when the incident occurred after a date than after dinner with her husband. The woman was not blamed, held responsible or punished when the incident occurred after a stranger followed her than either after a date or after dinner with her husband. People's attitudes about women's roles in the domestic and professional spheres were moderately related to their perceptions of the man's role in the sexual assault. The less

					traditional their attitudes about domestic and professional roles, the more of a role the man was viewed to play (i.e., the more he was blamed and held responsible for the incident occurring), the less justified his actions were deemed, and the more the incident was deemed serious.
Fiorillo-Ponte (1999)	37 victims of IPVAW	Physical violence	- Perceived severity of IPVAW	- One survey item addressed the participants' perception of the severity of their experienced abuse, asking them to describe the abuse from answers ranging from "not severe at all" to "life threatening"	Participants who experienced more severe abuse perceived the abuse as more severe than those who experienced less severe abuse.
Follingstad & DeHart (2000)	449 psychologists (251 men and 198 women)	Psychological violence	- Perceived severity of IPVAW in five clusters (threats to physical health; control physical freedom; general destabilization; controlling; ineptitude)	- Two random short forms of questionnaire were composed by 51 items (1. Decide if they believe that the behaviour was never abusive, in some contexts or always abusive. 2. If decided that the behaviour was abusive with a 5-point-Likert response). Form 1 (*n*=238), Form 2 (*n*=211)	The clusters "Threats to physical health" and "control physical freedom" obtained the highest mean scores in severity compared to clusters "general destabilization", "controlling", and "ineptitude".
Follingstad et al. (2004)	800 lawyers 449 psychologists	Psychological violence	- Perceived severity of IPVAW	- Psychological Abuse Scale (Follingstad & DeHart, 2000) to assess perceived severity of IPVAW	Psychologists were much more likely to view the abuse behaviors than the lay participants. Although psychologists were more likely to consider items to be psychological abuse, those lay participants who also determined them to be abusive were even more extreme in their ratings of the severity of the items. Females rated behaviors more severely than males, African American participants rated the behaviors as harsher than White participants, single participants were more severe in their ratings of behaviors labeled psychological abuse than either people living

					with a partner or those who had been previously married, and those people claiming to be a victim were more likely to label behaviors as abusive than those not labeling themselves as a victim.
Gilbert & Gordon (2017)	121 victims of IPVAW	Physical and psychological violence	- Abuse - Commitment with the relationship - Forgiveness of IPVAW - Minimization of IPVAW	- Conflict Tactics Scale (CTS; Straus, 1979) to assess abuse to resolve conflicts -Scale ad hoc to assess minimization of aggression (10 items; 5-point Likert response) - Acts of forgiveness scale (Drinnon, Jones, & Lawler, 2000) - Commitment Inventory (C.I.; Stanley & Markman, 1992)	Minimization of aggression was not significantly correlated with frequency of psychological and physical aggression, which suggests that minimization of aggression is a unique variable that is separate from the amount of actual violence that is experienced. Minimization of aggression did not significantly mediate either the relationship between personal dedication and forgiveness or constraint commitment and forgiveness. Commitment was positively related to minimization of aggression, and minimization of aggression was in turn significantly related to forgiveness.
Gracia et al. (2008)	145 police (115 men and 28 women)	Physical, psychological, and sexual violence	- Perceived severity of IPVAW - Level of the police involvement in the cases of IPVAW - Personal responsibility	- Perceived severity of incidents of partner violence against women scale (Gracia, García, & Lila, 2008) - Personal responsibility (Gracia et al., 2008) - Level of police involvement in the cases of IPVAW (Gracia et al., 2008)	The interaction between perceived severity and levels of police involvement was significant for the low and high perceived severity groups. Police officers perceiving incidents of IPVAWAW as more severe tend to choose the highest level of police involvement (law enforcement actions irrespective of the victim's wishes), as compared to police officers who perceived the same incidents of IPVAWAW as less severe. No significant differences were found in the perceived severity of IPVAW between gender, age, and years of experience as a police officer.

*Gracia et al. (2009a)	350 Latin American immigrants	Physical, psychological, and sexual violence	- Perceived severity of IPVAW	- Perceived severity of incidents of partner violence against women scale (Gracia, García, & Lila, 2008)	Men perceived lower levels of severity than women. High social disorder conditions, the level of perceived severity of domestic violence is higher when compared to low social disorder conditions.
Gracia et al. (2009b)	174 men 245 women	Physical, psychological, and sexual violence	- Perceived severity of IPVAW - Personal responsibility	- Perceived severity of incidents of partner violence against women scale (Gracia, García, & Lila, 2008) - Personal responsibility (Gracia et al., 2008) - Level of police involvement in the cases of IPVAW (Gracia et al., 2008)	Women perceived hypothetical scenarios of IPVAW as more severe, felt more personal responsible to act, and were more inclined to use mediating responses than men. The 25-45 age group also perceived the same scenarios as more severe and felt more personal responsible than those in the >45 years old group, however the youngest were those who felt less inclined to report the incidents to the police than the >45 years. The less educated perceived that the hypothetical scenarios of IPVAWAW were less severe, whereas the better educated were more willing to mediate. Participants who feel more personal responsible and perceive the same incidents of IPVAWAW as more severe (high perceived severity group) are more willing to report them to the police, as compared to those that perceive the same severity but feel less responsible.
*Gracia & Tomás (2014)	1,006 general population	Physical, psychological, and sexual violence	- Perceived severity of IPVAW - Perceived frequency of IPVAW - Victims blaming attitudes - Acceptability of IPVAW	- One item ad hoc “Please tell me whether you consider each of the following forms of domestic violence against women to be very serious (= 4), fairly serious (= 3), not very serious (= 2), or not serious at all (= 1) to assess perceived severity of different types of IPVAW - One item ad hoc “As far as you know, what is the frequency of domestic violence against women within Spanish families?” to assess perceived frequency of IPVAW	33% of the participants considered the provocative behavior of the woman as a cause of PV. Perceived severity of IPVAW had not significant association with victim blaming attitudes.

				- One dichotomy item "Please tell me whether you consider the provocative behavior of women to be a cause of domestic violence against women?" to assess victim blaming attitudes - One item ad hoc "In your opinion, is domestic violence against women?" (4-point Likert response)	
*Guerrero-Molina et al. (2017)	129 aggressors	Physical, psychological and sexual violence	- Perceived severity of IPVAW - Attribution of responsibility: blaming the victim, self-defense, self-attribution of blame, minimization - Ambivalent sexism - Self-esteem - Functional social support - Social desirability	- Attribution of Responsibility and Minimization of Harm Scale (Lila et al., 2008) to assess perceived severity of IPVAW and attribution of responsibility, blame victim, self-defense, and self-attribution of blame. - Ambivalent Sexism Inventory (ASI; Glick & Fiske, 1996), Spanish adaptation by Expósito, Moya, and Glick (1998) - Rosenberg Self-Esteem Scale (RSE; 1965), Spanish adaptation by Fernández-Montalvo and Echeburúa (1997) to assess self-esteem - Functional Social Support Questionnaire (FSSQ) by Broadhead, Gehlbach, Degruy, and Kaplan (1988), Spanish adaptation by Bellón, Delgado, Luna, and Lardelli (1996) - Social Desirability Scale (SDS; Crowne & Marlowe, 1960), the Spanish adaptation by Ferrando and Chico (2000) to assess social desirability	Most offenders have high scores on low minimization of the harm caused during the aggression. Minimization of harm done correlated with ambivalent sexism, hostile sexism, benevolent sexism, and it was not related to social support and self-esteem. Sexist attitudes predict minimization of the harm done.
Herzog (2004)	987 general population	Physical, psychological and sexual violence	- Perceived severity of IPVAW - Criminal offenses	- A Likert-type scale ranging from 1 = n*ot serious at all* to 11 =*very serious* to assess the perceived severity of 18 crime scenarios representing various criminal offenses including IPVAW	Jewish respondents considered marital assault as the third most serious offense evaluated, whereas Arab respondents perceived it as significantly less serious than all the other violent and nonviolent offenses evaluated, except for tax evasion. Arab and/or men respondents assigned significantly lower seriousness scores to these scenarios than did Jewish and/or women respondents.

*Kienas (2009)	326 students (183 men and 143 women)	Physical and sexual violence	- Victim minimization - Victim blaming - Identification with the victim - Feelings of anger and pity - Behavioral tendencies to protest - Desired length of penalty for the perpetrator	- Eight vignettes representing a specific combination of three of the study's independent variables: race of victim, race of perpetrator, and alcohol consumption - Rape-Supportive Attributions Scale (RSAS; Langhinrichsen-Rohling & Monson, 1998) to assess the participant's minimization of the seriousness of the rape. - Victim Blame Scale (VBS;Langhinrichsen-Rohling & Monson, 1998) to assess the victim blame attribution - Identification with the victim (Lodewijkx et al., 2005) - Tendency to protest short version (Zomeren & Lodewijkx, 2005) - Feelings of anger and pity (Zomeren & Lodewijke, 2005) - Modification of Rape Responsibility Questionnaire (RRQ; Deitz., Littman, & Bentley, 1984) by Szymanski et al. (1993) to assess desired length of penalty for the perpetrator	No significant differences were found to minimization between groups that participate in person or online. Men were more minimizing of the victim's experience than women. Victim minimization negatively correlated with victim blaming, identification with the victim, anger, pity, tendency to protest, and desire of penalty for the perpetrator.
*Lelaurain et al. (2018a)	115 men 120 women	Physical and psychological violence	- Perceived severity of IPVAW - Romantic love - Ambivalent sexism - Domestic myths	- 12 item ad hoc to assess victim blame, exoneration of the perpetrator, and perceived severity of IPVAW through a short scenario about IPVAW situation (7-point Likert response) - Attitude Toward Love Scale (Knox, 1970; Knox & Sporakowski, 1968) - Ambivalent Sexism Inventory (Dardenne et al., 2006; Glick & Fiske, 1996) - Domestic Violence Myth Acceptance Scale (Lelaurain, et al., 2018; Peters, 2008)	Romantic love was not a predictor of perceived severity of IPVAW. Perceived severity of IPVAW was correlated with romantic love, ambivalent sexism, domestic violence myths, victim blame and exoneration of perpetrator.
*Lelaurain, et al. (2018b)	75 men 72 women	Physical violence	- Perceived severity of IPVAW - Justification of IPVAW	- Vignette and conditional script questionnaire consisting of 18 items (4-point Likert) to measure perceived severity, and perceived justification.	Women participants perceived violence as more severe than did men participants. When the participants were interacting with men researcher perceived violence more severe than with a women researcher.

			- Legitimizing ideologies - Ambivalent sexism	- Domestic Violence Myth Acceptance Scale (Peters, 2008) - Ambivalent Sexism Inventory (Dardenne et al., 2006; Glick & Fiske, 1996)	
Marshall (1992)	915 women (707 students and 208 women community)	Physical, psychological and sexual violence	- Perceived severity of IPVAW	- Severity of violence against women scales (validation study) with10-point Likert response	46 acts were proposed to discriminate among nine dimensions of IPVAW against women. The women community perceived more severity IPVAW than women students.
Murphy & Smith (2010)	146 adolescent women	Psychological violence	- Perceived severity of IPVAW - Previous exposure to warning-sign behaviors - Response protectiveness	- Questionnaire booklet "What's OK and what's not in relationships?" that consisted in 21 items that assess: the perceived severity of psychology violence ("It this OK if it is happens in a relationship?" 5-Likert response), the previous exposure to warning-sign behaviors ("Has this happened to you in a relationship?" yes/no), and the response protectiveness ("How would you respond if a partner did this to you? 3-Likert response)	Jealous/possessive behaviors were perceived to be the least problematic domain. Verbal aggression was perceived to be the most serious problem in a relationship. Public debasement was considered more serious than personal putdowns. Broader exposure to exit-control tactics, jealousy/possessiveness, verbal aggression, and personal putdowns was weakly associated with lower perceived severity.
*Sánchez (1997)	106 men 120 women	Sexual violence	- Perceived severity of IPVAW - Tolerance / acceptability of rape - Opinions regarding punishment - Labelling of the event	- Scenario case history and 11 items ad hoc to assess perceived severity of IPVAW - Attitudes Toward Women Scale (Spence Helmreich, 1972) - Rape Myth Acceptance Scale (Burt, 1980)	Rape myth beliefs were significantly correlated with perceived severity of IPVAW. Individuals high in rape myth beliefs were more likely to disagree that a serious crime was committed. In contrast, those low in rape myth beliefs were more likely to agree that a serious crime was committed. There were significant differences between case histories on perceived severity of IPVAW, individuals in the stranger rape condition agreed more strongly with the statement than subjects in the marital rape condition.
Sánchez-Fernández et al. (2020)	344 students (120 men and 224 women)	Psychological violence	- Perceived severity of IPVAW - Justification of violence behavior	- One item ad hoc ""How severe do you consider the described episode?" (7-point Likert response) to assess perceived severity of IPVAW - One of the following items, according to the experimental condition: "How justified do you consider Juan's behavior to be" (observer	Statistically significant interaction between means of control that was used and the acceptability of IPVAW against women on the measure of perceived severity of the situation.

			- Experiences of controlling behaviors in participants' own relationships - Frequency of controlling behaviors in young couples - Subjective risk perceived of dating violence - Acceptability of IPVAW - Ambivalent sexism - Myths toward love	condition) or "How justified do you consider your partner's behavior to be" (protagonist condition) (7-point Likert response) to assess justification of violence behavior - One item ad hoc "How often have you experienced similar or equal situations in your relationships?" (7-point Likert response) to assess experiences of controlling behaviors in participants' own relationships - One item ad hoc "How often do you think these situations occur amongst young couples?" (7-point Likert response) to assess frequency of controlling behaviors in young couples - An adaptation of the self-anchoring scaling designed by Kilpatrick and Cantril (1960), to assess subjective risk perceived of dating violence - Acceptability of IPVAW against women (A-IPVAWAW; Martín-Fernández, Gracia, Marco et al., 2018) - Ambivalent Sexism Inventory (ASI; Glick & Fiske, 1996), Spanish adaptation by Expósito, Moya, and Glick (1998) - Myths Scale toward Love (Bosch et al., 2007; adapted in an adolescent sample by Rodríguez-Castro et al., 2013)	In face-to-face condition low levels of acceptability of IPVAW against women predicted a greater perception of severity in comparison with high levels. Statistically significant interaction between IV Means of Control and benevolent sexism on the 'perceived severity of the situation' measure. In the face-to-face condition, low levels of benevolent sexism predicted a greater perception of severity in comparison with high levels. High scores for A-IPVAWAW predicted a lower perceived severity. Significant interaction between adopted role on the scene and acceptability of IPVAW against women on the measure of perceived severity, so in the protagonist condition, low levels of acceptability of IPVAW against women predicted a greater perception of severity of the situation in comparison with high levels. High levels of hostile sexism predicted a lower perceived severity of the situation, high acceptability of IPVAW against women predicted a lower perceived severity of the situation, and high scores for myths about romantic love predicted low perception of severity.
Webster (2014)	27,622 general population	Physical, psychological and sexual violence	- Perceived severity of IPVAW - Gender roles	- Survey to assess different aspects. Specifically, one item to assess the perception of severity of IPVAW: "violence against women is a serious issue for our community" (somewhat agree; strongly agree)	There was a very high level of agreement with the statement that "violence against women is a serious issue for our community" (95%), with most respondents (83%) indicating that they 'strongly' as opposed to 'somewhat' agree with this proposition. This is virtually unchanged from 2009 levels (96%). Participants with a high score on the gender roles are more likely to agree that IPVAW is a serious issue in our community (98%), while

					a low gender roles score is linked with lower levels of agreement (91%).
*Yamawaki et al. (2009)	194 students (91 men and 103 women)	Physical violence	- Perceived severity of IPVAW - Excuse perpetrators - Blame victims - Ambivalent sexism - Gender roles	- Three fictitious scenarios (control; injury; frequency) - Five items ad hoc (7-point Likert response) to assess perceived severity of IPVAW - Five items ad hoc (7-point Likert response) to assess victim blame attribution - Three items ad hoc (7-point Likert response) to assess excuse-perpetrator - Ambivalent sexism inventory (Glick & Fiske, 1996) - Sex role ideology scale-short form (Kalin & Tilby, 1978)	Japanese participants tended to minimize the seriousness of IPVAW more than did American participants. The differences between men and women in perceived seriousness and excusing were not significant. There were significant mediated effects for gender in blaming victim and perceived severity of IPVAW via the effects of gender role traditionally.
*Yamawaki et al. (2012)	77 men 117 women	Physical violence	- Perceived severity of IPVAW - Victim blame attribution - Domestic violence myths - Perpetrator excuse	- Minimization scale (Yamawaki et al., 2009) to assess perceived severity of IPVAW - Victim blame attribution scale (Yamawaki et al., 2009) - Domestic violence myths scale (Yamawaki et al., 2011) - Perpetrator excuse scale (Yamawaki et al., 2009)	Men participants tended to minimize the seriousness of the assault more than women participants. Male participants and individuals who more strongly endorsed domestic violence myths tended to minimize the incident of domestic violence, more than female participants and individuals who endorsed the myths less.
*Yamawaki et al. (2018)	111 students (47 men and 64 women)	Physical and psychological violence	- Minimization of IPVAW - Victim blaming - Gender role traditionality - Victim blaming	- Two fictitious scenarios (Yamawaki et al., 2009) - Sex-role egalitarianism abbreviate scale (King, King, Carter, Surface, & Stepanski, 1994) - Perceived seriousness of violence measure (Yamawaki et al., 2009) to assess minimization of IPVAW - Victim blaming attitudes measure (Yamawaki et al., 2009) - Body shape measure (Bhuiyan, Gustat, Srinivasan, & Berenson, 2003)	The results indicated that the assault that was perpetrated by the female abuser was minimized more in comparison to the assault that was perpetrated by the male abuser, and male participants tended to minimize the seriousness of the IPVAW incident more than did female participants. Men minimization of the seriousness of the IPVAW incident more than women.

Note: IPVAWAW= Intimate Partner Violence Against Women; *Studies included in the meta-analysis.

IPVAW Perceived Severity Assessment

Four studies assessed physical violence, six psychological violence, two sexual violence, five physical and psychological violence, one psychological and sexual violence, and nine examined all of the types of violence (physical, psychological, and sexual). In this regard, although of terminology to evaluate perceived severity of IPVAW was similar among studies, the instruments to assess it was heterogeneous.

Particularly, some studies used items ad hoc to assess the perception of severity of IPVAW about a vignette or scenario (n = 11), warning sign behaviours (n = 1), statements about the IPVAW (n = 6), the victim's experience of abuse (n = 1), or applied specific questionnaires like Attribution of Responsibility and Minimization of Harm Scale (Lila et al., 2008; n = 1), Perceived Seriousness of Violent Measure (Yamawaki, Ostenson, & Brown, 2009; n = 3), Psychological Abuse Scale (Follingstad & DeHart, 2000, n = 1), and VEC Scale (Cantera, Estébanez, & Vázquez, 2009; n = 3).

Main Findings about Perceived Severity of IPVAW

Regarding the most relevant findings on the perception of severity of IPVAW, this systematic review showed that physical violence was perceived more severe by women than men (Lelaurain et al., 2018b; Yamawaki et al., 2012; Yamawaki et al., 2018), as well as among women who were victims of physical violence, with women reporting experiencing severe abuse perceiving IPVAW as more severe (Fiorillo-Ponte, 1999). Also, differences in the perception of physical violence according to nationality were found. Specifically, Japanese students tended to minimize the severity of physical IPVAW more than did American students (Yamawaki et al., 2009).

In relation to psychological violence, Cantera and colleagues (2009) found that almost half of the women did not perceive psychological violence as severe. Similarly, psychological violence was perceived more severe by psychologists than lawyers, and women perceived

psychological violence as more severe than men (Follingstad et al., 2004). Differences between groups were also found in the perception of the severity of sexual violence. For example, men minimized the severity of sexual violence more than women did (Adams-Clark & Chrisler, 2018). Likewise, when scenarios of sexual IPVAW were compared to violence by a stranger, individuals perceived sexual violence by a stranger as more severe than that of the partner (Diakonova-Curtis, 2013; Sánchez, 1997).

Other studies assessed physical, psychological, and sexual IPVAW but none of the studies analyzed the differences according to these types of violence. However, some studies found a relationship between certain socio-demographic variables such as marital status, education, age, nationality, or previous experiences of IPV, and the perception of severity of IPVAW. People with a partner were less likely to perceive psychological and sexual violence as severe (Delgado & Gutiérrez, 2013; Follingstad et al., 2004). Also, people with higher levels of education (Delgado & Mergenthaler, 2011; Gracia et al., 2009b), and younger people perceived IPVAW to be more severe (Delgado & Gutiérrez, 2013; Gracia et al., 2009b). However, no significant differences were found in the perceived severity of IPVAW according to age, in a sample of police officers (Gracia et al., 2008). Regarding nationality' differences, African American participants rated psychological violence as more severe than White participants (Follingstad et al., 2004); Jewish respondents considered marital assault as the third most serious offense evaluated, whereas Arab respondents perceived it as significantly less serious than all of the other violent and nonviolent offenses evaluated (Herzog, 2004); and Japanese participants tended to minimize the seriousness of physical violence compared to American participants (Yamawaki et al., 2009). Likewise, women who experienced IPV perceived it more severe than women who did not indicate experiences of IPV (Burke, 2015; Follingstad et al., 2004). These gender differences were not found in a sample of police officers (Gracia et al., 2008).

Relation between Perception of Severity and Attitudes toward IPVAW

Several studies explored the relation among perception of severity of IPVAW and some attitudinal variables. Specifically, perceived severity of IPVAW was negatively related to ambivalent, hostile, and benevolent sexism (Guerrero-Molina et al., 2020) and, traditional gender roles (Webster, 2014), while a high perception of severity of IPVAW was positively linked to a greater willingness to intervene by a sample of police (Gracia et al., 2008). However, perceived severity of IPVAW was not associated with victim blaming attitudes (García & Tomás, 2014), or frequency of physical and psychological violence (Gilbert & Gordon, 2017).

Likewise, perceived severity of physical and psychological violence was correlated with romantic love, ambivalent sexism, domestic violence myths, victim blaming, and exoneration of perpetrator (Lelaurain et al., 2018a). Perceived severity of physical violence was negatively related to domestic violence myths (Yamawaki et al., 2012), and perceived severity of physical and sexual violence was negatively associated with victim blaming, and positively associated with empathy for the victim, anger towards what happened to the victim, compassion for the victim, desire to protest IPVAW, and desire of penalty for the perpetrator (Kienas, 2009). Particularly, Kienas (2009) found that men reported a greater tendency to minimize the severity of the violent situation and blame the victim, as well as having less anger about what happened towards the victim, less compassion towards the victim, less desire to protest IPVAW, and a lesser desired of penalty for the perpetrator than women. Perceived severity of sexual violence was negatively related to attitudes about women's roles in the domestic and professional spheres (Diakonova-Curtis, 2013), as well as rape myth beliefs (Sánchez, 1997). Lastly, perceived severity of psychological violence was negatively linked to benevolent sexism and acceptability of IPVAW (Sánchez-Fernández et al., 2020). Contradictory results were found in the relationship between the perception of the severity of IPVAW and victim blaming, requiring more studies to clarify it.

Meta-Analysis Results

A total of six studies examined the relationship between attitudes towards IPVAW (ambivalent sexism, hostile sexism, benevolent sexism, domestic violence myth acceptance, rape myth acceptance, victim blaming attitudes, agreement with traditional gender roles, and attitudes that excuse the perpetrator's actions) and perceived severity of IPVAW (see Figure 2). We found a significant, negative relationship between accepting attitudes towards IPVAW and perceived severity of IPVAW (r = -0.28, 95% CI = -0.37, -0.17, p < .001). This means that the higher levels of agreement with favorable attitudes towards IPVAW, the less severe someone would perceive IPVAW to be. Additionally, we calculated a Classic Fail-Safe n of 358, meaning it would take 348 insignificant studies to nullify our current result, suggesting our result is robust against potential publication bias. Lastly, when examining if there was significant difference between men and women on their perceived severity of IPVAW, it was found that men perceived IPVAW as significantly less severe than women (Hedges g = -0.39, p < .001; See Figure 3).

Figure 2

Forest Plot for Meta-analysis on the Correlation between Attitudes Towards IPVAW and Perceived Severity of IPVAW

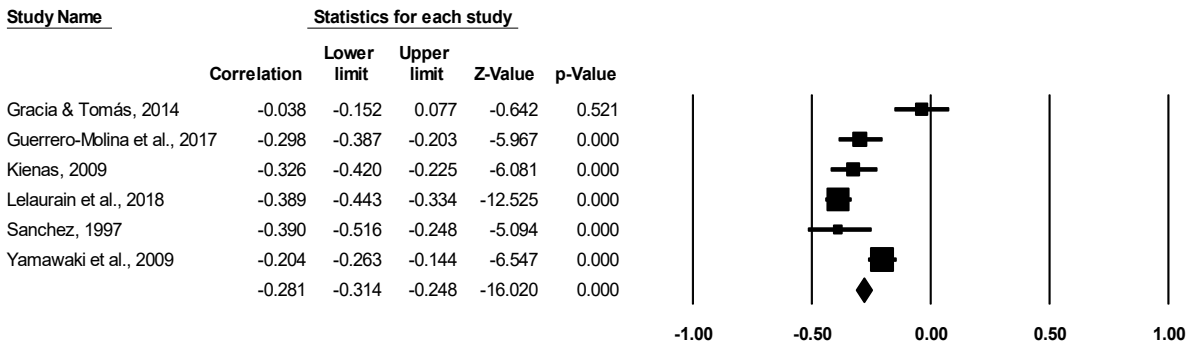
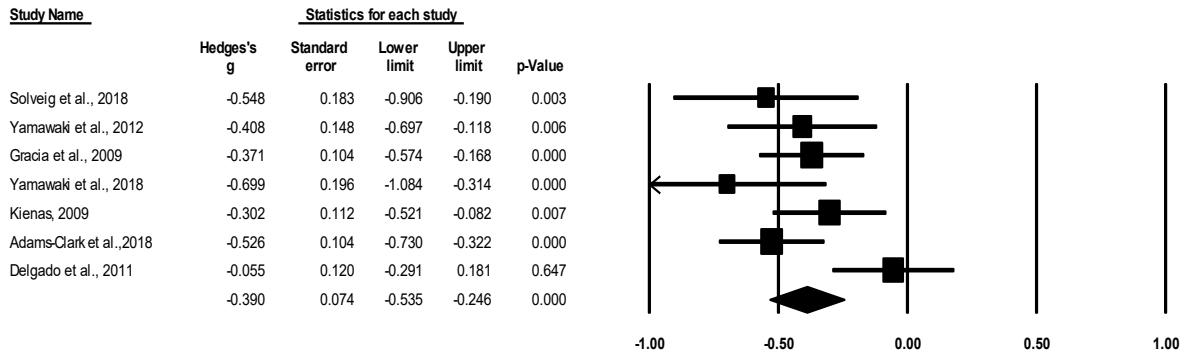


Figure 3

Forest Plot for the Difference between Men and Women on Their Perceived Severity of IPVAW (Hedges g; Women Used as the Control Group)



Note. Effect sizes (Hedges *g*) with a negative values indicates that men perceived IPVAW as less severe than women, and a positive value would indicate that women perceived IPVAW as less severe than men.

Discussion

Examining individuals' perceived the severity of IPVAW is critical for IPVAW prevention and intervention work. Knowing how IPVAW is perceived by different actors of society (e.g.: victims, perpetrators, students, or professionals), as well as its relation to attitudes towards IPVAW, can aid in the efforts to reduce IPVAW and support survivors. However, there are no studies that synthetize and analyze all information available on this topic. In order to address this gap, this study collected information about 27 studies that assessed perceived severity of IPVAW, and 12 studies were examined by meta-analysis.

The systematic review analyzed 27 studies that explored the perceived severity of IPVAW. The systematic review and the meta-analysis results revealed differences in the perception of severity of IPVAW by gender. Specifically, men showed lower perceptions of severity of IPVAW than women (Adams-Clark & Chrisler, 2018; Delgado & Gutiérrez, 2013; Delgado & Mergenthaler, 2011; Follingstad et al., 2004; Gracia et al., 2008; Gracia et al.,2009a; Gracia et al.,2009b; Kienas, 2009; Lelaurain et al., 2018b; Yamawaki et al., 2009; Yamawaki et.,2012; Yamawaki et al., 2018), supporting Hypothesis 2. These differences could

be explained by traditional gender roles based on gender inequality that, assuming a normalization of violence based on the superiority of men over women and constituting one of the main causes of IPVAW (Expósito & Herrera, 2009). Precisely, feminism involves a set of beliefs and ideas towards gender equality (Fiss, 1994), and feminist identification reflects attitudes towards the social construction of gender and is related to more favorable attitudes to support movements designed to achieve gender equality (Van Breen et al., 2017). It will be fundamental to educate in gender equality for minimizing the normalization of IPVAW.

The heterogeneity of studies regarding the sample and type of violence assessed should be noted. Out of the entire sample (n = 37,290), only 9.70% were differentiated by gender. It is noteworthy that although previous literature points to gender inequality as one of the main reasons for IPVAW (Gracia et al., 2019; Hunnicutt, 2009; WHO, 2005), the findings of our study displayed a low percentage of research committed to examining a gendered perspective related to attitudes toward IPVAW. In this regard, it will be essential to incorporate a feminist perspective in research, considering differences between women and men to solve traditional androcentrism (Eguiluz et al., 2011; Ferrer, & Bosch, 2005), as well as to adopt more specific and effective measures to address IPVAW. Also, United States and Spain were the countries with the highest number of studies on the subject. In this sense, the influence of social and cultural norms in IPVAW (Gracia et al., 2020; Ngoc et al., 2013) should be considered to explore cultural differences with other countries and when interpreting the results.

The meta-analytical results displayed a negative association between perceived severity of IPVAW and favorable attitudes toward IPVAW, such as sexism, victim blaming, excusing the perpetrator, rape myths beliefs, and gender roles (Adams-Clark & Chrisler, 2018; Gracia & Tomás, 2014; Guerrero-Molina et al., 2020; Kienas, 2009; Lelaurain et al., 2018a; Sánchez-Fernández et al., 2020; Webster, 2014; Yamawaki et al., 2009; Yamawaki et al., 2012; Yamawaki et al., 2018). These results confirm Hypothesis 1 and imply the need to focus on

attitudes that could make the perception of severity of IPVAW invisible. According to Gracia and colleagues (2020), attitudes toward IPVAW are related to perpetration and public response to IPVAW and reveal social and cultural norms that contribute to accepting or rejecting violence in the relationship. These findings have strong implications for victims because if they do not perceive the severity of the situation, or do not perceive supportive responses from society, they may be less likely to seek resources or support. Likewise, it will be essential to intervene in the elements that hinder the perception of severity of IPVAW by society as a first step in its approach, because if we do not consider the severity of a problem, we will not act accordingly. Therefore, the importance of continuing to explore attitudes and acceptance of IPVAW is paramount.

A key goal of the study was to examine the perception of IPVAW by different actors. Findings highlight the importance of examining the perceived severity of IPVAW, as well as the attitudes towards IPVAW, that professionals who support victims of IPVAW have. For example, it was found that lawyers perceived IPVAW as less severe than psychologists (Follingstad et al., 2004), which may indicate additional training related to IPVAW for lawyers who work on intimate partner violence cases. Although some studies analyzed the perception of severity of IPVAW in samples of professionals such as police (Gracia et al., 2008), lawyers (Follingstad et al., 2004), or psychologists (Follingstad & DeHart, 2000; Follingstad et al., 2004), we did not find any studies that explored the perceived severity of IPVAW by health care professionals. This is an important gap to address because women who suffer IPVAW visit healthcare centers three times more often than women who do not suffer IPVAW victimization (Shearer et al., 2006). Health care professionals can have an essential role in detecting warning signs of IPVAW among their patients (Shearer et al., 2006). According to Heron and Eisma (2020), health care professionals in healthcare service are in a privileged

position to prevent and intervene in IPVAW. Hence, future studies are needed to evaluate the perceptions and attitudes of health care professionals regarding IPVAW.

Although there was variation regarding the type of IPVAW (e.g., sexual, physical, or psychological) examined in each study, none of the studies examined differences in the perception of severity based on the type of IPVAW. Only a few studies assessed the perception of severity of IPVAW according to the type, such as sexual (Adams-Clark & Chrisler, 2018; Diakonova-Curtis, 2013; Sánchez, 1997) or psychological violence (Cantera et al., 2009; Delgado & Gutiérrez, 2013; Delgado & Mergenthaler, 2011; Follingstad & DeHart, 2000; Follingstad et al., 2004; Murphy & Smith, 2010; Sánchez-Fernández et al., 2020). Therefore, future research should consider the comparison among types of IPVAW due to the difficulty of detecting psychological violence compared to physical or sexual violence (Novo et al., 2016). Similarly, additional types of violence, such as cyber abuse, financial abuse, and stalking warrant attention for future research.

Although it was not the objective of this systematic review, several studies showed a significant relationship between perceived severity of IPVAW and socio-demographic variables. For example, having a partner decreases the perceived severity of psychological (Delgado & Gutiérrez, 2013; Follingstad et al., 2004) and sexual IPVAW (Delgado & Gutiérrez, 2013). Similarly, lower educational courses (Delgado & Mergenthaler, 2011; Gracia et al., 2009b) were associated with less perception of severity of IPVAW. Also, differences between nationalities such as African American vs. White American (Follingstad et al., 2004), Jewish vs. Arab (Herzog, 2004), and Japanese vs. American (Yamawaki et al., 2009) as well as differences between women who previously experienced IPV compared to women who were not victims of IPV (Burke, 2015; Follingstad et al., 2004) were found. Specifically, women who experienced IPV perceived it as more severe than those who not experienced IPVAW (Burke, 2015; Follingstad et al., 2004). It is noteworthy that no significant effects were found

among the perceived severity of IPVAW, and age, gender, or previous experiences were found by Gracia and colleagues (2008). In this line, Gutiérrez and Delgado (2013) showed that age only correlates negatively with the perception of severity of threats. According to the socio-ecological model of violence, the influence of social and cultural factors are needed to for understanding the IPVAW (Cummings et al., 2013), as well as for deepening its influence on the perceived severity of IPVAW, facilitating the design of more specific prevention programs.

Limitations and Future Directions

Although rigorous methods for this study were carried out, the findings should be interpreted with caution because the results are limited to the data obtained from the included studies. As for any systematic review and meta-analysis, it is always possible that there were studies that were missed from inclusion. Firstly, the number of studies included in the meta-analysis was limited (n = 12), and only six studies analysed the relation between perception of severity of IPVAW and attitudinal variables, requiring more research in this line to generalize the results. Secondly, the instruments to assess of perceived severity of IPVAW, as well as the type of IPVAW (physical, psychological and/or sexual) measured were heterogeneous. Nonetheless, the conceptualization of the perception of the severity of IPVAW was similar in all studies. Finally, the studies included in the systematic review examined a variety of samples. However, there were not enough studies to include in the meta-analysis and analyze the results according to sample. Specifically, only two studies assessed perceived severity of IPVAW in victims and a single study did so with aggressors. Future research may benefit from examining attitudes and perceptions of IPVAW with a variety of actors, such as victims and perpetrators of IPVAW.

In light of these limitations, future research should continue to explore what factors facilitate or impede how individuals perceive the severity of IPVAW, as well as to analyze the differences in it according to the sample and type of IPVAW. Likewise, ideological variables

(Vidal-Fernández & Megías, 2014), gender, culture, and legal contexts (Flood & Pease, 2009) should be considered as possible influencing factors in the perception of IPVAW severity, adopting an approach that considers the interaction of cultural, social, and psychological factors (Heise, 1998). It may also be useful to societal factors that may influence perceived severity of IPVAW, such as mass media (Anastasio & Costa, 2004; Flood & Pease, 2009; Herrera & Expósito, 2009) or feminist movements (De Miguel, 2005) that make violence visible. All of this would facilitate the visibility of the severity of IPVAW, and, consequently, more effective prevention programs and interventions.

Implications for Research, Practice, and Policy

The current study has robust implications for research, practice, and policy. It provides novel and current findings regarding how severity of IPVAW is perceived and its relation with certain attitudinal variables. Concerning research implications, the results obtained contribute to advancing the scientific knowledge on IPVAW, allowing other researchers continue exploring this topic based on previous conclusions. Also, this study suggests the need to carry out more research about perception of severity of IPVAW that: a) explore the reasons of gender differences; b) analyse the differences according to culture and socio-demographic variables; c) compare among types of IPVAW (physical, psychological, and sexual); d) focus on professionals who attend victims of IPVAW (Follingstad et al., 2004), and e) investigate the influence of ideological variables (Vidal-Fernández & Megías, 2014). This would allow us to adopt a global perspective of IPVAW, considering its impact at different levels (López-Ossorio et al., 2018).

In relation to practical implications, the results obtained in this study suggest the need to apply preventive measures focused on reducing favorable attitudes towards IPVAW that facility the normalization of IPVAW and difficult the perception of its severity. In this regard, education efforts that target attitudes towards IPVAW for professionals who attend victims of

IPVAW, such as police, lawyers, and health care professionals, is important due to their unique position to identify and assist victims of violence (Lila et al., 2010; Shearer et al., 2006). Likewise, institutions should make efforts to translate the empirical evidence into practice through investing on equality education and IPVAW prevention programs, training on IPVAW for professionals who could attend victims, and adopting political and legal measures to sensitize society about the severity and consequences of IPVAW (See Tables 2 and 3 for key findings from the study).

Table 2

Review of Critical Findings from the Study

Key Findings of the Study
1. A total of 27 studies were included in systematic review and 12 studies were included in the meta-analysis.
2. A significant, negative relationship was found between perceived severity of IPVAW and favorable attitudes toward IPVAW, such as sexist views, victim blaming, excusing the perpetrator, rape myths acceptance, and traditional gender roles.
3. The results showed that men perceived IPVAW as less severe than women.
4. In addition, the results suggest that having a partner, lower levels of education, older ages, and having not experienced IPVAW were related to perceiving IPVAW as less severe.

Note. IPVAW= Intimate Partner Violence Against Women.

Table 3

Implications for Research, Practice, and Policy

Implications Based on Research Findings
1. These findings contribute to advancing the scientific knowledge on IPVAW, allowing other researchers continue exploring this topic based on previous conclusions. Specifically, the results highlight the need for additional studies that explore the differences in perceived severity of IPVAW according to gender, type of violence, actors, and/or socio-demographic variables.
2. This study highlights the need to apply preventive measures focused on reducing favorable attitudes towards IPVAW that facility the normalization of IPVAW and contribute to difficulties perceiving IPVAW as severe.
3. Training on IPVAW for professionals who work with victims (e.g., lawyers, health care professionals, or police) and adopting political and legal measures to sensitize society about the severity and consequences of IPVAW may be beneficial.

Note. IPVAW= Intimate Partner Violence Against Women.

Conclusion

This study sought to examine the link between attitudes related to IPVAW and perceived severity of IPVAW. The meta-analysis concluded that men perceive IPVAW as less severe than women, and that favorable attitudes toward IPVAW like sexism, victim blame, excuse of perpetrator, rape myths beliefs, and traditional gender roles are negatively related to perceived severity of IPVAW. Further, the results suggest that having a partner, lower levels of education, older ages, and having not experienced IPVAW were related to perceiving IPVAW as less severe. The findings of this study highlight the need for increased awareness of attitudes towards IPVAW, considering gender differences, as well as the relationship with perceived severity of IPVAW. Continued gender equality education that can target attitudes and perceptions of IPVAW remain important and necessary.

CAPÍTULO 3: Mujeres víctimas de violencia de género

CHAPTER 3: Women victims of intimate partner violence against women

Llegó sin avisarte, y llegó sin preguntar, y en tus ojos adentrarse, y tu libertad llevarse a donde nunca quiso estar…pero tu amor ¡puede más! Ninguna estrella está sola ni deja de brillar…, no eres el miedo que ahoga, eres la vida que das

(Tú eres la vida. Maldita Nerea)

Estudio 3

Study 3

Spanish Adaptation and Validation of the World Health Organization's Violence Against Women Instrument

Adaptación y Validación Española del Instrumento de Violencia Contra las Mujeres de la Organización Mundial de la Salud

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Resumen

La Organización Mundial de la Salud (OMS) desarrolló un instrumento para detectar la violencia de género (VG) que ha sido ampliamente utilizado en varios países. A pesar de la importancia del instrumento para identificar la VG, éste no ha sido adaptado en población española. El objetivo de este estudio fue adaptar y validar el instrumento de VG de la OMS en España, facilitando la detección de la VG en este contexto y la comparación entre países. Concretamente, 532 mujeres de la población general en España completaron el instrumento tras su traducción y adaptación al español. El instrumento inicial constaba de 28 ítems. Se eliminaron tres ítems debido a su baja consistencia interna, resultando un total de 25 ítems en la versión final. Se obtuvo una adecuada consistencia interna mediante el análisis factorial confirmatorio para las subescalas de violencia física (α = .92), psicológica (α = .91), sexual (α = .86) y en conductas de control (α = .91), así como en la escala total (α = .95). El instrumento reveló alta prevalencia de VG (79,7%). El uso de la versión española del instrumento de VG contra las mujeres de la OMS, justifican su uso en España.

Palabras clave: violencia de pareja contra las mujeres, prevalencia, propiedades psicométricas, estudio instrumental

Abstract

The World Health Organization (WHO) developed an instrument to detect violence against women that has been widely used in several countries. Despite this instrument's importance to identify intimate partner violence against women (IPVAW), it has not been adapted for the Spanish population. The aim of this study was to adapt and validate the WHO violence against women instrument in a sample in Spain, facilitating the detection of IPVAW in this context and the comparisons across countries. After the instrument's translation and Spanish adaptation, 532 women from the general population in Spain responded to it. The initial instrument consisted of 28 items. We deleted three items due to their low internal consistency, resulting in 25 items in the final version. An adequate internal consistency was obtained through Confirmatory Factorial Analysis to physical (α = .92), psychological (α = .91), sexual (α = .86), and control behaviors subscales (α = .91) as well as the total scale (α = .95). The instrument revealed highly prevalent IPVAW in our sample (79.7%). The use of the Spanish version of the WHO violence against women instrument in Spain seems justified.

Keywords: intimate partner violence against women, prevalence, psychometric proprieties, instrumental study

Spanish Adaptation and Validation of the World Health Organization's Violence Against Women Instrument

Intimate partner violence against women (IPVAW), the most common form of violence women suffer, refers to any physical, psychological, or sexual abuse as well as controlling behaviors by a current or former intimate partner (Devries et al., 2013; World Health Organization; WHO, 2021). IPVAW is a major public health problem that erodes its victims' physical and mental health, causing injury, chronic pain, depression, and posttraumatic stress disorder, among other effects, and incurs a high economic and social cost (Campbell, 2002; López-Ossorio et al., 2018; Valpied & Hegarty, 2015; WHO, 2021). Further, more than 35% of all murders of women worldwide are committed by an intimate partner; femicide is the most extreme form of IPVAW (WHO, 2021). Due to the consequences this violence has for its victims and for society as a whole, the detection of all its forms is a necessity of the first order (Gracia et al., 2020).

The prevalence of IPVAW is estimated at 30% worldwide but could vary among countries (Ellsberg & Heise, 2005; WHO, 2021). Recently, a systematic review presented data from 90% of the global population of women and girls (15 years or older) from 161 countries and areas, showing highly prevalent physical and/or sexual violence across the globe (around 27%), often at an early age, affecting 24% of adolescent girls and young women (Sardinha el al., 2022). Also, Garcia-Moreno et al. (2006) indicated that 15%–71% of women from 10 countries (Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania) reported physical and/or sexual IPVAW in their lifetime. In the European Union, a survey carried out in the 28 member countries revealed a prevalence of physical and/or sexual IPVAW of 22% throughout women's lives (European Union Agency for Fundamental Rights, 2014). Likewise, a macrosurvey conducted in Spain showed that 14.2% of women over 16 years of age had suffered physical and/or sexual violence

by a partner or former partner, 31.9% psychological violence, and 32.4% all of them (Ministerio de Igualdad, 2020). This variation among countries may be explained in part by the differences in the methodologies used to detect IPVAW (Garcia-Moreno et al., 2006; Nybergh et al., 2013). Therefore, a universal IPVAW screening tool is required.

According to Escuela Andaluza de Salud Pública (2005), there are several international screening and diagnostic instruments for IPVAW, but almost all of them use English as the original language and have no cultural adaptation. Particularly, the Conflict Tactics Scale (Strauss, 1979), Domestic Abuse Assessment (Canterino et al., 1999), Hurt-Insult-Threaten-Scream (Sherin et al., 1998), Index of Spouse Abuse (Hudson & McIntosh, 1981), and Woman Abuse Screening Tool (Brown et al., 1996) were translated to Spanish for use mainly in primary or prenatal care. Although all these instruments aimed to assess IPVAW, we found differences in administration methods (e.g., self-administration or interviews), number of items (e.g., one or 60), response format (e.g., dichotomous or frequency), type of violence assessed (physical, psychological/emotional, verbal, or sexual), and application context (e.g., primary health or social services) (Escuela Andaluza de Salud Pública, 2005). For example, previous studies focused on physical and/or sexual violence to estimate the prevalence of IPVAW but did not consider other forms of IPVAW, such as psychological violence and controlling behaviors (Ellsberg et al., 2016; Garcia-Moreno et al., 2006; Gracia et al., 2019). Furthermore, controversy surrounding the psychometric properties of the IPVAW screening instruments has been noted (Rabin et al., 2009). These differences could make it difficult to generalize the results between and within countries and to detect IPVAW as a whole.

Given the need to improve the quality, quantity, and comparability of international data of IPVAW (Ellsberg & Heise, 2005), WHO violence against women (VAW) instrument (WHO, 2005) was developed for WHO Multi-country Study on Women's Health and Domestic Violence against Women by a core research team made up of international experts from WHO.

The instrument assessed physical, psychological and sexual IPVAW as well as control behaviors by partner in 10 countries (Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and United Republic of Tanzania), performing extensive independent back translations and piloting of the instrument, as well as allowing estimate the prevalence of different forms of IPVAW.

Since the development of the WHO's VAW instrument, it has been widely used in several countries; however, its psychometric properties have been poorly studied (Nybergh et al., 2013). Specifically, WHO Multi-country Study on Women's Health and Domestic Violence against Women confirmed adequate internal consistency (WHO, 2005). Likewise, good construct validity and internal reliability were demonstrated in an adult female population in Sweden (Nybergh et al., 2013) and Brazil (Schraiber et al., 2010). However, more peer-reviewed studies evaluating the psychometric properties of the WHO VAW instrument are needed, especially in Spain, where despite the instrument's usefulness in estimating the various types of IPVAW, it has not been adapted for the Spanish population. For it, in Spain is required urgently the adaptation and validation of this instrument. It will allow study of the prevalence of IPVAW in Spain as well as to carry out cross-country comparisons through the use of an instrument with adjusted psychometric properties.

The present study aimed to adapt and validate the WHO against women instrument (WHO, 2005) in a sample of women in Spain. Specifically, content, construct and reliability were analyzed. Also, usability improvements were proposed including frequency response items and deleting double questions.

Method

Participants

The sample consisted of 532 women from the general population in Spain. The participants' ages ranged from 17 to 72 years (M_{age} = 32.07, SD = 13.47). Of the total sample,

6.6% had reported their partner or a former partner for IPVAW, and 12% had requested help to attend to victims of IPVAW. Table 1 shows the sample's main characteristics.

Table 1

Main Characteristics of the Sample (N = 532)

	N (%)
Age Groups	
17-29	306 (57.50)
30-39	65 (12.21)
40-49	88 (16.55)
50-59	48 (9.02)
60 and over	24 (4.52)
Missing value	1 (0.20%)
Nationality	
Spanish	501 (94.2%)
Other	31 (5.8%)
Educational Level	
Elementary studies (primary and secondary)	17 (3.2)
Less than college degree	120 (22.57)
College degree	395 (74.23)
Family Income (euros)	
0−499	23 (4.3)
500−999	56 (10.5)
1000−1499	133 (25)
1500−1999	103 (19.4)
2000−2499	93 (17.5)
2500 or more	124 (23.3)
Employment Status	
Student	261 (49)
Employed	214 (40.2)
Unemployed	45 (8.5)
Retired	12 (2.3)
Civil Status	
Single	182 (34.2)
Dating relationship	165 (31)
Living with partner	85 (16)
Married	83 (15.5)
Another situation	17 (3.2)
Children	
Have children	144 (27.1)
Have no children	388 (72.9)
IPVAW Complaint	
Yes	35 (6.6)
No	497 (93.4)
Resources for IPVAW Victims	
Has requested help	64 (12)
Has no requested help	468 (88)

Note. IPVAW = Intimate Partner Violence Against Women.

Instruments

WHO Violence Against Women Instrument Modified Version (WHO, 2005). The original instrument was composed of 20 items, of which four assess physical violence (e.g., "Has your partner pushed or displaced you?"), six psychological violence (e.g., "Has your partner belittled or humiliated you in front of other people?"), three sexual violence ("Has your partner forced you to have sex when you did not want to?"), and seven partner's controlling behaviors (e.g., "Did your partner try to keep you from seeing your friends?"). For each question, respondents indicated whether they had that experience during the past year and throughout their life. The instrument presents adequate internal consistency. Also, previous studies found an adequate psychometric proprieties for the total scale in Sweden (α = .88), and Brazil (α = .88 to São Paulo; α = .89 to the Zona da Mata). In this study, in order to improve the instrument's usability, we separated double questions, obtaining a total of 28 items (eight regarding psychological violence, 10 regarding physical violence, three regarding sexual violence, and seven regarding controlling behaviors). Also, to avoid dichotomous responses and based on the original instrument, we included a Likert-type frequency response format (1 = *never* to 4 = *many times*) to determine the lifetime frequency of incidents of violence. Additionally, we asked women whether they had suffered any type of psychological, physical, and/or sexual violence as well as controlling behaviors from their partner or an ex-partner using an item repeated 4 times, once for each type of violence: "Have you experienced any of the above behaviors [psychological, physical, or sexual violence items] by your partner and/or ex-partner in your lifetime?"

IPVAW Complaint. To determine whether women had ever reported their partner or former partner for IPVAW, we included one ad hoc item with a dichotomous response (Yes/No): "Have you ever filed a complaint for gender violence?"

IPVAW Request for Help. To determine whether women had ever requested help to attend to victims of IPVAW, we included one ad hoc item with a dichotomous response (Yes/No): "Have you made use of any services for victims of IPVAW?"

IPVAW Perpetrator. To determine whether the participant had experienced IPVAW by a former partner, their current partner, or both, we asked them, "The experiences or situations mentioned above, have been carried out by 1) my current partner, 2) my past partner, 3) my current and past partner".

Demographic Information. We collected the women's age, educational level, family income, employment status, relationship status, civil status, and number of children.

Design and Procedure

An instrumental study was designed to assess the psychometric properties of WHO VAW instrument for detecting IPVAW in a sample of women in Spain. First, to adapt the instrument the guidelines for translation and adaptation of tests by Muñiz et al. (2013) were followed. A translation and back-translation process were performed (English–Spanish/Spanish–English) with two independent bilingual researchers. Then, four members of the research team, experts in IPVAW, met to discuss the appropriateness of the translation as well as about aspects that could improve the instrument's usability. To ensure this process's reliability, each member individually assessed the adequacy of the items in Spanish. Afterward, we resolved discrepancies by consensus among all expert members. Consequently, we divided some questions in two to avoid double questions, resulting in a total of 28 items (we eliminated three of the 28 items in the final version; see Table 2). Moreover, the dichotomous responses were replaced with a frequency response format.

The instrument was developed online using the Lime Survey research platform, and it was distributed through social networks. The participants were included in the study by incidental sampling if they were Spanish-speaking women in Spain. Then, they were informed

about the objective of the study and voluntarily agreed to collaborate in it, providing informed written consent in accordance with the Helsinki declaration. No reward was offered for participation. The study was developed obtaining the acceptance of the ethics committee of the University of Granada.

Table 2

Spanish Version of the WHO Violence Against Women Instrument

Instrumento de la Organización Mundial de la Salud sobre la Violencia Contra las Mujeres [World Health Organization Instrument on Violence Against Women]						
A continuación, se le presentan una sucesión de preguntas que hacen referencia a experiencias o situaciones que pueden haber acontecido en su relación de pareja actual (si la tiene) o en una relación pasada con un hombre. Por favor, léalas con atención e intente responder de manera honesta a cada una de las cuestiones. [Below are a series of questions that refer to experiences or situations that may have occurred in your current relationship (if you have one) or in a past relationship with a man. Please read them carefully and try to answer each question honestly]. 1. Nunca 2. Una vez 3. Pocas veces 4. Muchas veces [1. Never 2. One 3. Few 4. Many]						
Alguna vez su pareja actual y/o pasada... **[Has your current and/or past partner ever...]**	A lo largo de la vida [Throughout life]				En los últimos 12 meses [In the past 12 months]	
1. ¿Le ha insultado? [1. Insulted you?]	1	2	3	4	Si [Yes]	No [No]
*2. ¿Le ha hecho sentir mal consigo misma? [*2. Made you feel bad about yourself?]	1	2	3	4	Si [Yes]	No [No]
3. ¿Le ha menospreciado delante de otras personas? [3. Belittled you in front of other people?]	1	2	3	4	Si [Yes]	No [No]
4. ¿Le ha humillado delante de otras personas? [4. Humiliated you in fornt of other people?]	1	2	3	4	Si [Yes]	No [No]
5. ¿Le ha hecho cosas para asustarle a propósito? [5. Did things to scare you on purpose?]	1	2	3	4	Si [Yes]	No [No]
6. ¿Le ha hecho cosas para intimidarle a propósito? [6. Did things to intimidate you on purpose?]	1	2	3	4	Si [Yes]	No [No]

7. ¿Le ha amenazado con hacerle daño? [7. Threatened to hurt you?]	1	2	3	4	Si [Yes]	No [No]
8. ¿Le ha amenazado con hacerle daño a alguien que le importa? [8. Threatened to hurt someone you care about?]	1	2	3	4	Si [Yes]	No [No]
9. ¿Le ha abofeteado? [9. Slapped you?]	1	2	3	4	Si [Yes]	No [No]
10. ¿Le ha arrojado algo con lo que podría lastimarle? [10. Thrown something at you that could hurt you?]	1	2	3	4	Si [Yes]	No [No]
11. ¿Le ha empujado? [11. Pushed you?]	1	2	3	4	Si [Yes]	No [No]
12. ¿Le ha golpeado con el puño? [12. Hit you with his fist?]	1	2	3	4	Si [Yes]	No [No]
13. ¿Le ha golpeado con algo que pueda herirle o hacerle daño? [13. Hit you with something else that could hurt you?]	1	2	3	4	Si [Yes]	No [No]
14. ¿Le ha arrastrado? [14. Dragged you?]	1	2	3	4	Si [Yes]	No [No]
15. ¿Le ha golpeado con el pie? [15. Kicked you?]	1	2	3	4	Si [Yes]	No [No]
16. ¿Ha intentado estrangularle? [16. Choked you?]	1	2	3	4	Si [Yes]	No [No]
*17. ¿Le ha hecho quemaduras a propósito? [*17. Burnt you on purpose?]	1	2	3	4	Si [Yes]	No [No]
18. ¿Le ha amenazado con una pistola, un cuchillo o algo por el estilo? [18. Threatened to use or actually used a gun, knife or other weapon against you?]	1	2	3	4	Si [Yes]	No [No]
19. ¿Le ha obligado a tener relaciones sexuales cuando no quería? [19. Forced you to have sexual intercourse when you did not want to?]	1	2	3	4	Si [Yes]	No [No]
20. ¿Alguna vez tuvo relaciones sexuales cuando no quería porque tenía miedo de lo que podría hacerle? [20. Did you ever have sexual intercourse you did not want because you were afraid of what he might do?]	1	2	3	4	Si [Yes]	No [No]

21. ¿Le ha obligado a hacer algo sexual que ha encontrado degradante o humillante? [21. Did he ever force you to do something sexual that you found degrading or humiliating?]	1	2	3	4	Si [Yes]	No [No]
22. ¿Trató de evitar que viera a sus amigas/os? [22. Tries to keep you from seeing your friends?]	1	2	3	4	Si [Yes]	No [No]
23. ¿Trató de restringirle el contacto con su familia? [23. Tries to restrict contact with your family of birth?]	1	2	3	4	Si [Yes]	No [No]
24. ¿Insistió en conocer dónde estaba todo el tiempo? [24. Insists on knowing where you are at all times?]	1	2	3	4	Si [Yes]	No [No]
25. ¿Le ignoró o le trató con indiferencia? [25. Ignores you or treats you indifferently?]	1	2	3	4	Si [Yes]	No [No]
26. ¿Se enfadó si usted hablaba con otro/s hombre/s? [26. Gets angry if you speak with another man?]	1	2	3	4	Si [Yes]	No [No]
27. ¿Sospechaba a menudo que usted le era infiel? [27. Is often suspicious that you are unfaithful?]	1	2	3	4	Si [Yes]	No [No]
*28. ¿Esperaba que le pidiera permiso antes de buscar atención médica? [28. Expects you to ask his permission before seeking health care for yourself?]	1	2	3	4	Si [Yes]	No [No]

Note. WHO = World Health Organization; Items 2, 17, and 28 were deleted.

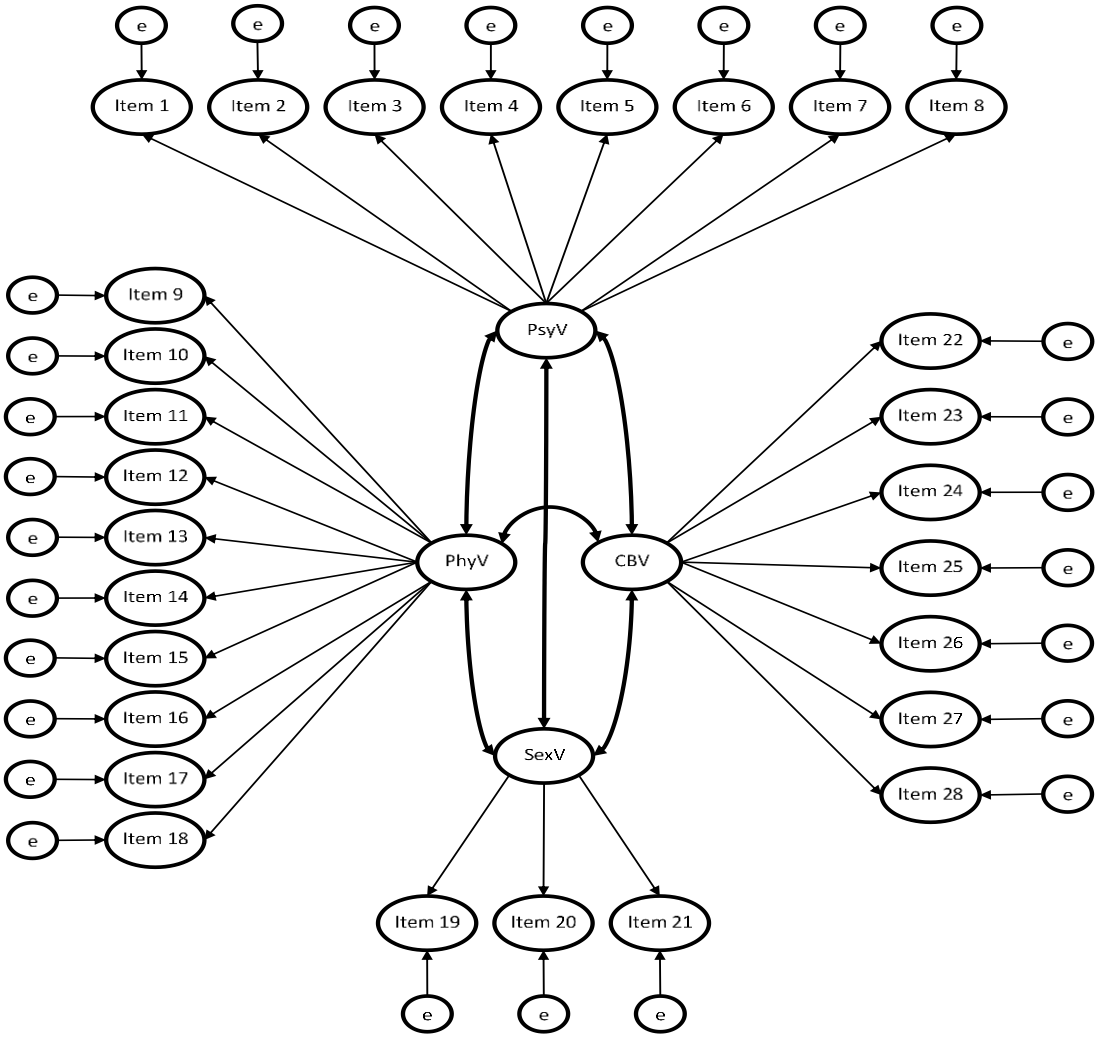
Data Analysis

Data analysis was carried out using the SPSS program version 22 and EQS 6.2 for Windows. First, to determine the appropriateness of the items in each of the instrument's subscales (physical, psychological, and sexual violence as well as controlling behaviors), an inter-judge concordance was conducted. Then, Cronbach's alpha index was applied to verify the internal consistency of the instrument and subscales, adding the Rho (ρ) composite reliability coefficient with the aim of making up of some of the possible limitations of alpha. After that, construct validity was calculated using confirmatory factor analysis (CFA) by Maximum Likelihood method to test the theoretical structure of the instrument (Figure 1).

Lastly, to explore the prevalence of IPVAW throughout life and in the last 12 months in our sample, descriptive statistics (mean and standard deviation) were performed.

Figure 1

Theoretical Model of WHO VAW Instrument



Note. VAW = Violence Against Women; PhyV = Physical Violence; PsyV = Psychological Violence; SexV = Sexual Violence; CBV = Control Behaviours Violence; Independence Model $\chi 2 = 12260.446$ (378 d.F.); $\chi 2 = 2187.235$ ($p < .01$): Bentler-Bonett Normed Fit Index = .82; Bentler-Bonett Non-Normed Fit Index = .83; Comparative Fit Index = .84; Root Mean Square Error of Approximation [90% CI] = .10 [.09, .10]; e = error.

Results

Prevalence of IPVAW in a Sample of Women in Spain

Descriptive frequency analyses to determine the prevalence of IPVAW in our sample of Spanish women showed that 79.7% of them had suffered some type of IPVAW (physical, psychological, or sexual violence and/or controlling behaviors) by their partner or a former partner, and 35.7% of women indicated that the violence had occurred in the past 12 months (see Table 3). Also, 33.3% of women who reported suffering physical violence indicated that it was perpetrated by their current partner (vs. 48.3% by a former partner and 18.4% by a current and former partner). Regarding psychological violence, 35.3% of women reported suffering it from their current partner, 52.6% from a former partner, and 12% from both. Women pointed out that their current partner (32%), a former partner (52.3%), or both (15.8%) had committed sexual violence. Finally, 33.3% reported controlling behaviors committed by the current partner (vs. 53% by a former partner and 13.7% by current and former partners).

Table 3

Prevalence of the Different Types of IPVAW in a Sample of Women in Spain

	N (%)			N (%)	
	Throughout life			Last 12 months	
IPVAW	Never	Once time	More than once	Yes	No
Physical Violence	386 (72.6)	66 (12.4)	80 (15)	138 (25.9)	394 (74.1)
Psychological Violence	207 (38.9)	61 (11.5)	264 (49.6)	36 (6.8)	496 (93.2)
Sexual Violence	315 (59.2)	53 (10)	164 (30.8)	65 (12.2)	467 (87.8)
Control Behaviors	168 (31.6)	48 (9)	316 (59.4)	137 (25.8)	395 (74.2)

Note: IPVAW= Intimate Partner Violence Against Women.

Table 4

Items Descriptive Statistics

Items	*M*	*SD*	Asimetry[a]	Curtosis[b]	DI
Item 1	1.96	1.14	.61	-1.21	.73
Item 2	2.68	1.19	-.33	-1.41	.66
Item 3	1.88	1.12	.72	-1.07	.70
Item 4	1.68	1.05	1.11	-0.33	.72
Item 5	1.65	1.09	1.28	-0.02	.79
Item 6	1.66	1.10	1.26	-0.10	.81
Item 7	1.34	.84	2.26	3.72	.75
Item 8	1.21	.69	3.17	8.86	.64
Item 9	1.13	.48	4.19	18.17	.56
Item 10	1.20	.61	3.05	8.49	.65
Item 11	1.42	.83	1.88	2.39	.72
Item 12	1.08	.41	5.54	31.59	.51
Item 13	1.12	.49	4.17	17.38	.59
Item 14	1.09	.41	5.06	27.01	.51
Item 15	1.11	.45	4.37	19.14	.56
Item 16	1.06	.36	6.62	46.30	.35
Item 17	1.01	.16	15.80	263.65	.22
Item 18	1.05	.30	6.32	45.80	.47
Item 19	1.91	1.24	.79	-1.15	.77
Item 20	1.49	.98	1.68	1.20	.75
Item 21	1.95	1.26	.73	-1.25	.75

Item 22	2.38	1.28	.09	-1.70	.63
Item 23	2.07	1.25	.51	-1.47	.72
Item 24	1.82	1.15	.95	-0.75	.71
Item 25	1.15	.60	3.90	13.94	.55
Item 26	1.71	1.05	1.06	-0.41	.65
Item 27	1.50	.99	1.68	1.21	.68
Item 28	1.43	.88	1.86	2.08	.61

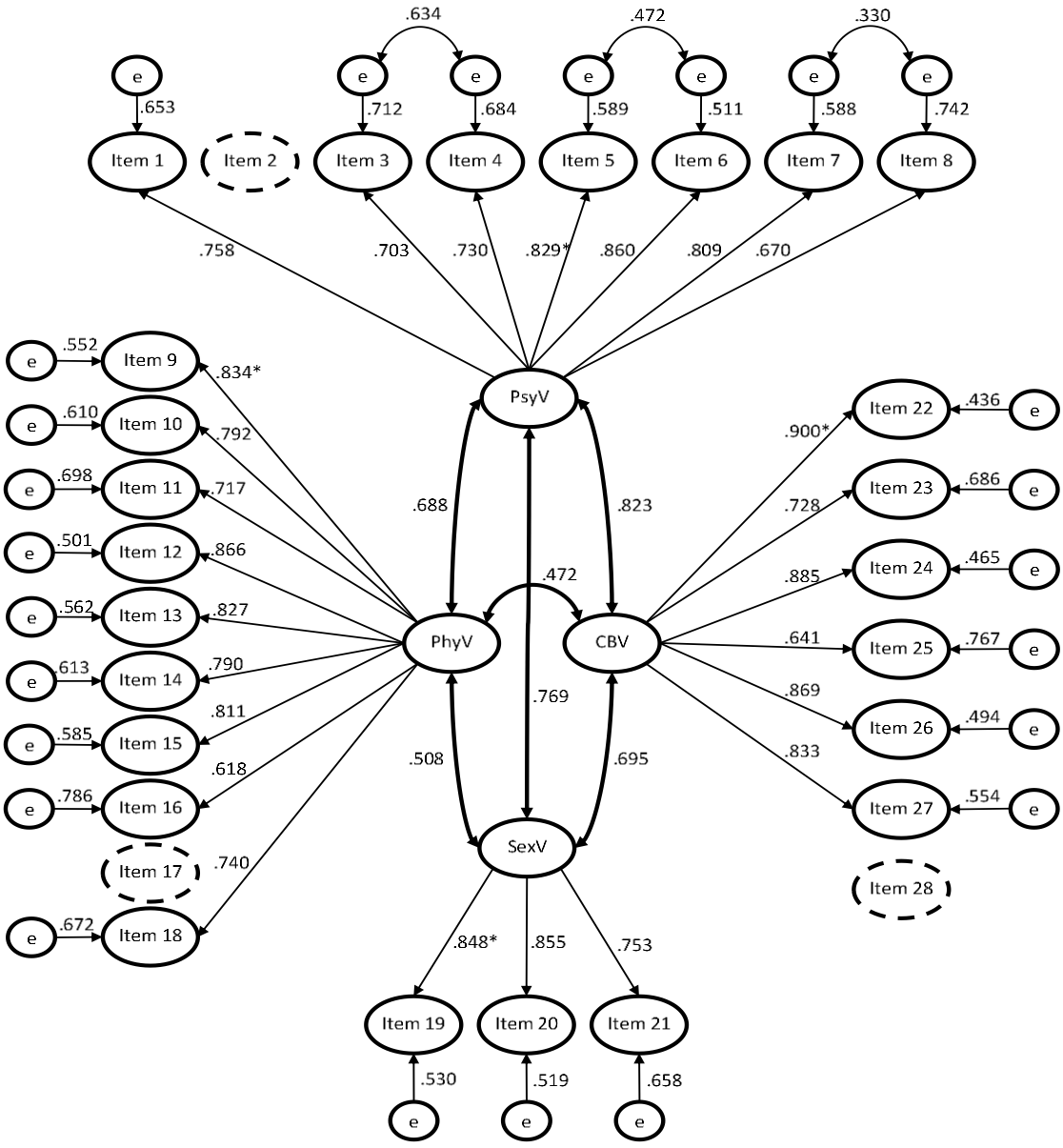
Note. a: Standar Error = .106; b: Standard Error = .211; DI = Discrimination Index.

Reliability and Validity

Concerning the validity of internal structure of the instrument, a CFA was performed using EQS 6.2 for Windows, finding the fit indices and saturations for all items except 2, 17, and 25, which were deleted, obtaining an adequate instrument' reliability (α = .95 [.94, .96]; ρ = .96; Figure 2). Intercoder reliability to determine final items and the response format of the Spanish version of the WHO VAW instrument were adequate, resulting in a kappa coefficient of .83. The descriptive statistics of the initial items of the instrument can be seen in the Table 4. Similarly, the final instrument, composed of 25 items, revealed high consistencies among subscales, resulting in a Cronbach's alpha of .95. Table 5 shows Cronbach's alpha for the total scale and subscales of the initial version (28 items) and the final version (25 items).

Figure 2

Final Confirmatory Factor Analysis Model Obtained in Standardized Values



Note. PhyV = Physical Violence; PsyV = Psychological Violence; SexV = Sexual Violence; CBV = Control Behaviours Violence. All coefficients are significant. The fixed parameters were marked with "*". Independence Model $\chi 2 = 11211.85$ (300 d.F.); $\chi 2 = 1238.20$ ($p < .01$): Bentler-Bonett Normed Fit Index = .89; Bentler-Bonett Non-Normed Fit Index = .90; Comparative Fit Index = 0.91; Root Mean Square Error of Approximation [90% CI] = .08 [.07, .08]; e = error.

Table 4

Items Descriptive Statistics

Items	*M*	*SD*	Asimetry[a]	Curtosis[b]	DI
Item 1	1.96	1.14	.61	-1.21	.73
Item 2	2.68	1.19	-.33	-1.41	.66
Item 3	1.88	1.12	.72	-1.07	.70
Item 4	1.68	1.05	1.11	-0.33	.72
Item 5	1.65	1.09	1.28	-0.02	.79
Item 6	1.66	1.10	1.26	-0.10	.81
Item 7	1.34	.84	2.26	3.72	.75
Item 8	1.21	.69	3.17	8.86	.64
Item 9	1.13	.48	4.19	18.17	.56
Item 10	1.20	.61	3.05	8.49	.65
Item 11	1.42	.83	1.88	2.39	.72
Item 12	1.08	.41	5.54	31.59	.51
Item 13	1.12	.49	4.17	17.38	.59
Item 14	1.09	.41	5.06	27.01	.51
Item 15	1.11	.45	4.37	19.14	.56
Item 16	1.06	.36	6.62	46.30	.35
Item 17	1.01	.16	15.80	263.65	.22
Item 18	1.05	.30	6.32	45.80	.47
Item 19	1.91	1.24	.79	-1.15	.77
Item 20	1.49	.98	1.68	1.20	.75
Item 21	1.95	1.26	.73	-1.25	.75
Item 22	2.38	1.28	.09	-1.70	.63
Item 23	2.07	1.25	.51	-1.47	.72
Item 24	1.82	1.15	.95	-0.75	.71
Item 25	1.15	.60	3.90	13.94	.55

Item 26	1.71	1.05	1.06	-0.41	.65
Item 27	1.50	.99	1.68	1.21	.68
Item 28	1.43	.88	1.86	2.08	.61

Note. a: Standar Error = .106; b: Standard Error = .211; DI = Discrimination Index.

Table 5

Internal Consistency of the WHO VAW Instrument Subscales

	WHO VAW instrument			
Subscales	**Nº items initial**	**$\alpha_{initial}$**	**Nº items final**	**α_{final}**
Complete Scale	28	.95 [.95, .96]	25	.95 [.94, .96]
Psychological Violence	8	.92 [.91, .93]	7	.91 [.91, .92]
Physical Violence	10	.91 [.90, .92]	9	.92 [.90, .93]
Sexual Violence	3	.86 [.83, .88]	3	.86 [.83, .88]
Control Behaviors Violence	7	.91 [.89, .92]	6	.92 [.90, .93]

Note. WHO VAW = World Health Organization violence against women; Nº items initial = 28 items of the initial version of the instrument; Nº items final = 25 items of the final version of the instrument, deleting 2, 17, and 28 items.

Discussion

IPVAW's effects on the victims' physical and mental health underline the importance of having appropriate tools for early detection. The WHO has recommended the WHO VAW instrument (WHO, 2005) to assess physical, psychological, and sexual IPVAW as well as controlling behaviors by a partner or former partner during the past year and throughout life among women worldwide. However, it has not been adapted and validated in Spain. The present study is the first to do it with a sample of Spanish-speaking women, providing effective

psychometric properties and allowing its usability in Spain. According to previous validation studies in other countries (Nybergh et al., 2013; Schraiber et al., 2010), with its high internal consistency, the instrument discriminates between victims and nonvictims of IPVAW as well as among different forms of violence (physical, psychological, or sexual violence and/or controlling behaviors) among Spanish-speaking women in Spain. These findings revealed that the Spanish version of the WHO VAW instrument is an effective tool to evaluate IPVAW in Spain.

Compared to the original instrument (WHO, 2005), the Spanish version of the WHO VAW instrument included some improvements. First, according to Muñiz and Fonseca-Pedrero (2019), items should be representative, relevant, clear, and simple and avoid excessively wordy or ambiguous statements. Therefore, research experts in IPVAW discussed aspects that could improve the instrument's usability in Spain; consequently, we deleted double questions and the dichotomous response format (e.g., "Has your partner or former partner put you down or humiliated you in front of other people?"). Instead, the inclusion of frequency response allowed more precise information to be obtained on the incidence of occurrence of the different forms of IPVAW manifestation. Also, results suggest that IPVAW is not a singular behavior; rather, it tends to be repeated over time. Specifically, the majority of women victims of IPVAW reported suffering it more than once. These findings are consistent with the theory of the cycle of violence (Walker, 2009), which indicates that without intervention and treatment, most aggressors will repeat the cycle of violence, which incidents becoming increasingly frequent and severe. Considering it will be critical because IPVAW does not always, or immediately, lead to women's death, however, women's health is progressively declining inadvertently (Zara & Gino, 2018), posing a danger to their lives. Similarly, alarming results were obtained regarding the perpetrators of violence, so approximately half of the included women were involved in a violent relationship by their current partner or were re-

victimized with another partner. The Spanish version of the WHO VAW instrument allows us to analyze the above-mentioned aspects, facilitating the collection of relevant data to address IPVAW.

Concerning psychometric proprieties, although an adequate internal consistency was demonstrated for the WHO VAW instrument, the methodological approach conducted in the present study has not been reported. Initially, inter-coder reliability was adequate, obtaining a kappa coefficient of .83. Then, a high Cronbach's alpha coefficient was obtained for the final instrument composed of 25 items, indicating that the Spanish version of the WHO VAW instrument seems an effective tool to assess IPVAW. Similarly, the present instrument differentiated among four subscales to differentiated types of IPVAW (physical, psychological, and sexual violence as well as controlling behaviors), showing high internal consistency. In this regard, differentiating among the various forms of IPVAW is essential because although IPVAW entails any physical, psychological, or sexual violence or controlling behavior abuse from a current or former intimate partner (WHO, 2021), the predominant type of violence manifested (e.g., physical violence) may influence key aspects of victims' decision-making processes such as their perception of severity, assessment of risk, or help-seeking behaviors (Cho et al., 2020; Novo et al., 2016; Wilson & Smirles, 2022). Ultimately, CFA yielded fit indices and saturations for the final 25 items included in the Spanish version of WHO VAW, obtaining a high internal consistency ($\alpha = .95$). It shows an adequate internal structure of the different items in each subscale, concluding the appropriation of this instrument for use in Spain.

Moreover, it is noteworthy that compared to previous studies in Spain (Ministerio de Igualdad, 2020), our results displayed higher rates of reported physical, psychological and sexual violence. Likewise, the majority of our sample were women under 30 years of age, and the manifestation of IPVAW through controlling behavior was the most common form of

violence experienced by women (68.4%) and repeated over time. However, Sánchez-Hernández et al. (2020) found that although young women considered it common among young couples, 82.9% had never or hardly ever suffered from these behaviors in their relationships, possibly due to the technological context, which would facilitate the acceptance of controlling behaviors in the relationship as normal. Therefore, more studies are required to identify the different forms of IPVAW manifestations, using a universal detection instrument with adequate psychometric properties that guarantee its applicability and facilitate comparisons. The WHO VAW instrument has been developed by leading professional members of the WHO, a referral organization for addressing health problems such as IPVAW, and its adaptation and validation for use by Spanish-speaking women sample allows for its application in any context of intimate relationships.

This study was subject to limitations. Specifically, although participants were women from the general population, most of them had high levels of education. Future researchers could improve this instrument accounting for age groups (e.g., adolescents), clinical samples (e.g., victims in women's centers), residence (e.g., rural area), and level of education (e.g., university studies), among other factors. Comparative studies could establish specific intervention programs to prevent IPVAW escalating and worsening. Furthermore, although we asked women whether the violence was perpetrated by a former partner or their current partner to assess the risk in their situation, we could not take protective measures due to the surveys' anonymity. In future studies and contexts of application of the Spanish version of the WHO VAW instrument, researchers should offer women the opportunity to provide contact information in case the investigators believe participants may need help. Likewise, it would be convenient to include at the end of the instrument the resources available to women in Spain who suffer IPVAW.

Lastly, some methodological points should be noted. On one hand, although the validation of the instrument conforms to the established minimum standards (Brown, 2015; Kline, 2015) and largely maintains the original structure of the instrument, future studies should make efforts to test other models which can fit better, such as taking account the interactions among factors. On the other hand, three items were eliminated; items 2 and 17 corresponded to double questions in the original instrument, while item 28 was a complete item for assessing control behaviors. In this regard, the elimination of items 2 and 17 would not seem to affect the original structure of the instrument. However, it would be advisable for future studies to create an alternative item to 28 ("Did you expect me to ask your permission before seeking medical attention?"), taking account the international test commission guidelines for test adaptation (Hernández et al., 2020).

Despite these limitations, this study bridges a gap in the application of research findings on the psychometric properties of the WHO VAW instrument as well as its adaptation for a sample of women in Spain, involving relevant implications. Specifically, the Spanish version of the WHO VAW instrument has demonstrated suitable psychometric properties and can be used in IPVAW research, promoting comparative studies. Also, professional contexts could benefit from the use of this instrument, especially healthcare centers, where women sometimes go with a covert reason and symptoms that are difficult to diagnose. Therefore, the instrument may be applied among women suspected of experiencing IPVAW, facilitating its detection to help victims.

In sum, an instrument to facilitate IPVAW detection as a whole, taking into account its manifestation through physical, psychological, and sexual violence as well as controlling behaviors by a partner or ex-partner, was adapted and validated in a sample of women in Spain. It was based on the reference tool developed by the WHO, which is widely used around the world. The adequacy of the psychometric properties of the Spanish version of the WHO VAW

instrument allows for its use among Spanish-speaking women to identify incidents of IPVAW throughout life and in the last 12 months. Usability improvements included collected information about the frequency of violence (never, once, a few times, or more than once) and perpetrator (past partner, current partner, or both). This instrument will be essential as an early screener of IPVAW in various contexts (e.g., healthcare centers, studies, or education centers) and to make comparisons.

Estudio 4

Study 4

Absence vs. Presence of Intimate Partner Violence in a Sample of Spanish Women: Conflict Resolution Strategies and Associated Variables

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Abstract

Through two studies (N = 544 women), the role of types of relational problems (absence vs. presence of intimate partner violence) in the use of conflict resolution strategies (exit and loyalty) was analyzed, considering the serial mediating effect of dependency and commitment and the moderating effect of benevolent sexism. The main results showed that higher scores in dependency and commitment predicted less use of exit strategies among women who reported intimate partner violence. No significant results were found regarding loyalty strategy and benevolent sexism. Ultimately, implications for women's perceived risk of future violence were discussed.

Keywords: dependency, commitment, benevolent sexism, risk perception, conflict resolution strategies

Absence vs. Presence of Intimate Partner Violence in a Sample of Spanish Women: Conflict Resolution Strategies and Associated Variables

Romantic relationships can be an important source of well-being, as well as causing severe distress and suffering (Valor-Segura et al., 2014). Numerous studies support the relevance of satisfactory romantic relationships to people's subjective well-being (e.g., Margelisch et al., 2017) and health (e.g., Shrout et al., 2020). However, relationship conflicts are inevitable and can have destructive effects within couples (Overall, 2018). Indeed, couple conflicts can affect people's physical and psychological functioning due to the stress caused by changes in the relationship (Hurtado et al., 2004) and influence the maintenance or breakdown of the relationship (Laursen & Hafen, 2010). Therefore, couple conflicts can present opportunities to strengthen relationships or a risk of increased dissatisfaction (Szczesna & Przybyla-Basista, 2019).

There are many ways to conceptualize and classify conflict according to severity and consequences for the couple and/or the relationship. Thus, some researchers consider conflict a continuum of severity, and others categorize by types, estimating the presence or absence of violence (Kline et al., 2006). Among the most dangerous couple conflicts, intimate partner violence (IPV) is the main type of violence suffered by women and may manifest through physical, sexual, or emotional violence (Devries et al., 2013). IPV presents a significant health problem, with one out of three women having suffered aggression and violence in a relationship. In these situations, episodes of conflict and post conflict could worsen the present violence (WHO, 2017), making it essential to adopt adequate conflict resolution strategies (CRS) focused on women protection. Unfortunately, women suffering aggression and violence from their partners could have fewer CRS and more difficulty leaving their relationships (Caetano et al., 2005).

Conflict Resolution Strategies and Related Variables

Rusbult et al. (1986) proposed a model to understand the CRS that people adopt to resolve couple conflicts and its consequences to the relationship. CRS refer to the impact of the response on the relationship (Rusbult et al., 1987) and, although Rusbult el al. (1986) mainly focused on nonviolent relationships, CRS might be also related to IPV (Love et al., 2018). In this regard, Rusbult and Zembrodt (1986) distinguished between constructive and destructive strategies that favor the maintenance or deterioration of a relationship, respectively. Specifically, constructive strategies include a) *voice*, an active response to face a problem and improve the relationship by adopting behaviors such as discussing problems; and b) *loyalty*, a passive response to conflict in which one waits for the situation to improve by itself and supports the partner. Meanwhile, destructive strategies include a) *exit,* an active response resulting in the end of the relationship; and b) *neglect*, a passive response that deteriorates the relationship due to behaviors such as ignoring the partner. However, the constructive effects of the loyalty strategy on relationships are contradictory (Drigotas et al., 1995; Rusbult et al., 1986). In this sense, Overall et al. (2010) found that loyalty behaviors did not predict positive outcomes in relationships and could have the same harmful consequences as destructive strategies. In this way, the use and effects of constructive or destructive strategies to the relationship can have the opposite effects on the well-being of women involving in IPV. For instance, an exit strategy is clearly destructive to the relationship but could also be an effective response to dangerous situations (Rusbult et al., 1987), such as IPV, in which preserving women's safety should be the priority.

Dependency and Commitment

Based on Interdependence Theory (Kelley & Thibaut, 1978) that suggests dependency as a key variable to understand why people remain in ongoing interdependent relationships, the Investment Model (Rusbult & Martz, 1995) emerges including commitment like another

relevant variable associate to dependency and significant to explain the response to stay or leave the relationship. In this regard, several studies indicate the influence of both variables, dependency (Valor-Segura et al., 2014) and commitment (Garrido-Macías et al., 2017) in managing and facing couples' conflicts. For instance, a meta-analysis showed that higher levels of dependency and relationship quality decrease the probability of ending the relationship (Le et al., 2010) and, therefore, the need to use an exit strategy.

Specifically, dependency is defined as a person's way of relating to others and includes thoughts, behaviors, and feelings centered on the need to interact and rely on the valuation of others (Valor-Segura et al., 2009). Likewise, dependency implies vulnerability (Rusbult & Langer, 2003) and could lead to differences in the use of CRS, depending on the type of relationship established. Empirical evidence suggests that individuals involved in abusive relationships show higher levels of dependency than individuals in nonabusive relationships (Tan et al., 2018). Furthermore, high levels of dependency could increase tolerance for abuse as a way to solve conflicts and maintain an unsatisfactory relationship (Rusbult & Langer, 2003; Tan et al., 2018; Valor-Segura et al., 2014). In this line, Beltrán-Morillas et al. (2019) observed that women with high levels of dependency showed greater forgiveness toward their transgressive partners, affecting their decision to stay in the relationship. Similarly, Valor-Segura et al. (2014) found high dependency in women to be related to more feelings of guilt, which seemed to facilitate the use of the loyalty strategy for preserving the relationship. In these cases, loyalty behaviors in women involved in violent relationships could pose a danger to their safety, despite being categorized as a constructive relationship strategy.

Similarly, commitment is defined in terms of reasons for persisting in the relationship (Arriaga & Agnew, 2001) and is also a significant predictor for women continuing or ending a relationship (Bell & Naugle, 2005; Le & Agnew, 2003) that could vary depending on the severity of the conflict (Garrido-Macías et al., 2017). Generally, greater commitment in a

relationship is related to stronger tendencies to use constructive strategies and lesser tendencies to use destructive strategies (Rusbult et al., 1986). Likewise, high levels of commitment might help maintain a relationship but could also support violent relationships, leading those involved to prioritize the relationship over their self-interest (Arriaga, 1997). In this connection, women involved in violent relationships reported higher levels of commitment than women in nonviolent relationships (Hanley & O'Neil, 1997), accepting that remaining in the violent relationship posed a risk for them.

In short, it is vital to analyze the influence of dependency and commitment variables in the use of CRS differentiating between women who informed (vs. not) about IPV. However, this area has not yet been studied. Exploring this gap will enable a better understanding of the complexity of decision-making in various conflict situations that can occur in the context of a couple. Moreover, it is essential because women suffering violence from their partners are at risk of harm, and in contrast to nonviolent relationships, the use of destructive CRS such as exit strategies could be adequate. Indeed, women's perceptions of increased violence have been significantly related to a greater commitment to ending the relationship (Pape & Arias, 2000) and seems to play a fundamental role in predicting the risk of future recidivism (Cattaneo et al., 2007). However, although some women correctly perceive the high probability of recurring partner violence and feel unsafe, they do not or cannot take action to escape or contain the violent situation (Gondolf & Beeman, 2003). Thus, as an additional objective of this study, it will be interesting to explore if women who reported IPV perceived the risk of repeated violence by their current partner.

The Present Research

Based on the aforementioned considerations, the present research was intended to explore the relation between the type of relational problem (absence vs. presence of IPV) and the use of CRS (exit and loyalty), considering the influence of several variables. For this

purpose, Study 1 analyzed the influence of dependency and commitment in the use of CRS according to the type of relational problem. Specifically, we expected women who reported IPV to get higher scores on partner dependency (Hypothesis 1a) and commitment (Hypothesis 1b) than women who not reported IPV. Furthermore, we hypothesized that those in IPV conditions would be less likely to use exit (Hypothesis 1c) and more likely to use loyalty CRS (Hypothesis 1d) strategies than those no-IPV conditions. Ultimately, we expected that women reporting IPV (vs. absence) would employ fewer exit and more loyalty CRS based on their effects on increasing levels of dependency and commitment (Hypothesis 2).

STUDY 1

Method

Participants

The sample size was calculated using the G*Power program (Faul et al., 2009). A total of 102 participants were studied to perform a mean difference test with a medium effect size of d =.50, a significance level of α =.05, and power of .80. The initial sample consisted of 201 participants, 73 of whom were excluded because they a) did not report couple conflicts or IPV, b) had been in a relationship less than a year, or c) were not 18 years old. Thus, the final sample consisted of 128 women from the general population (76 women discussed their most serious couple conflict and 52 women reported an episode of IPV). The age of the participants ranged from 18 to 54 years (M_{age} = 29.45, SD = 6.55). Of the 128 participants, 14.6% had children, and 27.3% reported maintaining a dating relationship, 48.4% were living with their partner, and 24.2 % were married. The average duration of the relationships was 81.92 months (SD = 67.46).

Instruments

WHO Violence Against Women Instrument (WHO, 2005). The instrument consisted of 13 items measuring experiences of violent acts carried out by a partner, including four items on emotional abuse (e.g., "Has your partner belittled or humiliated you in front of other people?"), six items on moderate and severe physical violence (e.g., "Has your partner pushed or displaced you?"), and three items on sexual coercion with and without the use of physical force (e.g., "Has your partner forced you to have sex when you did not want to?"). The response format was dichotomous (yes/no) and each item referred to the occurrence of violence in the past. To explore the perception of risk of future violence, we duplicated items asking about anticipation of future occurrences (e.g., "Do you think your partner is likely to push or displace you in the future?"). In this study, a translation and back-translation process was performed (English–Spanish/Spanish–English), obtaining a Cronbach's alpha for violence in the past of .73 and violence in the future of .80.

Couple Conflicts. The participants wrote about the most serious conflicts in their current relationships through the critical incident technique (Flanagan, 1954). Based on previous literature (Denes et al., 2020), the conflicts reported by the participants were classified by two experts into six categories: 1) jealousy; 2) infidelity; 3) family, financial, and illness problems; 4) support; 5) distancing; and 6) confidence, unsafety, and lying.

Spouse-Specific Dependency Scale (Rathus & O'Leary, 1997; Spanish version by Valor-Segura et al., 2009). This scale is composed of 17 items aiming to assess partner-specific dependency through three constructs: *anxious attachment* (e.g., "I feel rejected when my partner gets very busy"), consisting of five items, *exclusive dependency* (e.g., "If I lost my partner I would have no one to turn to") comprising six items, and *emotional dependency* (e.g., "I find it difficult to be separated from my partner") containing six items. The response format

was a Likert-type (1 = *totally disagree* to 6 = *totally agree*). In our sample, the alpha coefficient for the total scale was .73.

Perceived Relationship Quality Components (Fletcher et al., 2000). The inventory consisted of 18 items that measured perceived relationship quality through six constructs: *satisfaction, commitment, intimacy, trust, passion,* and *love*. In this study, we only used the subscale of *commitment* (e.g., "How faithful are you in your relationship?"). The response format was a 7-point Likert-type that ranged from 1 = *not at all* to 7 = *extremely*. A translation and back-translation process was performed (English–Spanish/Spanish–English). The Cronbach's alpha obtained for *commitment* was .74.

Accommodation among Romantic Couples Scale (Rusbult et al., 1986; Spanish version by Valor-Segura et al., 2020). The scale is composed of 28 items with response choices on a 9-point Likert scale ranging from 1 (*I never do that*) to 9 (*I always do that*). These items evaluate four dimensions: *exit, neglect, voice*, and *loyalty.* For this study, we only used the dimensions *exit* (e.g., "When I am unhappy with my partner, I suggest breaking up"), comprising seven items (α = .86), and *loyalty* (e.g., "When my partner hurts me, I don't say anything but simply forgive him/her"), including six items (α = .70), due to the opposite effects that it could have on the well-being of the woman compared to the relationship (Rusbult et al., 1987).

Demographic Information. The participants' age, sex, relationship status, duration of the relationship, and parent status were collected.

Design and Procedure

The present study followed a quasi-experimental design (Montero & León, 2007). Participants were included in the study if they were adult women (age ≥ 18) and had a relationship at least one year in duration. A survey was developed online using the LimeSurvey research platform, and all the questions included referred to the women's current relationships.

The online survey was the following: "*Heterosexual women of Spanish nationality, over 18 years of age, with a relationship of at least one year duration*". It was diffused through social networks, selecting participants through incidental sampling. Then, the participants were classified into two groups (absence vs. presence of IPV) according to their answers to the Violence Against Women instrument (WHO, 2005). That is, women who reported one or more instances of physical, psychological, or sexual violence in the past were included in the IPV group, while women who did not report violence were included in the absence of IPV group. All participants were informed about the general purpose of the study and agreed to participate voluntarily, providing their informed consent in accordance with the Helsinki Declaration. The confidentiality and anonymity of their answers were guaranteed, and no reward was offered for participation. The study was approved by the ethics committee of the University of Granada.

Analysis Strategy

The data were analyzed using the SPSS Program, version 23. First, descriptive analyses of frequencies were performed, considering the most frequent types of IPV and couple conflicts reported. Then, a multivariate analysis of covariance (MANCOVA) was performed to determine the effects of type of condition (absence vs. presence of IPV) on dependency, commitment, and CRS (exit and loyalty). In addition, to test if dependency and commitment mediated the effect of type of condition and CRS, a multiple serial mediation analysis was carried out using model 6 of the PROCESS program described by Hayes (2013). Specifically, two serial mediation analyses were performed, including type of condition as the predictor (X) and CRS as the criterion (Y) variables. Dependency (M1) and commitment (M2) were included as the mediating variables. Following Hayes' (2013) procedures for testing indirect effects with serial mediators, bias-corrected confidence intervals for indirect associations were estimated based on 10,000 bootstrap samples. In these models, a confidence interval (CI) that does not include 0 indicates a statistically meaningful association. The analyses were controlled for age,

relationship status, duration of the relationship, and having children. Finally, to explore the perception of the risk of future partner violence in women who reported IPV, a descriptive analysis of frequencies was implemented.

Results

Frequency of Type of IPV and Couple Conflicts

For IPV, the results showed that 40.6% of women had suffered some type of violence by their current partners. Specifically, 43% of women had suffered psychological violence, 8.6% physical violence, and 3.1% sexual violence. The most frequent conflicts reported were related to communication (31.6%), followed by confidence, unsafety, and lying (22.4%); family, financial, and illness problems (19.7%); jealousy (7.9%); distancing (7.9%); support (6.6%); and infidelity (3.9%).

Effect of the Condition (Absence vs. Presence of IPV) on Dependency, Commitment, and CRS

To test if women who reported IPV (vs. not reported IPV) got higher scores on dependency (Hypothesis 1a), lower scores on commitment (Hypothesis 1b), and were less likely to use exit CRS (Hypothesis 1c) than loyalty CRS (Hypothesis 1d), a MANCOVA was performed with type of condition (absence vs. presence of IPV) as the independent variable (IV) and dependency, commitment, and exit and loyalty strategies as the dependent variables (DVs).

[1]The results revealed higher scores in dependency, *Wilks' λ* =.791, F (1, 123) = 15.95, p = < .001, η_p^2 = .12, in women who reported IPV (M =2.73, SD = .56) than women who not reported IPV (M =2.32, SD = .52), confirming Hypothesis 1a. However, the results did not show significant differences between conditions (*Wilks' λ* =.791, F (1, 123) = 1.38, p = .242,

[1] Age, relationship status, duration of the relationship, and having children were included as covariate variables in the model without significant results.

η_p^2 = .01.) in the commitment variable. These findings do not support Hypothesis 1b. Concerning CRS, the results showed significant differences related to condition in the use of exit CRS, *Wilks' λ* =.791, *F* (1, 123) = 8.28, *p* = .005, η_p^2 = .06. Unexpectedly, women who reported IPV obtained higher scores in the tendency to use exit strategies (*M* = 3.66, *SD* = 1.77) than women who not reported IPV (*M* = 2.81, *SD* = 1.58), rejecting Hypothesis 1c. Regarding the use of loyalty CRS, no significant differences between conditions were found (*Wilks' λ* =.791, *F* [1, 123] = 0.61, *p* = .437, η_p^2 = .01), refuting Hypothesis 1d.

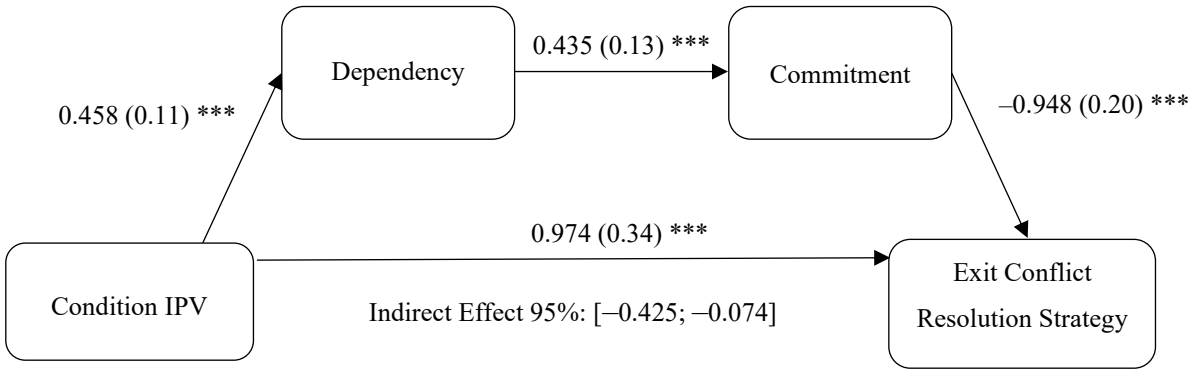
Mediating Effect of Dependency and Commitment on the Relationship Between the Type of Condition (Absence vs. Presence of IPV) and CRS

To test the mediating effect of dependency and commitment on the relationship between the type of condition and the use of CRS (Hypothesis 2), Model 6 of a multiple serial mediation of the PROCESS macro (Hayes, 2013) was performed. The dependency and commitment variables included in the model predicted a total of 27.4% of the variance in the use of exit CRS in IPV conditions. As shown in Figure 1 and Table 1, the results indicated that higher scores in dependency and commitment predicted less use of exit strategies in the group who reported IPV (indirect effect = –0.189, SE = 0.08, 95% CI [–0.425, –0.074]), confirming the sequential mediation of dependency and commitment on exit CRS (see Table 1). The rest of indirect effects were also significant (Table 1). [2]These findings partially support Hypothesis 2.

[2]No evidence of an indirect effect of type of condition on CRS was observed for loyalty CRS (Condition-Dependency-Commitment-Loyalty, b = –0.045, SE = 0.08, 95% CI [–0.111, 0.203]). The total effect observed of X on Y was b = 0.215, SE = 0.26, 95% CI [–0.302, 0.732].

Figure 1

Conceptual Model Showing the Proposed Relationship between Type of Condition and Exit CRS Mediated by Dependency and Commitment



Note. Unstandardized beta coefficients reported, with standard errors within parentheses. Condition 0 = couple conflict; 1 = IPV. *$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

Table 1

Multiple Mediation Analysis of the Type of Condition, Dependency, and Commitment on Exit Conflict Resolution Strategy

	Dependency		Commitment		Exit	
Background	*Coeff.*	Symmetric BCI	*Coeff.*	Symmetric BCI	*Coeff.*	Symmetric BCI
Constant	2.203***	[1.568, 2.837]	5.563***	[4.505, 6.622]	6.592***	[3.483, 9.702]
Type of condition	0.458***	[0.242, 0.675]	-0.387*	[-0.692, –0.083]	0.528	[–0.157, 1.213]
Dependency			0.435***	[0.177, 0.693]	0.585*	[0.029, 1.140]
Commitment					–0.948***	[–1.353, –0.542]
Age	–0.002	[–0.143, 0.021]	–0.008	[–0.031, 0.016]	0.029	[–0.037, 0.095]
Relationship status	0.045	[–0.143, 0.233]	0.132	[–0.108, 0.372]	0.012	[–0.539, 0.562]
Duration relationship	0.002	[–0.000, 0.004]	–0.002	[–0.006, 0.001]	0.000	[–0.006, 0.007]
Having children	-0.191	[–0.565, 0.181]	0.050	[–0.498, 0.599]	-0.803	[–2.147, 0.542]
	R^2 = 0.175 $F(5, 117) = 4.68$, $p = <$ 0.001		R^2 = 0.115 $F(6, 116) = 3.66$, $p = <$ 0.001		R^2 = 0.274 $F(7, 115) = 6.26$, $p <$ 0.001	

Indirect Effects	Effects	Symmetric BCI
Total	0.446	[0.075, 0.856]
I1	0.268	[0.039, 0.603]
I2	–0.189	[–0.325, –0.074]
I3	0.367	[0.115, 0.732]

Note. I1 = IPV → Dependency → Exit; I2 = IPV → Dependency → Commitment → Exit; I3 = IPV → Commitment → Exit; Symmetric BCI: Symmetric Bootstrapping Confidence Interval. The indirect effects are significant where the Bootstrap Confidence Interval does not include the value 0. *p< 0.05, **p< 0.01, ***p< 0.001.

Auxiliary Analyses: Perception of the Risk of Suffering Future Violence in Women who Reported IPV

Finally, a descriptive analysis of frequencies revealed that of the women who reported having suffered violence from their current partner, 69.2% perceived a risk of repeated violence, and 30.8% believed that violence would not happen in the future. Regarding the type of violence, 67.3% of women perceived a risk of suffering psychological violence in the future by their current partner. Notwithstanding, the majority of women did not perceive a risk of physical or sexual violence (only 15.4% and 3.8%, respectively).

STUDY 2

Benevolent Sexism

Sexism refers to discriminatory attitudes and stereotypes toward women, assuming a sex discrimination (Expósito et al., 1998) and has been linked to IPV (Expósito & Herrera, 2009; Juarros-Basterretxea et al., 2019). According to ambivalent sexism theory (Glick & Fiske, 1996), sexism is a multidimensional construct encompassing hostile and benevolent sexism. While hostile sexism involves negative attitudes toward women, considering them inferior to men, benevolent sexism presents subjective positive attitudes toward women, who are rewarded for adopting traditional sex roles and power relationships, thereby promoting gender inequality (Glick & Fiske, 2001). It is important to note that benevolent sexism manifested as care and protection toward women appears to have a greater influence on partners than hostile sexism (Overall et al., 2011). In this sense, women exhibiting benevolent sexism could assume gender roles in their relationships to avoid the perceived threat and probability of aggression from their male partners (Expósito et al., 2010) and would be willing to limit their behaviors even if they identify such limits as discriminatory (Moya et al., 2007). Based on previous findings, we consider necessary to investigate the moderating effect of benevolent sexism in violent relationships and related variables.

Thus, a second study was proposed to replicate the model and understand the possible moderating role of benevolent sexism. In this regard, we predicted higher scores on dependency (Hypothesis 3a), commitment (Hypothesis 3b), and benevolent sexism (Hypothesis 3c), as well as less use of exit (Hypothesis 3d) and more use of loyalty (Hypothesis 3e) CRS in women who reported IPV (vs. not reported IPV). Moreover, we hypothesized a moderating effect of benevolent sexism (Hypothesis 4a) on the effect of type of condition (absence vs. presence of IPV) on dependency and a serial mediation effect of dependency and commitment between type of condition and exit and loyalty CRS used (Hypotheses 4b and 4c, respectively). As an additional objective, in both studies, we explored whether women who reported IPV perceived a greater risk of experiencing violence again.

Method

Participants

The inclusion criteria were the same as in Study 1. A total of 475 women from the general population participated, and 59 were excluded because they did not meet the inclusion criteria. Thus, the sample consisted of 416 women (271 discussed the most serious couple conflict and 145 reported an episode of IPV). The age of the participants ranged from 18 to 63 years (M_{age} = 25.90, SD = 7.20). Of the 416 women, 6% had children, 59.6% reported maintaining a dating relationship, 32.7% were living with their partners, and 7.7% were married. The average duration of the relationships was 58.23 months (SD = 127.17).

Instruments

WHO Violence Against Women Instrument (WHO, 2005). This instrument was described in Study 1. In this study, the Cronbach's alpha was .69 for past violence and .81 for future violence.

Couple Conflicts. The procedure was the same as in Study 1.

Spouse-Specific Dependency Scale (Rathus & O'Leary, 1997; Spanish version by Valor-Segura et al., 2009). This scale was described in Study 1; α = .83.

Perceived Relationship Quality Components (Fletcher et al., 2000). This scale was described in Study 1*;* α = .72.

Accommodation Among Romantic Couples Scale (Rusbult et al., 1986; Spanish version by Valor-Segura et al., 2020). This scale was described in Study 1. The Cronbach's alpha for *exit* was .85 and for *loyalty* was .70.

Ambivalent Sexism Inventory (Glick & Fiske, 1996; Spanish version by Expósito et al., 1998). The inventory consisted of 22 items evaluating sexist attitudes. Of the 22 items, 11 were related to *hostile sexism* (e.g., "Women are very easily offended"), and 11 were related to *benevolent sexism* (e.g., "The man is incomplete without the woman"). The response format was a 6-point Likert-type that ranged from 0 = *totally disagree* to 5 = *totally agree.* High scores revealed more sexist attitudes. In the present study, we only measured *benevolent sexism* (α = .84).

Demographic Information. Information on the participants' age, sex, relationship status, duration of the relationship, and parent status were collected.

Design and Procedure

The second study replicated the procedure and design of Study 1. The participants were volunteers and completed consent forms ensuring the confidentiality and anonymity of their responses. All procedures were approved by the Ethics Committee of the University of Granada.

Analysis Strategy

The descriptive analysis of frequencies and MANCOVA performed in Study 1 were replicated in this study, adding benevolent sexism. Additionally, a simple moderation analysis was executed, applying Model 1 of the PROCESS program described by Hayes (2013) to

analyze whether benevolent sexism moderates the effect of the type of condition (absence vs. presence of IPV) on dependency. Ultimately, to replicate the model obtained in Study 1, we tested the effect of dependency and commitment as mediating variables in the relation between type of condition and CRS through various multiple serial mediation analyses (Model 6; Hayes, 2013).

Results

Frequency of Type of IPV and Couple Conflicts

Of the total sample, 34.9% of women reported having suffered some type of violence by their current partner. Specifically, 31.5% of women reported having suffered psychological violence, 8.4% physical violence, and 14.2% sexual violence. In a similar vein, communication was the most frequent type of conflict reported by women (51.7%), followed by distancing (12.9%); confidence, unsafety, and lying (11.1%); support (7%); infidelity (6.6%); jealousy (5.5%); and family, financial, and illness problems (5.2%).

Effect of on Dependency, Commitment, Benevolent Sexism, and CRS

[1]A MANCOVA was carried out to analyze whether the presence IPV group (vs. absence) showed higher scores in dependency (Hypothesis 3a), commitment (Hypothesis 3b), and benevolent sexism (Hypothesis 3c), as well as less use of exit (Hypothesis 3d) and more use of loyalty (Hypothesis 3e) strategies. The type of condition (absence vs. presence of IPV) was the IV, and dependency, commitment, benevolent sexism, exit, and loyalty strategies were the DVs.

The results showed higher scores in dependency, Wilks' λ =.886, F (1, 410) = 10.84, p < .001, $\eta p2$ = .03, in women who reported IPV (*M* = 2.70, *SD* = .68) than women who reported

1 The analyses were controlled by age, relationship status, duration of the relationship, and having children, finding significant results in the effects of a) age on commitment (p = .002) and exit (p = < .001) in older women; b) relationship status (p = .04) on commitment and exit (p = .01); and c) having children (p = .005) on benevolent sexism, with higher scores among women who reported having children ([*M* = .92, *SD* = 1.03]) than those who did not ([*M* = .61, *SD* = .65]). Specifically, women who lived with their partners and were dating scored higher on commitment compared to women who were married (Mlivingwiththeirpartner = 6.04, *SD* = .80; Mdatingrelationship = 6.02, *SD* = .79; Mmarried = 2.79, SD =1.54). Likewise, women who were married showed higher scores in exit strategies than women who were in dating relationships and living with their partners (Mmarried = 6.26, SD =.58; Mdatingrelationship = 3.04, *SD* = 1.56; Mlivingwiththeirpartner = 2.94, *SD* = 1.58).

couple conflicts (*M* = 2.47, *SD* = .63), confirming Hypothesis 3a. Concerning commitment, no significant differences were found (Wilks' λ =.886, F [1, 410] = 1.25, p = .264, ηp2 = .00; MIPV = 6.00, *SD* = .82; and MCouple Conflicts = 6.07, *SD* = .76), rejecting Hypothesis 3b. In line with expectations, the results revealed significantly higher scores in benevolent sexism (Wilks' λ =.886, F [1, 410] = 15.39, p < .001, ηp2 = .04) in the IPV group (*M* = .81, *SD* = .85) than the absence of IPV group (*M* = .53, *SD* = .55), confirming Hypothesis 3c. Regarding CRS (exit and loyalty), the findings indicated significantly higher scores in the use of exit CRS (Wilks' λ =.886, F [1, 410] = 38.35, p< .001, ηp2 = .09) in women who reported IPV (*M* = 3.56, *SD* = 1.52) than women who did not (*M* = 2.68, *SD* = 1.50), refuting Hypothesis 3d. Finally, the results showed significantly higher scores in the use of loyalty CRS (Wilks' λ =.886, F [1, 410] = 6.38, p = .012, ηp2 = .02) in the IPV group (*M* = 3.98, *SD* = 1.50) than the absence of IPV group (*M* = 3.62, *SD* = 1.37). These findings support Hypothesis 3e.

Moderating Effect of Benevolent Sexism on the Influence of Type of Condition (Absence vs. Presence of IPV) on Dependency

Lastly, to verify the mediating effect of dependency and commitment on the relation of condition (absence vs. presence of IPV) with a lower tendency to use exit (Hypothesis 4b) and higher tendency toward loyalty (Hypothesis 4c) CRS, various multiple serial mediation analyses (Model 6 of the PROCESS macro; Hayes, 2013) were carried out.

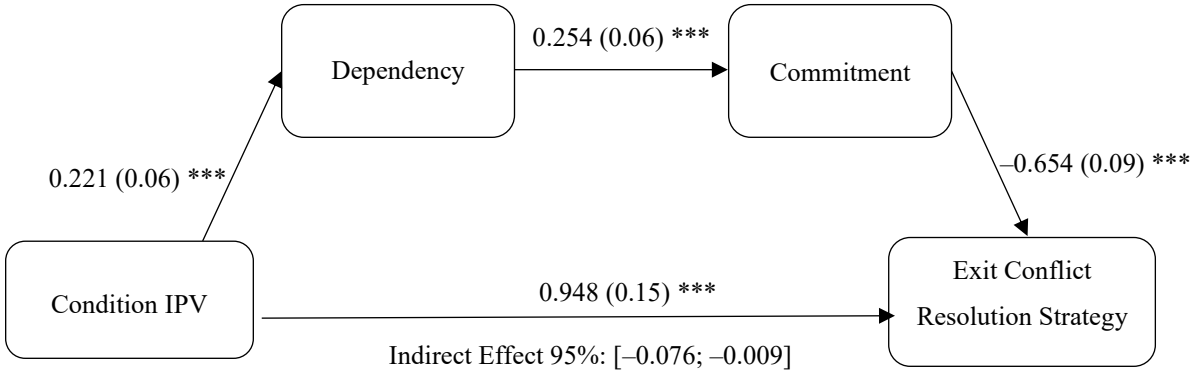
Regarding the effect of dependency and commitment on exit CRS, these variables predicted a total of 21.6% of variance in the willingness to use exit CRS, confirming Hypothesis 4b. As shown in Table 2 and Figure 2, higher scores in dependency and commitment predicted less tendency to use exit strategies in the presence of IPV group (indirect effect = –0.037, SE = 0.02, 95% CI [–0.076, -0.009]). [2]Likewise, age, relationship status,

2 We found significant results of age on commitment (b = –0.020, SE = 0.00, 95% CI [–0.034, –0.006]), indicating more commitment at younger ages, and on exit (b = 0.046, SE = 0.01, 95% CI [0.020, 0.072]), pointing to more use of exit CRS in older women. Similarly, we also found significant effects of the relationship status on exit (b = –0.283, SE = 0.14, 95% CI [–0.550, –0.015]). Specifically, women in dating relationships showed higher tendencies to use exit strategies compared to women who lived with their partners or were married (Mdatingrelationship = 3.04, *SD* = 1.56; Mlivingwiththeirpartner = 2.94, SD =1.58; Mmarried = 2.79, SD =1.54).

duration of the relationship, and having children were included as covariates, finding significant effects of age and relationship status (see Table 2). Concerning loyalty CRS, no significant results were found. Dependency and commitment did not predict greater loyalty (b = –0.006, SE = 0.00, 95% CI [–0.021, 0.004]) according to the type of condition (absence vs. presence of IPV), rejecting Hypothesis 4c. The total effect observed of X on Y was b = 0.372, SE = 0.15, 95% CI [0.082, 0.662].

Figure 2

Conceptual Model Showing the Proposed Relationship between Type of Condition and Exit CRS Mediated by Dependency and Commitment



Note. Unstandardized beta coefficients reported, with standard errors within parentheses. Condition 0 = couple conflict; 1 = IPV. *$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

Table 2

Multiple Mediation Analysis of the Type of Condition, Dependency, and Commitment on Exit Conflict Resolution Strategy

	Dependency		Commitment		Exit	
Background	*Coeff.*	Symmetric BCI	*Coeff.*	Symmetric BCI	*Coeff.*	Symmetric BCI
Constant	2.655***	[1.829, 3.481]	6.486***	[5.477, 7.496]	4.685***	[2.493, 6.877]
Type of condition	0.221***	[0.089, 0.353]	–0.146	[–0.302, 0.011]	0.821***	[0.532, 1.120]
Dependency			0.254***	[0.140, 0.367]	0.313**	[0.099, 0.526]
Commitment					–0.654***	[–0.833, –0.475]
Age	–0.008	[–0.020, 0.004]	–0.020**	[–0.034, -0.006]	0.046***	[0.020, 0.078]
Relationship status	0.060	[–0.064, 0.183]	0.140	[–0.005, 0.284]	–0.283*	[–0.550, –0.015]
Duration relationship	–0.000	[–0.001, 0.000]	0.000	[–0.001, 0.001]	–0.001	[–0.002, -0.000]
Having children	–0.034	[–0.362, 0.294]	–0.375	[–0.757, 0.008]	0.229	[–0.479, 0.938]
	$R^2 = 0.034$ $F(5, 410) = 2.90$, $p = 0.013$		$R^2 = 0.073$ $F(6, 409) = 5.440$, $p = < 0.001$		$R^2 = 0.216$ $F(7, 408) = 16.11$, $p < 0.001$	

Indirect Effects	Effects	Symmetric BCI
Total	0.128	[0.016, 0.245]
I1	0.069	[0.013, 0.142]
I2	0.095	[–0.007, 0.206]
I3	–0.037	[–0.076, –0.009]

Note. I1 = IPV → Dependency → Exit; I2 = IPV → Commitment → Exit; I3 = IPV → Dependency → Commitment → Exit; Symmetric BCI: Symmetric Bootstrapping Confidence Interval. The indirect effects are significant where the Bootstrap Confidence Interval does not include the value 0. *p< 0.05, **p< 0.01, ***p< 0.001.

Auxiliary Analysis: Perception of the Risk of Suffering Future Violence Among Women who Reported IPV

Ultimately, a frequency analysis was performed to explore the perception of the risk of future violence by current partners in the group of women who reported IPV. Specifically, 61.4% perceived a risk for future violence, and 38.6% believed that the violence would not be repeated. Regarding the type of violence, a little more than half of women (54.5%) believed they were likely to suffer psychological violence again, while only 10.3% and 14.5% of women perceived the risk of suffering physical or sexual violence, respectively, in the future from their current partner.

Discussion

The present study was intended to test a conceptual model assessing the effect of several variables such as dependency, commitment, and benevolent sexism on the use of exit and loyalty CRS, differentiating between women who informed or not physical, psychological or sexual IPV. Specifically, we wanted to test Rusbult el al. (1986) CRS model in women to reported IPV (vs. not) basing on the assumptions of the Investment Model (Rusbult & Martz, 1995). The results support several hypotheses but, counterintuitive other hypothesEs were rejected.

More precisely, it was hypothesized that higher scores in dependency and commitment predicted less use of exit and more use of loyalty CRS in the group of women who reported presence of IPV (vs. absence). The results partially supported the hypothesis. According to previous studies that referred to dependency (Bell & Naugle, 2005; Le & Agnew, 2003) and commitment (Rusbult et al., 1986) as predictor variables for the management of couple conflicts, the conceptual model intended to analyze the effects of these variables on the use of exit CRS in presence of IPV group was confirmed. The findings indicate that women who reported IPV showed higher scores in dependency, favoring their commitment to the

relationship, and consequently using less exit CRS. These novel findings were replicated in Study 2 by expanding the sample, obtaining a significant model for exit CRS. In this regard, we must consider the context in which the study is framed because, although IPV is widespread all over the word (WHO, 2012), according to the socio-ecological model of violence the influence of social and cultural factors could be relevant to understand the IPV (Cummings et al., 2013).

Precisely, women who reported IPV (vs. absence of IPV) exhibited greater dependency, while no significant differences were found between the groups in the level of commitment to the relationship. Concerning the differences in the use of exit CRS, contrary to expectations, both studies displayed a greater use of exit CRS in women who reported IPV. However, although some women ended their relationships, other women did not, often returning to the abuser and making several attempts before breaking off the relationship successfully (Gilbert & Gordon, 2017; Yamawaki et al., 2012). Similarly, Gordon et al. (2004) pointed out a significant relation between commitment and forgiveness of abuse by women's partners, favoring a return to the relationship. In this respect, when dependency and commitment variables were included, the relation between the IPV group and the use of exit strategy was reversed, probably because dependent people increase their tolerance to abuse to maintain the relationship (Rusbult & Langer, 2003; Tan et al., 2018; Valor-Segura et al., 2014) and tend to forgive their partners more easily than nondependent people (Beltrán-Morillas et al., 2019). Moreover, the level of commitment in a relationship could influence the perception of opportunities to leave it, demonstrating that people in dating relationships are less committed than married couples and therefore perceived as more likely to break up (Yamawaki et al., 2012). In this respect, both studies controlled the analyses by relationship status without significant results in Study 1, but with significant influence on commitment and exit CRS in

Study 2, finding contradictory results like higher levels of commitment in younger women, and less use of exit CRS in dating relationships (vs. married or living with partner).

Otherwise, the conceptual model did not apply to loyalty CRS. This is possibly because even though the IPV group obtained higher scores in loyalty CRS in Study 2, no differences between groups were found in commitment, which is considered a predictor of relationship maintenance (Arriaga, 1997), especially in women involved in violent relationships (Hanley & O'Neil, 1997). The facilitating role of guilt in the relation between dependency and the use of loyalty CRS might better explain this relationship, taking into account the type of condition (absence vs. presence of IPV; Valor-Segura et al., 2014). In light of these findings, it is necessary to highlight the relevance of these results because, although several research studies have focused on variables related to IPV and relationship decision-making, the mediating influence of dependency and commitment in the relation between type of condition and the use of exit or loyalty CRS has not yet been studied. Therefore, it is recommended that future studies replicate these findings, considering the role of guilt in these results.

Study 2 also considered the inclusion of benevolent sexism as a possible moderator due to its relation to higher levels of dependency and violent relationships (Matos & Rivas, 2018), not finding significant results. However, the role of sexist attitudes in IPV cannot be overlooked, and it is important that the results showed a significant effect of benevolent sexism on dependency. Similarly, women who reported IPV (vs. absence of IPV) exhibited higher levels of benevolent sexism, providing novel results in line with previous studies relating sexist attitudes to IPV (Expósito & Herrera, 2009; Juarros-Basterretxea et al., 2019).

Lastly, the perception of the risk of future violence from current partners was explored, finding that almost half of the women did not believe that the violence would be repeated in the future. Only between 3–16% of women victims perceived a risk of physical or sexual violence happening again, and between 55–68% believed they were likely to suffer future

psychological violence from their current partner. Interestingly, although women reported violence, many of them were unaware of their risk levels. In fact, Campbell et al. (2003) indicated that half of victims murdered by their partners did not consider themselves to be at risk of death. Further, according to the type of violence, previous studies have pointed out that physical violence and serious injuries would be perceived as more serious (Yamawaki et., 2009) and be more easily recognized than psychological violence (Novo et al., 2016). For this reason, victims might consider the future occurrence of sexual or physical violence less likely than psychological violence. Moreover, women victims of IPV sometimes do not perceive their vulnerability to future IPV because they do not consider themselves victims. Previous research indicated that despite being victims of abuse, 70–80% of women do not perceive themselves as such (García-Díaz et al., 2017). Other times, women perceive the risk of future violence but do not take action to finish the relationship (Gondolf & Beeman, 2003).

In short, the results obtained in the study are alarming and highlight the desirability of continuing to explore the role of other possible factors involved, such as cognitive distortion, which could be a relevant factor for women in making decisions about leaving or maintaining a relationship (Heim et al., 2018). Regarding the findings obtained in the present study about the use of loyalty CRS, the relation between commitment and loyalty in women victims of violence could be explained by the presence of cognitive distortion. In this line, Gilbert and Gordon (2017) showed the mediating effect of minimization cognitive distortion about the severity of aggression on commitment and forgiveness of partners for women involved in violent relationships. Similarly, other cognitive distortions such as comparison with others, denial, and/or rationalization could present in women victims of IPV as a way for them to reassess the violent situation and be consistent with their decision to continue the relationship (Nicholson & Lutz, 2017). This could be construed as an important obstacle in women's

decision-making regarding the management of their relationships and an interesting avenue to contemplate in future research.

Limitations and Future Directions

Some limitations should be addressed in the future to offer new research opportunities. First, in this study, the type of conflict and frequency were taken into account, with communication the most frequent type of conflict reported by women (30–50%). Nonetheless, the severity of couple conflicts reported were not contemplated. In this respect, future investigations should consider intragroup differences according to the type of conflict and its severity, because that might influence the management of couple conflicts (Garrido-Macías et al., 2017). Additionally, although the critical incident technique (Flanagan, 1954) is a good way to get information about a couple's most serious conflict, it is based on participants' subjective perceptions, which can be a problem due to some participants not remembering any couple conflicts or not perceiving them as serious. Second, the frequency of IPV was not evaluated, which may be necessary because repeated abuse could decrease the likelihood that the abuse was accidental, manifesting the intentions of the aggressor and influencing the perception of the seriousness of the incident (Yamawaki et al., 2009). Similarly, could be necessary to consider control behaviors to understand the differences in IPV experiences (Hardesty et al., 2015), as well as their escalation over time, frequency and severity in order to make a more precise distinction between situational couple violence and IPV (Hardesty et al., 2015). Third, future studies should balance the sample in terms of socio-demographic variables, such as marital status, to avoid counter-intuitive results. In addition, others research benefit from analyzing the influence of women's socioeconomic status (income and control over it) in their responses to IPV (WHO, 2005) as well as social norms that perpetuate inequality (WHO, 2021), assuming the main causes for IPV (WHO, 2017) and relating to greater tolerance towards aggression (Fitzpatrick et al., 2004). In this regard, the findings should be interpreted

with caution because these are limited to the data obtained from Spanish women. So, although IPV can happen to any women in the world, its prevalence could vary among countries due to the influence of social and cultural factors (Ngoc et al., 2013). For example, Ismayilova (2009) found a significantly relation between patriarchal gender beliefs regarding the social justifiability of wife abuse and individual and community risk for IPV. Likewise, women's perception of the severity of violence is one reason for staying in or returning to a violent relationship (Fanslow & Robinson, 2010). Hence, measuring women's perceptions of the severity of IPV will be essential to understand their decision-making about relationships. Finally, further studies are needed to adapt Rusbult's model (1986) focusing on the benefits or risks involved in the use of CRS to the well-being of women victims of IPV, which will be a priority over the maintenance of the violent relationship, as well as examining all of forms of CRS (exit, loyalty, voice, and neglect) to obtain a broader view of victims' response to IPV.

Conclusion

Decision-making in favor of women's well-being and integrity is essential, especially in the context of violent relationships. This study extends prior research and provides novel evidence for understanding the complex process of relationship decision-making for women, having important theoretical and practical implications. On one hand, the proposed conceptual model displayed the mediating effect of dependency and commitment on the lower use of exit CRS in women who reported IPV. Likewise, some women's lack of risk perception is alarming, and it is worth investigating the variables that hinder it. On the other hand, these findings provide relevant information for workers in the field of IPV, who can consider the complexity of women's situations and adapt interventions according to the women's needs. Finally, although conflicts are inherent in relationships, IPV implies a risk to women's health. In this regard, it is necessary to continue investigating the mechanisms that make it difficult for women to break off violent relationships and become aware of their risk levels.

Estudio 5

Study 5

Barriers to Help-Seeking in a Spanish Sample of Women Victims of Intimate Partner Violence

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Abstract

Intimate partner violence against women (IPVAW) is a major public health problem globally affecting women. However, victims could present psychological barriers that make it difficult to seek help. Understanding women's victimization process might be the first step in identifying these barriers and helping victims. This study was aimed to test a conceptual model to analyze the mediating effects of perceived severity and assessed risk in the relationship between dependency and help-seeking behaviors in psychological, physical, and sexual violence. The sample consisted of 266 victims of IPVAW (M_{age} = 27.88 years; *SD* = 9.49), of which 23.7% reported having suffered physical violence from their partner or ex-partner, 83.8% psychological violence, and 54.1% sexual violence. Our results showed that higher scores in dependency were related to lower perceived severity of violence, lower assessed levels of risk, and thus elevated difficulty in engaging in help seeking in all types of violence. These findings highlight the importance of raising awareness about IPVAW's magnitude, severity, and consequences for victims' health to facilitate their decisions to seek help. Furthermore, preventing IPVAW through gender equality education from an early age could also be essential to address IPVAW by preventing the development of dependent and unequal power relationships.

Keywords: intimate partner violence against women, dependency, perceived severity, risk assessment, help-seeking behaviours

Barriers to Help-Seeking in a Spanish Sample of Women Victims of Intimate Partner Violence

Intimate partner violence against women (IPVAW) is a global public health problem that affects one in three women worldwide (Peterman et al., 2020; World Health Organization; WHO, 2022). IPVAW involves any physical, psychological, or sexual abuse by a current or former intimate partner and represents a violation of women's human rights (WHO, 2022). Further, it is important to emphasize IPVAW's devastating consequences for women's physical and mental health, which include injury, chronic pain, anxiety, and post-traumatic stress disorder among others (Campbell, 2002; Wang, 2016). As a fatal result of IPVAW, some women are intentionally murdered by their partners or ex-partners (United Nations, 2018). However, it seems that not all IPVAW victims seek help, despite its serious effects, and instead suffer in silence and even take more than eight years to verbalize the situation and/or file a complaint (Satyen et al., 2019; Spanish Ministry of Equality, 2020; Wang, 2016). The present study was aimed to examine the barriers that IPVAW victims encounter in seeking help, focusing on individual variables such as dependency, perceptions, and IPVAW assessment.

Help-Seeking Behaviours in IPVAW Victims and Related Variables

Help-seeking can be defined as the process of locating and utilizing formal (e.g., police) or informal (e.g., friends) resourses for victim support (Boldero & Fallon, 1995; Goodson & Hayes, 2021). Previous research seems to have identified multiple factors such as psychological (e.g.: attachment to the relationship), sociocultural (e.g.: culture), or demographic (e.g.: age) that may affect IPVAW victims' help-seeking behaviors (Cho et al., 2020; Hien & Ruglass, 2009). In this regard, according to Liang et al. (2005), the decision to seek help could be understood by ecological framework (Bronfenbrenner, 1979), suggesting that human behaviour may be explained by the interrelation of hierarchical systems: macrosystem (e.g., culture), exosystem (e.g., institutions), mesosystem (e.g., family), and

microsystem (e.g., individual). Specifically, of all the previously mentioned systems, individual factors (e.g., type of abuse and education level) seem to be significantly related to help-seeking behaviors (Goodson & Hayes, 2021). Moreover, given the variety of help-seeking behaviors related to IPVAW as well as the inconsistencies in the recording of formal requests and the lack of registration of informal demands, an adequate understanding of individual barriers to help-seeking in IPVAW victims will be crucial to provide appropriate resources and reach out to those who do not seek help.

Dependency, Perceived Severity, and Risk Assessment

To predict IPVAW victims' help-seeking and reporting behaviors, we must know how victims perceive IPVAW (Kuijpers et al., 2021). Specifically, perceived severity involves people's beliefs about IPVAW's magnitude and significance (Riddle & Di, 2020; Witte, 1994). According to Fanslow and Robinson (2010), failure to perceive IPVAW's severity is one of the main reasons victims do not seek help. In these cases, although women sometimes recognize IPVAW's objective indicators, they do not perceive the magnitude of the problem and, consequently, do not identify themselves as victims (Hamby & Gray-Little, 2000; Spanish Ministry of Equality, 2020). That is why it is necessary to explore the influence of obstacles (e.g., dependency on the partner) to perceiving IPVAW's severity, to understand women's responses to IPVAW.

Dependency refers to the affective need for love and support from a partner and influences the individual's responses—thoughts, feelings, affects, and self-control—depending on the partner's actions (Rusbult, & van Lange, 2003; Valor-Segura et al., 2014). In this sense, several studies have indicated that high levels of dependency in women could favor their tolerance for abuse, leading them to passively face violence and remain in their relationships (e.g., Rusbult & Langer, 2003; Tan et al., 2018; Valor-Segura et al., 2014). In relation to this last aspect, one of the consequences of a woman's permanence in a violent relationship is her

tendency to deny or minimize the abuse and her victimization (Amor et al., 2006). Specifically, Garrido-Macías et al. (2020a) found that higher levels of dependency in women predicted lower perceived severity of sexual transgressions and lower probability of leaving relationships after such offenses. This could be dangerous for women because if they do not perceive IPVAW's severity and make an adjusted assessment of the risk to which they are exposed, it will be difficult for them take self-protective measures such as seeking help (Badenes-Sastre & Expósito, 2021).

A reasonable assessment of victims' perceived IPVAW risk could be critical in seeking help. According to Brewer and colleagues (2004), when people perceive a high risk of harm, it should encourage them to take action to decrease their risk. However, victims of IPVAW do not always appreciate the risk of their situations. Specifically, as stated by Campbell et al. (2003), half of women killed by their partners or ex-partners did not consider themselves to be at risk of death. Thus, although seeking formal or informal help increases the likelihood of ending a violent relationship, a macro-survey conducted in Spain showed that only 21.7% of IPVAW victims reported their situations (Spanish Ministry of Equality, 2020). Other times, even after perceiving the risk of suffering violence from their partner again, victims do not take measures to end the violent situation (Gondolf & Beeman, 2003). Therefore, to try to clarify the barriers victims face in getting out of violent relationships, it could be relevant to examine how dependency, perceived severity, and assessed risk are related, focusing on the victims' search for help. The present study is aimed to address this gap because it will be essential for understanding IPVAW victims' obstacles in seeking help, thus contributing to a more specific and effective approach to this issue.

Additionally, it is noteworthy that the different forms of IPVAW manifestation may influence perceptions of severity and assessments of risk in that victims are more likely to tolerate threats or less-severe physical aggression than other forms of violence (Gracia &

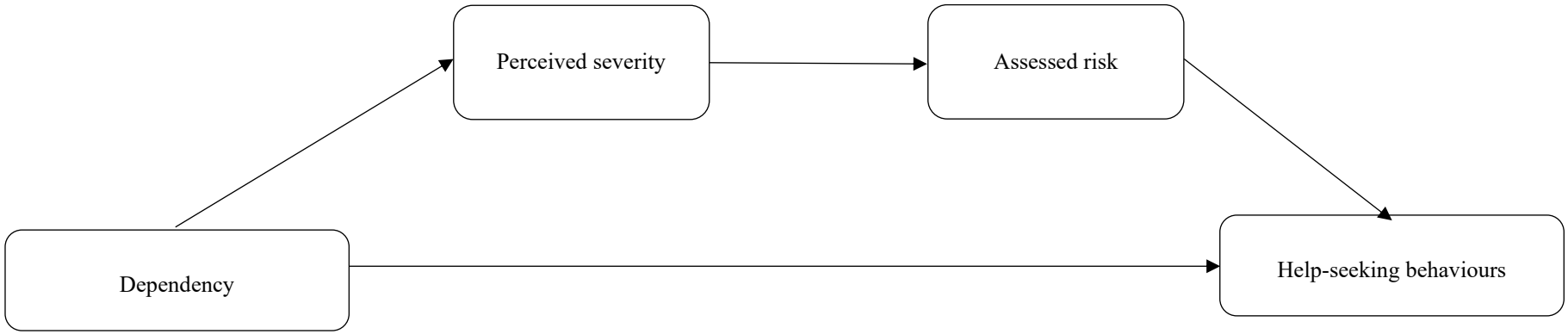
Herrero, 2006). Likewise, more overt violence such as physical violence, is perceived as more severe than other violence more subtle, such as psychological (Novo et al., 2016; Wilson & Smirles, 2022). Ultimately, it should be noted that help-seeking behaviors in victims may vary depending on the type of IPVAW they are facing and the consequences of their victimization. Surprisingly, research has shown that victims of psychological violence only are more likely to seek help than women who suffer multiple forms of IPVAW (Cho et al., 2020). Hence, it will be of interest to examine possible differences in perceived severity, assessed risk, and help seeking according to IPVAW type (physical, psychological, or sexual).

The Present Research

The present study was aimed to explore and understand the barriers to help seeking in IPVAW victims. We conducted this study to test a conceptual model (Figure 1) analyzing the mediating effects of perceived severity and assessed risk in the relationship between dependency and help-seeking behaviors in victims of psychological, physical, and sexual IPVAW. Specifically, we expected that lower dependency scores would relate to higher perceived severity and assessed risk of violence, thus favoring help-seeking behaviors in physical (Hypothesis 1), psychological (Hypothesis 2), and sexual (Hypothesis 3) violence. Additionally, we explored relationships among scores in dependency, perceived severity, assessed risk, and help-seeking behaviors according to the type of IPVAW suffered by the victims.

Figure 1

Conceptual Model Showing the Proposed Relationship between Dependency and Help-Seeking Behaviours in IPVAW Mediated by Perceived Severity and Assessed Risk



Note. IPVAW = Intimate partner violence against women.

Method

Participants

The sample size was calculated using the G*Power program (Faul et al., 2009). A total of 84 participants were estimated to correlations with a medium effect size of .30, a significance level of α =.05, and power of .80. The initial sample consisted of 472 women from the general population, of whom 206 were excluded because they did not report psychological, physical, or sexual intimate partner violence. Thus, the final sample comprised 266 IPVAW victims. The participants' ages ranged from 18 to 69 years old, with an average age of 27.88 years (*SD* = 9.49). Most of the participants (98.5%) had higher education experience (vs. 1.5% with elementary education). Concerning relationship status, 41.4% were dating, 22.2% were cohabiting, 11.3% were married, and 25.2% were not in a relationship. Moreover, 15.8% of the participants had children.

Instruments

WHO Violence Against Women Instrument (WHO, 2005). The instrument includes 13 items with a dichotomous response format (*yes*/*no*) that assess experiences of violent acts carried out by a partner. Four items relate to psychological violence (e.g., "Has your partner threatened to harm you?"), six items relate to physical violence (e.g., "Has your partner slapped you?"), and three items relate to sexual coercion, with or without the use of physical force (e.g., "Has your partner forced you to have sex when you did not want to?"). We performed a translation and back-translation process following the usual standards (English–Spanish, Spanish–English). We asked participants whether they had suffered any type of psychological, physical, and/or sexual violence from their partner or an ex-partner using an item repeated three times, once for each type of violence: "Have you experienced any of the above behaviors [psychological, physical, or sexual violence items] by your partner and/or ex-partner in your lifetime?"

Perceived Severity of IPVAW. To evaluate how the participants perceived the violence's severity, we included an ad hoc item with a Likert-type response format (1 = *nothing severe* to 7 = *very severe*) for each type of violence: "To what extent do you perceive the behavior [psychological, physical, or sexual violence items] as severe?"

Risk Assessment of IPVAW. We included another ad hoc item to measure the participants' assessment of the risk to their life due to the different types of IPVAW. The responses ranged, on a Likert-type scale, from 1 (*the experiences of violence would not pose any risk to my life*) to 7 (*the experiences of violence would totally pose a risk to my life*). For each type of violence, we asked the participants, "To what extent do you believe it [psychological, physical, or sexual violence items] would involve a risk to your life?"

Seeking Social Support Subscale of the Ways of Coping Questionnaire (Folkman & Lazarus, 1985, 2005; expanded version by Menssink, 2017). This subscale comprised seven items that assessed help seeking. Three items related to formal help seeking (e.g., "I talked to someone who could do something concrete about the problem"); and four items related to informal help seeking (e.g., "I talked to someone about how I was feeling"). The response options were as follows: 1 = *Does not apply or not used*; 2 = *Used somewhat*; 3 = *Used quite a bit*; and 4 = *Used a great deal*. We administered the measure three times, once for each type of violence (psychological, physical, and sexual). The alpha coefficients obtained for psychological, physical, and sexual violence were .80, .83, and .88, respectively.

Spouse-Specific Dependency Scale (SDSS; Rathus & O'Leary, 1997; Spanish version by Valor-Segura et al., 2009). This scale assessed partner-specific dependency through 17 items with a Likert-type response format ranging from 1 (*totally disagree*) to 6 (*totally agree*). The items were distributed among three constructs: anxious attachment (five items; e.g., "I feel bad if my partner has a good time without me"), exclusive dependency (six items; e.g., "My partner is the only one I could turn to in case of a problem"), and emotional dependency (six

items; e.g., “If I have problems, I cannot pass without asking my partner’s opinion”). In this study, the Cronbach’s alpha for the scale was .81.

Demographic Information. At the end of the survey, the participants’ age, education level, relationship status, and having children were collected.

Design and Procedure

A no-experimental associative study was performed. The study was developed obtaining the acceptance of the ethics committee of the University of [blinded for reviewers]. Then, an online survey was diffused through social networks (Facebook, Instagram and groups of WhatsApp) as well as institutional mail service, selecting participants via incidental sampling. Participants were included in the study if they were adult women (at least 18 years old) and reported psychological, physical, or sexual IPVAW in the WHO Violence Against Women instrument. All participants were informed about the study’s purpose, provided informed written consent according to the Helsinki Declaration, and were ensured confidentiality and anonymity. No monetary incentives were provided for participation.

Analysis Strategy

The SPSS Program, version 23, was used to analyze data. First, to explore the prevalence of physical, psychological, and sexual violence among the women in our sample, as well as their perceptions of severity and assessed risk according to the type of violence, descriptive analyzes were conducted. After that, a Person correlation was performed to analyze the associations among the variables. Finally, to determinate whether perceived severity and assessed risk mediated dependency’s effect on help-seeking behavior, several multiples serial mediation analyses were executed using Model 6 of the PROCESS program (Hayes, 2013). The analyses were controlled for age, educational level, relationship status, and having children.

Results

Exploratory Analyses: Dependency, Perceived Severity, Assessed Risk, and Help-Seeking Behaviours according to the Type of IPVAW

Of the 266 victims, 23.7% reported having suffered physical violence from their partner or ex-partner, 83.8% reported psychological violence from a partner, and 54.1% reported sexual violence from a partner. In general, the victims presented medium levels of dependency (M = 3.02, SD = .67) and high scores (over 6 points) in their perception of severity and risk assessed for all types of IPVAW (see Table 1).

As shown in Table 1, the Pearson correlation analysis revealed significant correlations between help-seeking behavior and dependency, perceived severity, and assessed risk, except for help-seeking behavior and dependency in physical violence ($p > 0.05$).

Table 1

Correlations and Means of Help-Seeking Behaviours, Dependency, Perceived Severity, and Assessed Risk according to the Type of IPVAW

	1	2	3	4	*M*(SD)
Physical violence					
1. Help-seeking behaviours	-				3.14 (0.62)
2. Dependency	.006	-			3.02 (0.67)
3. Perceived severity	.298***	-.199***	-		6.94 (0.37)
4. Assessed risk	.395***	-.159**	.669***	-	6.83 (0.55)
Psychological violence					
1. Help-seeking behaviours	-				2.76 (0.62)
2. Dependency	-.126*	-			3.02 (0.67)
3. Perceived severity	.270***	-.294***	-		6.81 (0.64)
4. Assessed risk	.369**	-.229***	.500***	-	5.81 (1.41)
Sexual violence					
1. Help-seeking behaviours	-				2.48 (0.85)
2. Dependency	-.156**	-			3.02 (0.67)
3. Perceived severity	.269***	-.294***	-		6.62 (0.83)
4. Assessed risk	.360***	-.239***	.463***	-	4.96 (1.72)

Note. IPVAW = intimate partner violence against women; *M* = mean; *SD* = standard deviation. *$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

Mediating Effect of Perceived Severity and Assessed Risk on the Relationship between Dependency and Help-Seeking Behaviours according to the Type of IPVAW

To test the mediating effect of perceived severity and assessed risk on help-seeking behaviors in physical (Table 2), psychological (Table 3), and sexual violence (Table 4), we used Model 6 of the PROCESS program (Hayes, 2013), controlling the results by age, educational level, relationship status, and having children. The results displayed significant mediating effects of perceived severity and assessed risk on the relationship between dependency and help-seeking behaviors in physical violence (b = −0.040, SE = 0.03, 95% CI [−0.110, −0.003]), psychological violence (b = −0.042, SE = 0.02, 95% CI [−0.075, −0.016]), and sexual violence (b = −0.048, SE = 0.02, 95% CI [−0.087, −0.020]). These effects support our main hypothesis, that lower dependency scores would relate to higher perceived severity and assessed risk of violence, thus favoring help-seeking behaviors in physical violence (Hypothesis 1), psychological violence (Hypothesis 2), and sexual violence (Hypothesis 3). Specifically, the perceived severity and assessed risk variables predicted a total of 2.68% of the variance in help-seeking behaviors to physical violence, 1.72% in situations involving psychological violence and 3.67% in those involving sexual violence. Moreover, we found that having children had statistically significant results in situations involving physical violence; there were higher levels of assessed risk (p = .008) among women who reported not having children (Table 4).

Table 2

Multiple Mediation Analysis of the Dependency, Perceived Severity, and Assessed Risk on Help-Seeking Behaviours in Physical Violence

	Perceived severity		Assessed risk		Help-seeking behaviours	
Background	*Coeff.*	Symmetric BCI	*Coeff.*	Symmetric BCI	*Coeff.*	Symmetric BCI
Constant	7.540***	[6.966, 8.114]	0.200	[–0.990, 1.391]	–1.660	[–3.337, 0.017]
Dependency	–0.107***	[–0.174, –0.041]	-0.029	[-0.103, 0.046]	0.061	[–0.043, 0.166]
Perceived severity			0.969***	[0.835, 1.103]	0.159	[–0.093, 0.411]
Assessed risk					0.388***	[0.216, 0.560]
Age	–0.004	[–0.011, 0.002]	–0.006	[–0.013, 0.002]	0.008	[–0.002, 0.019]
Educational level	–0.004	[–0.065, 0.057]	–0.004	[–0.071, 0.063]	–0.002	[–0.096, 0.092]
Relationship status	0.002	[–0.017, 0.057]	0.005	[–0.036, 0.046]	–0.008	[–0.066, 0.049]
Having children	-0.096	[–0.269, 0.077]	0.086	[–0.104, 0.277]	0.359**	[0.091, 0.627]
	$R^2 = 0.049$		$R^2 = 0.468$		$R^2 = 0.187$	
	$F(5, 260) = 2.71$, $p = < 0.021$		$F(6, 259) = 38.04$, $p = < 0.001$		$F(7, 258) = 8.46$, $p < 0.001$	

Indirect Effects	Effects	Symmetric BCI
Total	–0.074	[–0.171, –0.004]
I1	–0.018	[–0.075, 0.017]
I2	–0.012	[–0.048, 0.013]
I3	–0.044	[–0.117, –0.003]

Note. I1 = Dependency → Perceived severity → Help-seeking behaviours; I2 = Dependency → Assessed risk → Help-seeking behaviours; I3 = Dependency → Perceived severity → Assessed risk → Help-seeking behaviours. Symmetric BCI: Symmetric Bootstrapping Confidence Interval. The indirect effects are significant where the Bootstrap Confidence Interval does not include the value 0. *p< 0.05, **p< 0.01, ***p< 0.001.

Table 3

Multiple Mediation Analysis of the Dependency, Perceived Severity, and Assessed Risk on Help-Seeking Behaviours in Psychological Violence

	Perceived severity		Assessed risk		Help-seeking behaviours	
Background	*Coeff.*	Symmetric BCI	*Coeff.*	Symmetric BCI	*Coeff.*	Symmetric BCI
Constant	7.700***	[6.740, 8.661]	–1.633	[–4.006, 1.279]	1.304*	[0.024, 2.583]
Dependency	–0.279***	[–0.390, –0.168]	-0.197	[-0.427, 0.031]	–0.022	[–0.134, 0.084]
Perceived severity			1.069***	[0.829, 1.309]	0.101	[–0.032, 0.233]
Assessed risk					0.139***	[0.080, 0.198]
Age	0.004	[–0.007, 0.016]	–0.006	[–0.028, 0.017]	0.003	[–0.008, 0.013]
Educational level	–0.011	[–0.114, 0.091]	–0.059	[–0.260, 0.142]	–0.008	[–0.105, 0.089]
Relationship status	–0.024	[–0.087, 0.038]	0.084	[–0.039, 0.207]	–0.011	[–0.071, 0.049]
Having children	-0.028	[–0.318, 0.261]	0.434	[–0.135, 1.003]	0.017	[–0.259, 0.293]
	$R^2 = 0.093$		$R^2 = 0.279$		$R^2 = 0.147$	
	$F(5, 260) = 5.34$, $p = < 0.001$		$F(6, 259) = 16.77$, $p = < 0.001$		$F(7, 258) = 6.37$, $p < 0.001$	

Indirect Effects	Effects	Symmetric BCI
Total	–0.097	[–0.190, 0.036]
I1	–0.028	[–0.105, 0.011]
I2	–0.027	[–0.066, 0.010]
I3	–0.041	[–0.075, –0.016]

Note. I1 = Dependency → Perceived severity →Help-seeking behaviours; I2 = Dependency → Assessed risk →Help-seeking behaviours; I3 = Dependency → Perceived severity → Assessed risk→ Help-seeking behaviours. Symmetric BCI: Symmetric Bootstrapping Confidence Interval. The indirect effects are significant where the Bootstrap Confidence Interval does not include the value 0. *p< 0.05, **p< 0.01, ***p< 0.001.

Table 4

Multiple Mediation Analysis of the Dependency, Perceived Severity, and Assessed Risk on Help-Seeking Behaviours in Sexual Violence

	Perceived severity		Assessed risk		Help-seeking behaviours	
Background	*Coeff.*	Symmetric BCI	*Coeff.*	Symmetric BCI	*Coeff.*	Symmetric BCI
Constant	7.526***	[6.288, 8.764]	1.751	[–1.185, 4.688]	0.464	[–1.077, 2.006]
Dependency	–0.353***	[–0.497, –0.209]	–0.285	[–0.570, 0.001]	–0.077	[–0.228, 0.073]
Perceived severity			0.911***	[0.679, 1.144]	0.128	[–0.007, 0.262]
Assessed risk					0.147***	[0.083, 0.212]
Age	0.003	[–0.012, 0.018]	–0.026	[–0.054, 0.002]	0.005	[–0.010, 0.020]
Educational level	0.034	[–0.100, 0.163]	–0.170	[–0.421, 0.081]	0.006	[–0.126, 0.138]
Relationship status	0.015	[–0.066, 0.095]	0.092	[–0.061, 0.245]	–0.045	[–0.126, 0.035]
Having children	–0.073	[–0.446, 0.300]	–0.257	[–0.968, 0.454]	0.322	[–0.050, 0.694]
	$R^2 = 0.092$		$R^2 = 0.247$		$R^2 = 0.162$	
	$F(5, 260) = 5.29$, $p = < 0.001$		$F(6, 259) = 14.17$, $p = < 0.001$		$F(7, 258) = 7.13$, $p < 0.001$	

Indirect Effects	Effects	Symmetric BCI
Total	–0.135	[–0.224, –0.064]
I1	–0.045	[–0.111, 0.008]
I2	–0.042	[–0.100, 0.003]
I3	–0.048	[–0.086, –0.020]

Note. I1 = Dependency → Perceived severity → Help-seeking behaviours; I2 = Dependency → Assessed risk → Help-seeking behaviours; I3 = Dependency → Perceived severity → Assessed risk → Help-seeking behaviours. Symmetric BCI: Symmetric Bootstrapping Confidence Interval. The indirect effects are significant where the Bootstrap Confidence Interval does not include the value 0. *p< 0.05, **p< 0.01, ***p< 0.001.

Discussion

IPVAW victims face psychological barriers that make it difficult to perceive IPVAW as a major problem and, consequently, adopt help-seeking behaviors to end their violent relationships. Understanding these barriers will be the first step in helping victims. Based on previous findings, the present study's aim was to fill this research gap by testing a conceptual model in which we analyzed the mediating effects of perceived severity and assessed risk in the relationship between dependency and help-seeking behaviors. The results confirmed all our hypotheses, demonstrating that higher dependency in IPVAW victims relates to lower perceived severity, decreasing victims' assessed risk to their health and, consequently, making victims less likely to engage in help-seeking behaviors. Efforts must be directed to preventing IPVAW by raising awareness of its magnitude, severity, and consequences for victims.

According to Spencer and colleagues (2019) the strongest risk markers for IPVAW victimization were those located in the microsystems (i.e., the victims' perspectives). In this line, based on our findings, we should pay attention to the influence of victims' dependency in their assessment of IPVAW, which could explain their deficits in perceiving the danger of their violent relationships (Witte & Kendra, 2010). Generally, women show higher relationship dependency scores than man making them more likely to forgive partners' transgressions (Beltrán-Morillas et al., 2019; Valor-Segura et al., 2014), assuming an obstacle for help seeking. Evidence supports the notion that regardless of the types of violence women suffer (physical, psychological, and/or sexual), dependency influences victims' perceptions and assessments of their intimate partner relationships, thus impacting their help-seeking behavior. Although previous studies have suggested different levels of perceived severity, assessed risk, and help-seeking behavior in IPVAW victims depending on the type of IPVAW they suffer (Cho et al., 2020; Garrido-Macías et al., 2020a; Gracia & Herrero, 2006; Novo et al., 2016; Wilson & Smirles, 2022), IPVAW should be understood as a set of violent behaviors, all of

which can pose a risk to victims. Specifically, results indicated that dependency affects severity perceptions, risk assessment and help-seeking in all three types of violence, meaning it must be addressed for all contexts.

Particularly, in our sample, IPVAW victims showed medium levels of dependency as well as high levels of perceived severity for the three types of IPVAW, especially physical violence. However, assessed risk scores were lower than perceived severity scores, mainly for sexual intimate partner violence, which was assessed as a medium risk to women's health. In this line, it is worth noting that even though sexual violence produces severe physical and psychological consequences (WHO, 2022) and seems to be more easily identified by women than subtler forms of violence (e.g., psychological violence; Novo et al., 2016), victims make unrealistic risk assessments about this type of violence. In couples' context, due to the different tactics used and the invisibility of some actions by partner, it is possible an ambiguous perception of the victims of sexual violence, normalizing the violent situation, do not identify themselves as victims, and consequently do not report it (Garrido et al., 2020b). Moreover, attitudes toward IPVAW, culture, or myths about relationships could influence the normalization of sexual violence and inhibit help-seeking behavior (Goodson & Hayes, 2021; Satyen et al., 2019). According to Zapata-Calvente and colleagues (2019), to reduce the rates of IPVAW victimization and facilitate victims' searches for help, efforts should be directed toward promoting gender equality and changing traditional gender role socialization.

Lastly, the help-seeking behavior variable correlated to perceived severity and assessed risk in all three manifestations of IPVAW and to dependency in manifestations other than physical violence. That is, dependency was not directly related to help-seeking behavior in victims of physical violence, but it was when that relation was mediated by perceived severity and assessed risk in situations involving physical IPVAW. It is interesting to note because it will be necessary focusing on the factors that favour help-seeking behaviours in victims of

physical IPVAW, increasing their perceived severity and health risk assessed that violence implies for them to facilitate help-seeking behaviours.

Limitations and Future Directions

Although the obtained findings suppose an advancement in the literature about this topic, some limitations should be noted. First, because it was not study's aim, women did not ask if they suffered IPVAW by current or former partner, which could affect their perception of severity and risk assessment of IPVAW. A macro-survey in Spain displayed that victims experiencing IPVAW with their current partners were less likely to report it than those who had experienced it with former partners. Furthermore, among the main reasons for not having reported IPVAW, victims indicated solving the problem alone or not giving importance to what happened (Spanish Ministry of Equality, 2019). Thus, it will be important to assess whether the violence was perpetrated by the women's partner or former partner as well as exploring the reasons women give for seeking or not seeking help.

Second, other types and manifestations of IPVAW as well as their interactions should be considered. Specifically, although controlling behavior is considered IPVAW and can be appear in multiple forms, including through new technology, this behavior tends to be normalized (Sánchez-Hernández et al., 2021; WHO, 2022) requiring its assessment. Also, although it would be interesting to investigate, the simultaneous experience of several types of violence in some participants was not controlled because the main interest of the study was to explore in IPVAW victims whether the model (see Figure 1) is replicated in the different types of IPVAW.

Third, we did not analyze differences in victims' perceived severity and assessed risk depending on the type of violence suffered because of the imbalance of participants in each category. In this regard, the limited previous research that has explored these differences has suggested that psychological violence might be perceived as less severe than physical or sexual

violence (Novo et al., 2016; Wilson & Smirles, 2022). Exploring possible differences among IPVAW manifestation will be critical to establish specific prevention and intervention programs.

Regarding to future directions, to advance understanding of the mechanisms involved in help-seeking by IPVAW victims, more research is needed. Particularly, several relevant variables related to the relationship status (e.g., aggressor partner or former partner), violent episodes (e.g., frequency of violence), or among others would be assessed in future studies to recognize its impact on women's perceptions of severity and risk and, consequently, on help-seeking decisions.

More, according to previous literature (Dobash el al., 2007; 2011; Liem et al., 2009; Spanish Ministry of Equality, 2020), leaving the violent relationship and/or reporting the aggressor may increase the risk for IPVAW victims and/or their children. In this context, it would be beneficial for future studies to investigate the victims' assessment of the consequences of certain decisions (e.g., leaving or staying in the relationship) in increasing or decreasing the perceived risk to their life and/or that of their children. Finally, IPVAW is a global problem that affects women worldwide (WHO, 2022), necessitating future research to replicate these findings in other countries.

Implications for Research, Practice, and Policy

This study's findings have several important implications for future research, practice, and policy. Concerning research implications, the obtained results allow us to understand some of the individual barriers to victims' help seeking, thus facilitating scientific progress regarding IPVAW. Other investigations can continue examining relevant aspects concluded in this study so, although individual factors were associated to help-seeking behaviours (Goodson & Hayes, 2021), interrelation among several systems could also influence in make-decisions (Bronfenbrenner, 1979). Regarding practical implications, the obtained results reveal the

importance of establishing dependency-free relationships as well as favoring the perception of severity of IPVAW in the victims of IPVAW and assessing its risk in order to seek help. IPVAW should not be underestimated, and we must be able to identify it in all its manifestations (e.g., insults or isolation). Thus, it is necessary to educate children regarding equality from an early age, working on the dependency to partners by reinforcing self-esteem and strengthening personal resources as well as promote specific and efficient campaigns to highlight IPVAW's severity and the risk it poses for women. Moreover, continued efforts are needed to make victim support resources early accessible to women, thus offering them security and confidence. Finally, IPVAW should be depoliticized and understood as a public health issue, and the social responsibility for addressing that should not depend on the political party in power. In this regard, a key policy priority should therefore be to plan for IPVAW's long-term care via implementing prevention and intervention programs based on evidence.

Conclusion

To date, this study is the first to reveal the mediating effects of perceived severity and assessed risk on the relationship between dependency and help-seeking behaviors, providing relevant implications for understanding IPVAW victims' barriers to help seeking. Particularly, as opposed to in situations involving psychological and sexual violence, help-seeking behaviours in physically violent situations was not explained by dependency, requiring victims to have high levels of perceived IPVAW severity and assessed risk to seek help, considering also the influence of having children on women's assessment of the risk to their lives. Furthermore, the results suggest that victims underestimated the risk of sexual violence to their health. These findings provide a comprehensive view of individual barriers to help seeking in IPVAW victims which could help in establishing prevention programs focused on target variables as well as previously established macro-factors, such as unequal gender roles, which could be the basis of it.

Estudio 6

Study 6

Transformative Effect of Intimate Partner Violence Against Women Based on Sociocultural Factors Trapping Women in Violent Relationship

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Abstract

IPVAW is the most frequent type of violence experienced by women, with devastating consequences for their physical and mental health. Due to exposure of women to the violence, their perceptions and interpretations of the situation may be distorted, making it difficult to leave the violent relationship. Exploring the obstacles that women must verbalize their situation or ask for help will be critical to prevent IPVAW. For this purpose, two studies were implemented: Study 1 included a focus group of seven women victims of IPVAW, and Study 2 included 550 women (n = 258 suffer IPVAW, and n = 292 not suffer IPVAW). In Study 1, women informed about perceptions (e.g., minimization of the situation), interpretations (e.g., justifying the aggressor), and feelings (e.g., guilt) as the main obstacles in leaving the violent relationship. Study 2 revealed that women who suffered IPVAW obtained lower scores in perceived severity, and attribution of responsibility of the aggressor, as well as higher scores in feelings of embarrassment and guilt than women who had not suffered IPVAW. No significant differences were found in risk assessed and feelings of fear among women's group. These findings highlight the serious consequences of the exposure to IPVAW for victims, requiring the implementation of preventive programs to address the distortion of reality they present due to the aggressor's manipulation, as well as the influence of sociocultural factors on the construction of women's role in relationships.

Keywords: intimate partner violence against women, focus group, victims, attributions, feelings

Transformative Effect of Intimate Partner Violence Against Women Based on Sociocultural Factors Trapping Women in Violent Relationship

Intimate partner violence against women (IPVAW) involves any physical, psychological, or sexual abuse, as well as control behaviors by a current or former intimate partner and is the most frequent type of violence experienced by women, affecting one in three of them worldwide (World Health Organization; WHO, 2020). The prevalence of physical and/or sexual IPVAW in the European Union was estimated around 22% throughout women's lives (European Union Agency for Fundamental Rights, 2014). Likewise, in Spain 14.2% of women over 16 years of age had experienced physical and/or sexual violence by a partner or former partner, 31.9% psychological violence, and 32.4% all these forms of violence (Spanish Ministry of Equality, 2020).

The impact of IPVAW in the women's physical and mental health could be devastating. Specifically, women who experienced IPVAW could present deterioration of physical health (e.g., injuries or headaches), sexual and reproductive health (e.g., unwanted pregnancies or sexually transmitted diseases), mental health (e.g., posttraumatic disorder or depression) or even fatal consequences (e.g., homicide or suicide) (Campbell, 2002; WHO, 2022). IPVAW also has public health costs and consequences, indicating the general wellbeing and health of the population (Spaid et al., 2016). Despite this, most IPVAW victims suffer their violent situation in silence, sometimes taking more than eight years to verbalize the problem and/or filing a complaint (Spanish Ministry of Equality, 2020).

It seems that women victims of IPVAW may find it challenging to end their relationships (Caetano et al., 2005). Particularly, a macro survey conducted in Spain (Spanish Ministry of Equality, 2020) revealed that 78.3% of women who suffered IPVAW never reported it and, among women who did report, the percentage of reports decreased significantly when the aggressor was their current partner (5.4% vs. former partner 25%). Also, in cases

where women broke their silence, they were more likely to tell other women (54.7% to friends; 36.2% to their mother; and 25.4% to their sister). It seems that any action involving the verbalization of IPVAW by victims has a positive impact on escaping the relationship so, among women who sought formal or informal help, 81.9% broke off the relationship compared to 49.6% who never sought help (Spanish Ministry of Equality, 2020). Focusing on the obstacles IPVAW victims face in leaving their violent relationships and getting to safety will be critical to their protection.

Theoretical Framework

Patriarchal power structure and misogynistic culture are the main causes of IPVAW advocated by feminist theories (Bosch & Ferrer, 2000). It implies gender inequality, an assumption of stereotyped social and cultural roles according to sex and/or gender that contributes to IPVAW, favouring attitudes of tolerance towards aggression (European Institute for Gender Inequality, 2020). In this line, feminist theory is an attempt to dismantle the different forms of IPVAW legitimization in society, as well as understanding social perceptions and attitudes toward IPVAW (De Miguel, 2005).

Furthermore, the gas lighting effect is fundamentally a social phenomenon that has its roots in social inequalities, particularly related to gender and sexuality, and is carried out within intimate relationships characterized by power imbalances (Sweet, 2019). It refers to the emotional manipulation by the aggressor towards the victim to convince her that she misunderstands situations, sowing doubts in her (Stern, 2019). Gaslighting is common in IPVAW, mentally confusing and exhausting the victims, distorting reality in favor of the aggressor and hindering decision-making that would help them end the violent relationship (Daw et al., 2022).

In this sense, the consequences of gas lighting could be destructive for IPVAW victims, with the goal of the aggressor being to persuade the victim that her perceptions, judgments,

memories, thoughts, and assessments of the situation are highly flawed, to the extent that she should adopt the aggressor's perspective and discredit her own (Spear, 2019; Sweet, 2019). Violence against women by men might be explained like a product of social structural conditions (Hunnicutt, 2009), resulting in difficulties for IPVAW victims to leave the violent relationship due to their perceptions and interpretations of the situation are affected by exposure to the gas lighting exerted by their abusive partner. Also, difficulty in understanding how their partner can intentionally hurt them could lead to inconsistency-tension in the women, misinterpreting reality (Grawe, 2004; Loinaz, 2014). Hence, it will be essential to explore these aspects in order to implement IPVAW prevention programs.

Elements Related to IPVAW Trapping Women in Violent Relationships

Making the decision to end a relationship can be one of the most challenging choices individuals may encounter in their lives (Garrido-Macías, 2017). Specifically, for women in violent relationships this type of decision is particularly complex. In this respect, it has been established that the influence of variables such as dependency (Badenes-Sastre et al., 2023a; Le et al., 2010; Valor-Segura et al., 2014), commitment and satisfaction (Badenes-Sastre et al., 2023a; Garrido-Macías et al., 2017), or cognitive distortions (Nicholson & Lutz, 2017), among other, is present in the decision-making process with respect to the relationships. Particularly, (Badenes-Sastre et al., 2023a) pointed that IPVAW victims present higher partner-dependency, commitment, and in this turn, use less exit strategies for leaving the relationship than women who have not reported IPVAW. Additionally, women who have a high degree of dependency on their partners reported experiencing higher levels of guilt and, consequently, predicted a greater likelihood of exonerating their abusive partner (Valor-Segura et al., 2014).

Among the primary factors that prevent victims from reporting or verbalizing their situation are because they do not identify themselves as victims, downplaying the importance of the situation, and presenting feelings of embarrassment, guilt, or fear (Spanish Ministry of

Equality, 2020). No woman begins a relationship with fear, guilt, and dependency, it is part of a process due to the interaction between sociocultural factors and the individual context. In this regard, the influence of sociocultural factors as well as the consequences of IPVAW exposure in the individual victim's responses should also be considered to understand the complexity for victims in making decisions to break away from the violent relationship (Spanish Ministry of Equality, 2020; Yamawaki et al., 2009).

Specifically, because of experiencing IPVAW, women may be susceptible to the gas lighting effect, affecting their perceptions and interpretations about the violent situations in the relationship (Spear, 2019; Sweet, 2019), potentially becoming an obstacle in leaving the violent relationship. In fact, although women sometimes recognize IPVAW's objective indicators, they may normalize violence without perceiving its severity, which is one of the main reasons victims continue or return with the aggressor partner (Fanslow & Robinson, 2010; Spanish Ministry of Equality, 2020). Furthermore, many women who experience violence from their current partner do not anticipate that the violence will occur again in the future (Badenes-Sastre et al., 2023), implying it an obstacle for their self-protection. Particularly, Campbell et al. (2003) showed that even half of the victims who were killed by their partners did not believe they were at risk of being murdered. In this regard, the perception of IPVAW can vary in difficulty depending on the type of violence experienced, with physical violence being more easily recognized and perceived as more serious than other subtler forms of violence, such as psychological or sexual violence (Badenes-Sastre et al., 2021; Novo et al., 2016; Yamawaki et al., 2009).

Otherwise, feelings of embarrassment, guilt, or fear could be obstacles for women to verbalize or report their situation (Spanish Ministry of Equality, 2020). According to Puente-Martínez et al. (2016), the risk of staying in violent relationships increases with high levels of embarrassment and guilt. Particularly, embarrassment generates discomfort and confusion in

the victim and impedes action, while guilt repairs the aggressor's negative behaviors and keeps the woman in the abusive relationship. In this line, feelings of embarrassment or guilt in victims of IPVAW could make them underestimate the severity of the violent situations in their relationships as well as justifying the aggressor's behavior in order to explain situations of IPVAW that are difficult to understand (Herrera & Expósito, 2009; Valor-Segura et al., 2014). Likewise, although feelings of fear would drive women away from the violent relationship, when violence is chronic, fear makes women stay in the relationship, encouraging new violent behaviors towards them (Fanslow & Robinson, 2010; Puente-Martínez et al., 2016). Fear of IPVAW is powerful in both women who have suffered violence by their partner or former partner and women who have not. To release themselves from these negative emotions, women who have not suffered IPVAW could blame victims for the situation (Yamawaki et al., 2009), while victims of IPVAW may use strategies such as denial, normalizing the situation, or forgiving the aggressor (Puente-Martínez et al., 2016). Further research is necessary to comprehensively understand the psychological and emotional processes that IPVAW victims go through, to develop tailored specific measures that can effectively support them. Through the present study, this gap is addressed by utilizing a mixed-methods approach and gathering firsthand accounts from women who have experienced IPVAW, thereby providing unique and novel data to the previous literature.

Hence, this research aimed to explore the obstacles that IPVAW victims face in getting out of the violent relationship. To do so, two studies were performed using an explanatory sequential mixed methodology. In the Study 1, the IPVAW victims' experiences about their violent relationships were collected through a focus group in order to explore the obstacles they encountered in leaving the violent relationship. Then, based on the main obstacles mentioned by victims related to perceptions, interpretations, and feelings about IPVAW, a second study was carried out to analyze the consequences of the IPVAW exposure, evaluating these

obstacles quantitatively through a survey of women who informed (and those who did not) IPVAW, establishing differences in them according to the sample.

STUDY 1

Method

Participants

A total of seven women who experienced physical, sexual, and/or psychological IPVAW participated in the focus group. Participants were recruited through their previous participation in the University of [blinded for reviewers] program of [blinded for reviewers]. The participants' ages ranged from 20 to 60 years (M = 42.14; SD = 13.15). The educational level indicated by the participants was low (n = 3), medium (n = medium), and high (n = 3). All of them were Spanish and their marital status was separate. Five of them reported having children.

Design and Procedure

A qualitative phenomenological study to explore perceptions, interpretations, feelings, and triggers to leave IPVAW in women victims was performed. This method provides information about human experiences through the descriptions provided by the people involved (Neubauer et al., 2019). In this regard, focus group is an appropriate method to collect information about attitudes, knowledge, and experiences (Myers, 1998). Following Myers' recommendations (Myers, 1998), a semi-structured interview was conducted through a focus group of IPVAW victims in 2017. The group was selected by convenience sampling based on a psychosocial care program for minors and their mothers who are victims of gender violence carried out at the University [blinded to reviewers].

The categories to be explored were determined before conducting the group interview. Researchers engaged in a reflective dialogue based on previous literature, establishing the objectives of the study and the research questions for the interview (see Table 1).

The duration of the interview was 2 hours and 13 minutes. Women were provided with information about the study's purpose gave their voluntary consent by signing an informed consent form, adhering to the principles of the Helsinki declaration. The study was approved by the ethics committee at the University of [blinded for reviewers], and women did not receive any compensation for their participation. Lastly, the interview was audio- recorded to transcribe it into text. Two professional psychologists facilitated the discussions in the group using a semi-structured guide and analyzed data.

Table 1

Interview Questions for Focus Group

1. Perceptions about the abusive relationship	*1.1. How did you perceive that the relationship was not normal?* *1.2. Did you perceive that you were in a risky situation? What helped you perceive risk? What situations did you perceive as maximum risk?* *1.3. Could you perceive IPVAW in other people's relationships but not in your own? Why do you think that happens?*
2. Interpretations about the abusive relationship	*2.1. How did you react to signs that the relationship was not normal?* *2.2. Did you have any doubts about the IPVAW situation?* *2.3. Did you end up believing what the aggressor argued?* *2.4. When you justified the situation, you normalized it and minimized its severity, why do you think you did that?*
3. Feelings during the abusive relationship	*3.1. Have you felt embarrassed?* *3.2. Have you felt guilty?* *3.3. Have you felt fear?* *3.4. How did you manage these feelings? What situations provoked these feelings in you?*
4. Triggers for leaving the abusive relationship	*4.1. What would you identify as triggers to leave the violent relationship?*

Note. IPVAW = Intimate partner violence against women. Translated from Spanish into English.

Analysis Strategy

The data gathered from the focus group was subjected to a content analysis. The analysis was organized using the four main topics addressed in the script as a reference. Based on a predefined procedure, two independent coders (M.B. and A.B.) categorized the citations of participants regarding their obstacles to leaving the violent relationship in perceptions, interpretations, feelings, and triggers to leave IPVAW, ensuring accuracy and reliability of the coding results. First, the researchers independently read the transcribed interview and included the participants citations in the previously established categories. After that, they shared their results and discussed any discrepancies with a third researcher. The agreement index was calculated for the inclusion of citations in each category: perceptions ($\kappa = 0.87$), interpretations ($\kappa = 0.82$), feelings ($\kappa = 0.94$), and triggers to leave IPVAW ($\kappa = 1$). At the end of the process, total agreement was obtained from the three researchers for the inclusion of citations in each category.

Results

According to research' objectives, participants informed about their IPVAW experiences. In the following section results from the study will be presented in subsections.

1. Perceptions about the violent relationship

In general, women showed a low perception of severity of IPVAW during their relationship, tending to normalize it even if other people alerted them:

Women 1: *"My relationship was completely normal"* (Comment 1).

Women 2: *"I thought everything that happened was normal. They know how to do it so well that you don't notice the IPVAW"* (Comment 2).

Women 3: *"In my case, many people told me so, but I didn't believe it. If he is your first partner and he does these things to you, you think it's normal. Lack of information"* (Comment 3).

Women 4: *"Maybe the situation is not as serious as I think"* (Comment 4).

Specifically, women informed about different abuse and control situations which were not perceived as alarm signals:

Women 5: *"He would take my cell phone and I would say that I have nothing to hide, I don't care. I didn't perceive the situation as: It's mine! Why are you touching it?"* (Comment 5). *"For example, I had no money and when I had to buy shoes for the child or something else, I had to pay for it somehow. He told me: If you don't comply as a woman, then... I had to do what he asked me to do. And the next day, I was having lunch with him in the neighborhood on the weekend, laughing at the table as a happy family"* (Comment 6). *"He was watching over his daughters, he told them: Don't go out because it's very cold. Don't go out because it's too hot. Let's go home because I want to watch TV. And I thought: He is a good father; he takes care of us! And I felt it was normal"*. (Comment 7). *"I didn't work because he told me that He didn't want to hire someone to take care of the daughters". It seemed normal to me but then I couldn't do anything without his permission. I didn't even know how to withdraw money from the bank"* (Comment 8). *"He wouldn't let me give my opinion, I said one thing and he said the opposite"* (Comment 9).

Women 3: "*Even though I worked and kept the house, I could not buy a television, I could not buy anything…"* (Comment 10). *"I didn't realize he was isolating me"* (Comment 11).

Women 6*: "I used to say: Wow, how he cares about me! He would go everywhere with me, because wouldn't let me see my friends or anything, but I saw it as normal"* (Comment 13). *"The first three months after I met him, everything went very well, without any fights, a very wonderful summer. When he started coming to sleep with me on the weekends, that's when it started to go bad, but I saw it as normal"* (Comment 14). "*The first slap I did not see it as*

normal, but he apologized and justified himself by telling me that he thought I had been unfaithful, and I normalized his behavior" (Comment 15).

Women 4: *"The money was all and absolutely for him even though I worked for it"* (Comment 16). *"The beatings came and went, and I tried not to cry so that my parents wouldn't wake up and notice"* (Comment 17). *"I learned how to apply makeup to remove the bruises on my face and no one in my family knew about it"* (Comment 18). *"At the beginning I thought my relationship was normal, I also had nothing to compare it to"* (Comment 19).

However, when IPVAW occurred to other women, some participants did not normalize the situation and were able to perceive the severity in which other women found themselves. At other times, they can perceive IPVAW when they are already out of the violent relationship.

Women 2: "*I did not see her relationship as normal. He was there, there... until he took her away from her friends, from us"* (Comment 20).

Women 7: *"I said to her, what he is doing to you is not normal. The girl was so manipulated and absorbed by him that there was nothing we could do"* (Comment 21).

Women 4: *"I realize it now; I didn't realize it before. I didn't realize it until I got out of the relationship"* (Comment 22). *"If I thought it would happen to me again, I wouldn't let anyone near me"* (Comment 23).

Women 5: *"Now I have learned a lot, I am a person, I know what I am worth"* (Comment 24). *"Before, I didn't know it was abuse, I thought it was the novelty of being married, that maybe my mother had also lived through it and put up with it, but then she calmed down because I have never seen my parents fight"* (Comment 25).

Women 3: *"Now, this monster comes along, and I say Hey, I could detect it"* (Comment 26).

Also, women had difficulty perceiving the risk they were facing. Consequences of IPVAW for victims, the children's response to the situation, lack of autonomy, threats or attempted murder were some of the elements or situations that helped victims IPVAW perceive that they might be at risk of death.

Women 6: *"When I went to prison for what happened"* (Comment 27).

Women 5: *"When he held up a knife to me. The frightened faces of my daughters saying "Shut up, mom, he'll kill us right here! And I thought, what movie am I living?"* (Comment 28).

Women 3: *"In my case, he sent me to work; if I didn't work, I didn't eat. I was unemployed for 3 days and he kept me in a locked room for 3 days and kept telling me you don't work, you don't eat"* (Comment 29).

Women 4: *"First, when my daughter was born, all hell broke loose".* (Comment 30). *"When I decided to leave the relationship. Then, he put a tombstone in the WhatsApp status with the date of our wedding"* (Comment 31).

2. Interpretations about the violent relationship

IPVAW victims' interpretations of the aggressor's behaviors could be distorted as a result of exposure to violence as well as previous sociocultural factors. It can be reflected in the women's narratives regarding different types of abusive situations such as physical, psychological, sexual, or control abuse.

Women 4: "*He had alcohol problems and I justified it with that. He was telling his sorrows around. There came a time when I even wondered if I was making a mistake"* (Comment 32). *"I worked miles away from home, I left work at two in the morning and walked home whether it rained or snowed... It seemed normal to me. Because if he had to get up in the morning to work, he wasn't going to come at two o'clock in the morning to pick me up. It didn't seem strange to me that he would make it difficult for me to get my driver's license"* (Comment 33). *"When you have only had one partner and you start with him when you are 15 years old,*

that's what you got, you don't know if he is more or less aggressive sexually…" (Comment 34). *"My lifelong friends were more his friends than mine, I couldn't tell them anything, he was right"* (Comment 35).

Women 6: *"When he hit me, he tried to justify it"* (Comment 36).

Women 3: *"He told me: Your family doesn't love you, there's only me, the day you leave me, or something happens you'll be under a bridge with the girls because you're not capable of anything. Finally, I really thought my family didn't love me"* (Comment 37).

Women 5: *"I depended on him. He made me think that what I had lived, was not what I had lived. It was what he told me that I had lived"* (Comment 38). *"Many times, I would serve him last so that his food would not get cold, and he would say to me: Why do I bring the money home, so that you eat first and I can be the shit and eat last? Then I would justify myself and not do it again. Also, he would make me stand at the other end of the table."* (Comment 39).

Women 1: *"I attributed it to my strong character. If you hurry, I can justify his behavior years later"*. (Comment 40). *"Sometimes, I still wonder why. I don't understand a lot of things"*. (Comment 41). *"Normally I would think this can't be happening to me! I want to die!"* (Comment 42).

Women 2: *"I justified it to my family and hid other things"* (Comment 43).

When women were asked why they justified the aggressor's behaviors, women informed about the inexperience, lack of information, embarrassment or sexist beliefs as factors favoring the interpretations mentioned above.

Women 3: *"Due to lack of information, especially if he is your first partner"* (Comment 44).

Women 1: *"Lack of support. Nobody believed me"* (Comment 45).

Women 2: *"In my case it was because of the role I had in my family. What my family inculcated in me about relationships"* (Comment 46).

Women 4: *"Because women have to be more submissive"* (Comment 47). *"Also, because I felt embarrassment or guilt. If you didn't guilt yourself, he blamed you"* (Comment 48).

3. Feelings during the violent relationship

During the violent relationship, women informed feeling embarrassment, guilt, and fear because of exposure to the abuser's violent behaviors.

Embarrassment

Women 5: *"You don't say the first slap, you keep quiet out of embarrassment"* (Comment 49).

Women 3: *"I didn't say about the bed. How are you going to tell the police that your husband makes you get into bed? The most of them do it!"* (Comment 50).

Women 4: *"I have felt embarrassment in situations of violence and have justified it"* (Comment 51).

Guilt

Women 4: *"I blamed myself, and if I didn't, he did it"* (Comment 52). *"I avoided going to bars and it suited him fine. Then the relationship deteriorated"* (Comment 53).

Women 5: *"I was told at a women's aid service that I was mistreating my daughters because I was aware of what was happening"* (Comment 54).

Women 1: *"I made me feel that I was responsible for having been a victim of violence"* (Comment 55).

Fear

Women 1: *"I went through a lot of fear, and I have struggled a lot to overcome that fear and have a normal life. Nothing could be worse than being on the lookout for when I was going to kill myself. Uncertainty, a lot of fear"* (Comment 56).

Women 5: *"I'm still scared, I'm terrified for my daughters, because we had a restraining order that is now over"* (Comment 57). *"Just knowing that it was time for him to come home from work made me afraid"* (Comment 58). *"Listening to his motorcycle or his car already scared me"* (Comment 59).

Women 3 and 4: *"I was afraid when I heard the door open"* (Comment 60).

Women 3 and 5: *"I was very afraid that he might hurt my daughters"* (Comment 61).

In response to guilt, embarrassment, and guilt feelings, women used different coping strategies:

Women 1: *"What could I say if they made me feel responsible for not having acted otherwise? I didn't tell anything"* (Comment 62). *"I felt he was going to kill me, and I was so distressed, without any family support… Alcohol gave me strength, took away my fear"* (Comment 63).

Women 5: *"For fear that he would do something to my daughters, I would tell them to go give daddy a kiss, I know you love me, don't give it to me"* (Comment 64). *"He would come in drunk at night and wake the children to scold them. Then I learned that if I gave him money he would keep drinking and disappear for a few days. It was the only way to keep him away"* (Comment 65). *"I have felt a lot of fear even after the relationship ended. The first thing I did when I arrived home with the car was to check that he had not jumped over the balcony to enter my house. I knew he was capable of anything"* (Comment 66). *"In the end, I went to a social security psychologist to tell her that I was afraid to leave the house and I didn't know why"* (Comment 67).

4. Triggers for leaving the violent relationship

Although the women were exposed to different situations of violence, only some of them were decisive in their decision to leave the violent relationship:

Women 5: *"I was told I didn't have cancer and I thought I had to fight. To think that my daughters have had to take care of me. They don't have to take care of a mother (she bursts into tears). That gave me strength and I went to file a complaint"* (Comment 68). *"Also, I reported because he was going to kill me. The frightened faces of my daughters will never be forgotten"* (Comment 69).

Women 1: *"He left home and me, then, a few months later, I filed for divorce"* (Comment 70). *"Three friends who supported me and told me to report my situation"* (Comment 71).

Women 3: *"When, one day, he came to my daughters' school and in front of everyone he started to insult me and wanted to hit me. So, I said, I'm filing a complaint"* (Comment 72).

Women 4: *"When he really believed that I was going to separate from him, then he threatened me, and I decided to report"* (Comment 73).

Women 2: *"I went to the doctor with two anxiety attacks and the doctor, without telling me anything, filed a report"* (Comment 74).

STUDY 2

Hypothesis

Hypothesis 1: IPVAW women will get lower scores in perceived severity (Hypothesis 1a), risk assessed (Hypothesis 1b), and attribution of responsibility of the aggressor (Hypothesis 1c), as well as higher scores in feelings of embarrassment (Hypothesis 1d), guilt (Hypothesis 1e), and fear (Hypothesis 1d) than women who not referred IPVAW.

Method

Participants

[1] The necessary sample size of 102 participants was determined using the G*Power program (Faul et al., 2009) based on a medium effect size of d = .50, a significance level of α

[1]Part of the sample was extract of a broader project [blinded for reviewers].

= .05, and a power of .80, for the purpose of conducting a mean difference test. The final sample comprised 550 women, 258 of whom reported physical, psychological, and/or sexual intimate partner violence. The participants' age ranged from 18 to 60 years old, with a mean age of 24.43 years (*SD* = 8.57). Most women had university education (84.2%), and the rest vocational training (4.2%) or bachelor's studies (11.6%). Regarding employment status, 59.8% of women were students, 35.1% employees, and 5.1% unemployed. Finally, of the 550 participants, 12.4% had children, and 72.2% reported maintaining a relationship (vs. 27.8% without a partner).

Instruments

WHO Violence Against Women Instrument (WHO, 2005). This instrument assesses experiences of violence against women by partner or former partner by means of 13 items with dichotomous response (Yes/No). Specifically, six items measured physical violence (e.g., “Has your partner pushed you?”), four items psychological violence (e.g., “Has your partner humiliated you in front other people?”), and three items sexual violence with or without use of physical force (e.g., “Did you ever have sexual intercourse you did not want because you were afraid of what he might do?”). A translation and back-translation process (English-Spanish/Spanish-English) was conducted for the instrument used in this study. Participants were asked whether they had experienced any type of physical, psychological, or sexual violence from their current or former partner(s) and were asked to respond with either "yes" or "no". The items were grouped into three blocks, one for each type of IPVAW (physical, psychological, and sexual). Information was obtained on the type of IPVAW experienced by repeating one item three times for each type of IPV: "Have you experienced any of the behaviors listed above [psychological, physical, or sexual violence items] by your partner and/or ex-partner at any point in your life?". In this way, information was obtained on whether the women had suffered physical, psychological and/or sexual IPVAW.

Perceived severity of IPVAW. Based on previous studies (Sánchez-Hernández et al., 2020), participants had to imagine that their partner performed some violent behavior (items of the WHO instrument) towards them. Then, they were asked: "To what extent do you perceive these behaviors [psychological, physical, or sexual violence items] as severe?" (Response range of 1 = nothing severe to 7 = very severe). This question was asked three times, once for each type of IPVAW. Lastly, the three items were averaged to obtain the total score.

Risk assessment of IPVAW. Based on previous studies (Badenes-Sastre et al., 2023a; Garrido-Macías et al., 2017), participants had to imagine that their partner performed some violent behavior (items of the WHO instrument) towards them. Then, they were asked: "To what extent do you consider that these behaviors [psychological, physical, or sexual violence items] would be a risk to your life?" (Response ranged of 1 = the experiences of violence would not pose any risk to my life to 7 = the experiences of violence would totally pose a risk to my life). This question was asked three times, once for each type of IPVAW. Lastly, the three items were averaged to obtain the total score.

Attribution of responsibility (McCullough et al., 2003). Participants had to imagine that their partner performed some violent behavior (items of the WHO instrument) towards them. Then, they were asked: 1) "How intentional do you think his behavior would be? (Response range of 0 = not at all intentional to 6 = totally intentional); 2) "How much is the offender to blame for what he did to you?" (Response range of 0 = not guilty to 6 = totally guilty); and 3) "Could your offender have known you would be hurt?" (Response ranged of 0 = no knowledge at all to 6 = complete knowledge). These questions were asked three times (once for each type of IPVAW). To apply this instrument in our study, we conducted a translation and back-translation process (English-Spanish/Spanish-English). The three total items were averaged to obtain the total score. The alpha coefficients for physical, psychological, and sexual violence were .64, .66, and .67, respectively.

The Positive and Negative Affect Schedule (PANAS; Watson et al., 1988; Spanish version by Sandín et al., 1999). The questionnaire included 20 items, of which 10 of them measured positive affective (e.g., interest), and the other 10 evaluated negative affect (e.g., guilt). Based on the results obtained in Study 1, we only evaluated three items of negative affective: embarrassment, guilt, and fear. Participants had to imagine that their partner performed some violent behavior (items of the WHO instrument) towards them. Then, they were asked: "To what extent would you feel [embarrassment, guilt, or fear] if your partner performed any of the above behaviors [physical, psychological, or sexual violence] towards you?" (Response range of 0 = not at all to 4 = very much). The question was asked for each type of IPVAW, as well as for each emotion (embarrassment, guilt, and fear). To obtain the embarrassment score, the participants' responses on all three types of IPVAW were averaged. The same procedure was followed to obtain the guilt and fear scores.

Demographic information. Participants were asked about age, education level, employment situation, relationship status, and having children at the end of the survey.

Design and Procedure

A non-experimental comparative study was performed. Firstly, the Lime Survey research platform was utilized to create an online survey. After obtaining approval from the ethics committee of the University of [blinded for reviewers], the survey was disseminated in Spain through social networks and participants were selected through incidental sampling. The inclusion criterion for participation in the study was to be an adult woman (age ≥ 18). Participants were informed about the objective of the study, signing informed consent according to the Helsinki Declaration and ensuring the confidentiality and anonymity of their data. After that, participants were classified into two groups (IPVAW victims vs. non-IPVAW victims) based on their responses to the Violence Against Women instrument (WHO, 2005). If the participants had suffered any type of violence mentioned in the WHO items, they were

included in the group of IPVAW victims. Otherwise, they were included in the group of non-IPVAW victims. No monetary incentives were provided for participation.

Analysis Strategy

The statistics program IBM SPSS Statistics 23 was used to perform the statistical analyses. Initially, descriptive analyses were done to explore the frequency of IPVAW in our sample recruited in Spain. Then, scores and correlations among severity perceived, risk assessed, responsibility of the aggressor, and feelings of embarrassment, guilt, and fear were performed differentiating by groups (IPVAW victims vs. non-IPVAW victims). Finally, the differences according to victims who suffered IPVAW (n = 258) and not (n = 292) were calculated by Student t test for independent samples to determinate the existence of any differences in perceived severity, assessed risk, attribution of responsibility of the aggressor, and feelings of embarrassment, guilt, and fear.

Results

Elements Related to IPVAW Trapping Women in Violent Relationships: Perceived Severity, Risk Assessed, Attribution of Responsibility to the Aggressor, and Feelings of Embarrassment, Guilt, and Fear

Of the total of participants, 53.1% (n = 292) had never suffered violence from their partner or former partner, and 46.6% (n = 258) informed suffering physical, psychological, and/or sexual intimate partner violence. Table 2 shows the characteristics of the participants according to whether they suffered IPVAW by their partner or former partner. Likewise, the Pearson correlation analysis revealed significant correlations among the main variables evaluated (see Table 3).

Table 2

Characteristics of the Participants According to Whether or Not They Suffered IPVAW

	Total (*n* = 550) N (%)	IPVAW victims (*n* = 258) N (%)	Non-IPVAW victims (*n* = 292) N (%)
Age			
18-29	402 (73.1%)	177 (68.6%)	225 (77.1%)
30-39	99 (18%)	57 (22.1%)	42 (14.3%)
40-49	34 (6.2%)	17 (6.6%)	17 (5.9%)
50-60	15 (2.7%)	7 (2.7%)	8 (2.7%)
Educational level			
Less than college degree	87 (15.8%)	39 (15.1%)	48 (16.4%)
College degree	463 (84.2%)	219 (84.9%)	244 (83.6%)
Employment status			
Student	329 (59.8%)	154 (59.7%)	175 (59.9%)
Employed	193 (35.1%)	89 (34.5%)	104 (35.6%)
Unemployed	28 (5.1%)	15 (5.8%)	13 (4.5%)
Civil status			
Single	153 (27.8%)	66 (25.5%)	87 (29.8%)
Dating relationship	224 (40.8%)	107 (41.5%)	117 (40.1%)
Living with partner	113 (20.5%)	58 (22.5%)	55 (18.8%)
Married	60 (10.9%)	27 (10.5%)	33 (11.3%)
Children			
Have children	68 (12.4%)	37 (14.3%)	31 (10.6%)
Have no children	482 (87.6%)	221 (85.7%)	261 (89.4%)

Note. IPVAW = Intimate Partner Violence Against Women; N = number of participants.

Table 3

Correlation Analysis Among Perceived Severity, Risk Assessed, Attribution of Responsibility to the Aggressor, and Feelings of Embarrassment, Guilt, and Fear

	1	2	3	4	5	6
1. Perceived Severity	-					
2. Risk Assessed	.685**	-				
3. Attribution of Responsibility to the Aggressor	.553**	.484**	-			
4. Embarrassment	-.055	-.008	-.032	-		
5. Guilty	-.133**	-.032	-.221**	.481**	-	
6. Fear	.268**	.450**	.285**	.176**	.176**	-

Note. N = 550.*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

Mean Differences in the Obstacles in Leaving Violent Relationships According to Whether Women Suffered IPVAW (or Not)

Table 4 displays the results from Student *t* test for independent samples, showing significant differences between the groups of IPVAW victims (vs. non-IPVAW victims). Particularly, IPVAW victims (vs. non-IPVAW victims) by their partner or former partner, obtained significantly lower scores in perceived severity (t (401) = -2.65, $p < .01$, 95% *CI* [-0.16, -0.02], $d = -.09$)**,** attribution of responsibility to the aggressor(t (548) = -2.40, $p < .01$, 95% *CI* [-0.27, -0.03], $d = -.15$)**,** and higher scores in embarrassment (t (547) = 3.50, $p < .001$, 95% *CI* [0.16, 0.57], $d = .36$), and guilt (t (548) = **4**.37, $p = .001$, 95% *CI* [0.23, 0.59], $d = .41$)**,** confirming Hypothesis 1a, 1c, 1d, and 1e. However, no differences were obtained between the two samples in the variables risk assessed (t (494) = -1.56, $p > .05$, 95% *CI* [-0.20, 0.02], $d = -.09$)**,** and fear (t (548) **=** -.13, $p > .05$, 95% *CI* [-0.13, 0.11], $d = -.01$)**,** rejecting Hypothesis 1b and 1f.

Table 4

Mean Differences in Perceived Severity, Risk Assessed, Attribution of Responsibility of the Aggressor, and Feelings of Embarrassment, Guilt, and Fear According to Whether Participants Suffered IPVAW or Not

	IPVAW victims (*n* = 258) *M* (SD)	Non-IPVAW victims (*n* = 292) *M* (SD)	*t*	*p*	95% (*CI*)	*d*
Perceived Severity	6.79 (.48)	6.88 (.28)	-2.65	.006	[-0.15, -0.03]	-.09
Risk Assessed	6.43 (.72)	6.51 (.59)	-1.56	.119	[-0.20, 0.02]	-.09
Attribution of Responsibility of the Aggressor	5.18 (.82)	5.33(.65)	-2.40	.017	[-0.27, -0.03]	-.15
Embarrassment	2.59 (1.13)	2.23 (1.30)	3.50	.001	[0.16, 0.57]	.36
Guilt	1.48 (1.12)	1.07 (1.07)	4.37	.000	[0.23, 0.59]	.41
Fear	3.30 (.71)	3.31 (.71)	-0.13	.895	[-0.13, 0.11]	-.01

Note. M = Mean; *SD* = Standard Deviation; *n* = number of participants.

Auxiliary Analysis: Perceived Severity, Risk Assessed, Attribution of Responsibility to the Aggressor, and Feelings of Embarrassment, Guilt, and Fear According to Type of IPVAW

Finally, a frequency analysis was conducted to investigate the frequency of each type of IPVAW in the sample. [1]The results showed that of the 46.6% of women who reported IPVAW, 23.3% of them had suffered physical violence, 83.3% psychological violence, and 54.3% sexual violence. Also, differences in perceived severity, risk assessed, attribution of responsibility to the aggressor, and feelings of embarrassment, guilt, and fear according to the type of IPVAW were explored through a linear repeated measures ANOVA.

The results indicated that type of IPVAW influenced the perceived severity, $F(1, 257) = 11.53$, $p < 0.001$, $\eta_p^2 = 0.043$; risk assessed, $F(1, 257) = 65.33$, $p < 0.001$, $\eta_p^2 = 0.203$; feelings of guilt, $F(1, 257) = 17.98$, $p < 0.001$, $\eta_p^2 = 0.065$; feelings of embarrassment, $F(1, 257) = 7.86$, $p = 0.005$, $\eta_p^2 = 0.030$; and feelings of fear, $F(1, 257) = 5.49$, $p = 0.020$, $\eta_p^2 = 0.021$. No significant results were obtained in the attribution of responsibility based on the type of IPVAW ($p > 0.05$).

Specifically, physical violence was perceived as more severe ($M = 6.94$, $SD = .38$) than psychological ($M = 6.81$, $SD = .65$) and sexual violence ($M = 6.62$, $SD = .83$); just as it was also assessed as more risky for life ($M = 6.83$, $SD = .55$) than psychological ($M = 5.82$, $SD = 1.41$) and sexual violence ($M = 4.96$, $SD = 1.71$). Furthermore, physical violence was generated less feelings of guilt ($M = 1.17$, $SD = 1.41$) than psychological ($M = 1.45$, $SD = 1.20$) and sexual violence ($M = 1.82$, $SD = 1.52$); less feelings of embarrassment ($M = 2.35$, $SD = 1.51$) than psychological ($M = 2.59$, $SD = 1.31$) and sexual violence ($M = 2.83$, $SD = 1.30$); and more feelings of fear ($M = 3.82$, $SD = .50$) than psychological ($M = 3.14$, $SD = 1.01$) and sexual violence ($M = 2.95$, $SD = 1.26$).

[1] Most of the women reported more than one type of IPVAW. For this reason, the sum is different from 100%.

Ultimately, the application of the Bonferroni test for pairwise comparisons indicated the existence of significant differences between physical and psychological violence in perceived severity ($p < .01$, 95% CI [0.039, 0.217]); risk assessed ($p < .001$, 95% CI [0.816, 1.1207]); feelings of guilt ($p < .001$, 95% CI [–0.465, –0.100]); feelings of embarrassment ($p < .01$, 95% CI [–0.414, –0.066]); and feelings of fear ($p < .001$, 95% CI [0.546, 0.826]). Also, significant differences were found between physical and sexual violence in perceived severity ($p < .001$, 95% CI [0.204, 0.424]); risk assessed ($p < .001$, 95% CI [1.622, 2.130]); feelings of guilt ($p < .001$, 95% CI [–0.887, –0.416]); feelings of embarrassment ($p < .001$, 95% CI [–0.711, –0.251]); and feelings of fear ($p < .001$, 95% CI [0.676, 1.061]). Likewise, significant differences were obtained between psychological and sexual violence in perceived severity ($p < .01$, 95% CI [–0.318, –0.054]); and risk assessed ($p < .001$, 95% CI [–1.122, –0.607]). Lastly, although the attribution of responsibility was not significant based on the type of violence, differences were observed in pairs between the types of violence. Specifically, significant differences were observed between physical and psychological violence ($p < .001$, 95% CI [0.303, 0.606]) as well as physical and sexual violence ($p < .001$, 95% CI [0.198, 0.482]).

Discussion

The current study investigated the psychological and emotional process in which IPVAW victims are involved and its impact on their decision-making. In this regard, prior studies have noted the importance of variables such as dependency, commitment with the relationship, cognitive distortions, or feelings of embarrassment, guilt, or fear (Badenes-Sastre et al., 2023a; Garrido-Macías et al., 2017; Le et al., 2010; Nicholson & Lutz, 2017; Spanish Ministry of Equality, 2020; Valor-Segura et al., 2014), in victims' making decisions in their relationship. However, as far as we know, this is the first study to analyze the IPVAW effect on victims, comparing their experiences with those of women who have not experienced IPVAW, facilitating the understanding of this problem.

These novel findings offer insight into this gap, taking account the IPVAW victims' perspective as well as the devastating effects of gas lighting that IPVAW victims are subjected to. The experiences informed by the participants in the focus group offered relevant information. Particularly, women informed about their difficulty in perceiving the reality of the situation they experienced. The main obstacles that women encountered in becoming aware of their situation and ending the relationship were: a) minimizing the situation; b) not assessing the risk of IPVAW adequately; c) justifying the aggressor; d) blaming themselves; e) being embarrassed and not telling anyone about it; and f) fearing for their life or their children's lives. According to previous literature (Heim et al., 2018), this dysfunctional information processing may play a crucial role for women when deciding whether to end or continue a relationship. Hence, to help IPVAW victims, the first step will be to comprehend the effects of IPVAW on their mental and emotional state and establishing prevention programs.

According to WHO (2020), IPVAW can be prevented by mitigating risk factors. Specifically, the most important sociocultural risk factors that explain the occurrence of IPVAW are the prevailing attitudes and beliefs toward IPVAW, which create an environment of acceptance and tolerance (Ferrer-Pérez et al., 2020). The acceptability of IPVAW, and namely victim-blaming attitudes, is still widespread, condoning IPVAW (Herrero et al., 2017). In Spain, the majority of the population still tends to think that women exaggerate the problem of male violence, and they even consider that most women file false complaints for financial gain and to the detriment of men (Sociological Research Center, 2017). These permissive and tolerant public attitudes toward IPVAW could also influence the individual responses of women involved in violent relationships (Gracia et al., 2020). Therefore, it will be a major task to make the severity and consequences of IPVAW visible at the social level as well as to train professionals who could attend to women from different services, especially from healthcare centers where victims frequently go with symptoms that are difficult to filter to diagnose and

where health care professionals are uniquely positioned to detect and prevent IPVAW (Coll-Vinent et al., 2008; WHO, 2022).

In relation to Study 2, the results confirmed Hypothesis: "IPVAW women will get lower scores in perceived severity (1a) and attribution of responsibility of the aggressor (1c), as well as higher scores in feelings of embarrassment (1d) and guilt (1e)". Based on the gas lighting effect (Spear, 2019; Sweet, 2019), it seems that IPVAW victims (vs. non-IPVAW victims) perceive less the severity of IPVAW, attribute less responsibility to the aggressor, and feel more embarrassment and guilt, as a possible consequence of the exposure to the aggressor's manipulation. These differences between both, women who suffered IPVAW (vs. those who did not) should be highlighted, so the victims' confusion about the situation they are in or have experienced could put them at risk (Badenes-Sastre & Expósito, 2021), staying in the violent relationship. Just as IPVAW, the gaslighting effect is rooted in gender inequality that fosters unequal intimate power relations. The aggressor uses gender stereotypes, structural and institutional inequalities to manipulate the victim easily by basing their arguments on the social reality of inequality (Sweet, 2019). This can be reflected in some of the quotes from the participants in Study 1: "*I had no money and when I had to buy shoes for the child or something else, I had to pay for it somehow. He told me: If you don't comply as a woman, then... I had to do what he asked me to do"* (Comment 6); *"I couldn't do anything without his permission. I didn't even know how to withdraw money from the bank"* (Comment 8).

In this regard, because of gas lighting effect, victims of IPVAW may begin to doubt their experiences and feel powerless to leave their violent relationships. To address this problem, it is essential to provide support to victims that recognizes the impact of gaslighting. This can include providing education about the gaslighting effect, validating victims' experiences, and helping them develop adequate coping strategies. It is also crucial to address

the impact of gaslighting on victims of IPVAW, helping them understand what is happening and empowering them to seek help and leave their violent relationships.

Severity minimization and low attribution of responsibility to the aggressor should be cognitive distortions, an erroneous way of interpreting reality (Loinaz, 2014). According to Grawe's consistency theory (Grawe, 2004), posits that IPVAW conflicts with women's motivational goals, leading to a state of inconsistency-tension. To alleviate this inconsistency-tension, women may choose to leave their abusive partner or alter their thoughts (e.g., attributions) in a manner that is congruent with their experience of partner violence. In this regard, women who have not suffered IPVAW would not be exposed to this inconsistency and would, therefore, make a more accurate interpretation of the reality. These findings show the transformative effect of IPVAW on the individual response of women so; although most people consider IPVAW unacceptable (92% vs. 14% who justify it) (Government Delegation for Gender-based Violence, 2014), in contrast to others forms of violence, IPVAW is a multifaceted and complex phenomenon that is heavily shaped by social and cultural norms surrounding the acceptability of using violence in intimate relationships (Gracia et al., 2020). It seems that sociocultural factors would reinforce the idea that there are reasons to justify IPVAW, the same reasons that make 14% of the population consider IPVAW somewhat acceptable. Thus, addressing these collective reasons to perceive the devastating effects of IPVAW will therefore be critical to eliciting individual responses from victims that will enhance their protection.

Likewise, in relation to feelings of embarrassment and guilt, previous studies point out that these feelings are generated by the exposition to IPVAW, influencing in the maintenance of the relationship (Escudero et al., 2005), possibly not because of the violence itself but rather by the meaning given to the situation based on the previously internalized sociocultural construction. Embarrassment is linked to public exposure and negative self-evaluation, while

guilt would tend to promote in women the thought that they have done something wrong (Smith et al., 2002). Both, embarrassment, and guilt may make it difficult for the victims tell their situation to others as well as adopting a different interpretation of reality than women who have not experienced IPVAW. Taking these differences between groups of women into account will be important to understand and approach the transformative effects of IPVAW in their interpretations and responses to this issue.

Otherwise, Hypothesis: "IPVAW women will get lower scores in risk assessment (1b), as well as higher scores in feelings of fear (1f)" were rejected. No differences were found between the groups of IPVAW victims and non-IPVAW victims. In this line, according to Gondolf and Beeman (2003), at times, women may recognize the risk of IPVAW, but they may not take steps to terminate the violent relationship. In this case, the victims' assessment of risk would not be affected by IPVAW and, other factors such as the above mentioned, should be the focus of future interventions. Lastly, IPVAW victims (vs. non-IPVAW victims), showed no differences in feelings of fear, possibly because, irrespective of whether they suffer IPVAW, women have personal awareness and fear of the personal costs of the violence by men, being fundamental in creating a society in which women can live without fear of men's violence (Brownhalls et al., 2020). Therefore, both individual and collective commitment is required from public institutions to generate a culture of equality as an alternative to misogyny (Bosch & Ferrer, 2000). Furthermore, fear within the context of a relationship could have an ambivalent effect, driving women away from IPVAW or habituating them to the threatening situation (Puente-Martínez et al., 2016). In the latter case, the habituation of victims to fear could explain why no differences were found between the groups. In this sense, although in Spain 32.4% of women reported having suffered IPVAW, only 13.9% of the total sample reported feeling fear for their partner and/or former partner. Particularly, among women who experienced violence from their current partner, a high percentage did not feel afraid, with

84.6% for psychological violence, 44.1% for physical violence, and 61.8% for sexual violence. These percentages decreased for former partners (50.4%, 19.8% and 24.9%, respectively) (Spanish Ministry of Equality, 2020). For a better understanding of the role of fear in relationships, more research is needed.

In sum, this work presents important implications; so, exposure to IPVAW has serious consequences for women, even affecting their interpretation of reality and generating negative emotions such as feelings of embarrassment, guilt, and fear. In this respect, when women are involved in IPVAW, social perceptions about reasons of IPVAW would play an important role. In this way, to educate in gender equality for minimizing the normalization of IPVAW will be a first order necessity. Preventive programs are required to raise social awareness and make the consequences of IPVAW visible for victims. This is an essential point because it will allow the victims to identify what is happening to them and it will also help the professionals who care for them (e.g., health care professionals) to identify these obstacles and offer victims help. Also, institutions should consider these findings as elements to assess the risk in which the victims find themselves, giving a practical application to this empirical evidence.

Limitations and Future Directions

It is unfortunate that the study did not ask women whether the violence was perpetrated by their current or former partner, so according to the experiences related by women who participated in focal group, when women have left the violent relationship, they can begin to perceive the severity and risk they were in, changing their interpretation of reality. Also, it would be important to consider if women have received psychological help and/or treatment because of IPVAW because it could influence access to information and understanding the problem could minimize these obstacles. It would be advisable for future studies to explore this gap.

Otherwise, although IPVAW affects women globally (WHO, 2020), the response to this problem depends to some extent on the cultural context, including beliefs, attitudes, and laws (Spencer et al., 2020). In this regard, the interpretation of the results of this study should be limited to the Spanish context from which the sample was recruited. Similarly, it would be interesting balance the sample taking account socio-demographic variables so, despite the use of snowball sampling, most of the women who participated in the survey had a high level of education.

Notwithstanding these limitations, the study suggests that perceptions and interpretations about the violent behaviors of the aggressor partner could be distorted in IPVAW victims and, along with feelings of embarrassment, guilt, and fear resulting from this vision of reality, getting out of the violent relationship would not be the first option. Future studies should continue research along this line to understand and adequately address the obstacles IPVAW victims face to become aware of the reality they are experiencing. Likewise, the development of effective prevention and intervention programs is necessary. On the one hand, prevention programs should address gender and power inequality in relationships, offering information on how this inequality favors the establishment of violent relationships. On the one hand, intervention programs should be focused on help IPVAW victims to recognize the reality and impact of the gas lighting effect on their perceptions, interpretations, and emotions, as well as the consequences that IPVAW implies for their lives.

Conclusion

Exposure to IPVAW has a transformative effect on victims, affecting their perception and interpretation of reality and generating emotions such as embarrassment, guilt or fear that would make it difficult to leave the violent relationship. Also, unlike women who have not experienced IPVAW, victims of IPVAW show lower severity perceived and attribution of responsibility to the aggressor, as well as higher feelings of embarrassment and guilt. Addressing these obstacles to get out of the violent relationships, taking account the influence of sociocultural factors, will be critical to understanding the individual victims' responses and to implementing appropriate prevention programs to end IPVAW.

CAPÍTULO 4: Profesionales del ámbito sanitario

CHAPTER 4: Health care professionals

"Ante las atrocidades tenemos que tomar partido. El silencio estimula al verdugo"

(Elie Wiesel)

Estudio 7

Study 7

Obstacles and Limitations in the Use of Protocols Responding Intimate Partner Violence Against Women from the Health System in Spain

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Abstract

Intimate partner violence against women (IPVAW) is a public health problem that affects women worldwide. Consequently, victims frequently go to health care centers, usually with a cover reason. To address this problem, national and autonomic protocols to respond to IPVAW in health systems have been developed in Spain. In this regard, the role of primary care physicians (PCPs) will be essential for addressing IPVAW, but they could encounter obstacles in doing so. The purpose of this study was to explore how IPVAW is addressed in health care centers in Spain. This study synthesized the information available in the protocols to address IPVAW among health care workers in Spain and analyzed it according to WHO guidelines. Additionally, PCPs' perspectives on these protocols and the nature of IPVAW attention from health care centers were explored through a focus group. The findings displayed that, although the protocols mostly conform to WHO guidelines, they are insufficient to address IPVAW. Generally, PCPs were unaware of the existence of the protocols and referred to the lack of training in IPVAW and protocol use as one of the main obstacles to intervening, along with a lack of time and feelings as well as cultural, educational, and political factors. The adoption of measures to ensure that PCPs apply these protocols correctly and to address PCPs' obstacles for addressing IPVAW in consultations will be crucial for the care of victims.

Keywords: healthcare centers, protocols, requirements, primary care physicians, focus group

Obstacles and Limitations in the Use of Protocols Responding Intimate Partner Violence Against Women from the Health System in Spain

Intimate partner violence against women (IPVAW) is a public health problem that involves physical, psychological, or sexual abuse, as well as controlling behaviors by a current or former intimate partner, affecting one in three women in their lifetime (World Health Organization; WHO, 2021). The consequences of IPVAW could be devastating to women's physical and mental health, even after the abuse has ended, causing hematomas, fractures, chronic pain, posttraumatic stress disorder, depression, or anxiety, among others (Campbell, 2002; Ellsberg et al., 2008; Sarasua el al., 2007; Wang, 2016). Consequently, victims of IPVAW tend to have worse general health than women who do not suffer it and frequently visit health care centers, requiring wide-ranging medical services (Campbell, 2002; Taft et al. 2013).

Health care centers can prevent, detect, and mitigate IPVAW through the role of the primary care physician (PCP). It is crucial for IPVAW victims to identify PCPs as referral professionals to disclose their situation (Badenes-Sastre et al., 2021; Fernández, 2015; Ruiz-Pérez et al., 2004). However, in Spain, although most PCPs consider IPVAW a public health issue, their responses (e.g., injury reports) encompass only 9.6% of the total number of IPVAW complaints, reflecting the need for greater involvement in this issue (Consejo General del Poder Judicial, 2019; Lorente, 2020). The lack of time, knowledge, and training in IPVAW; fear of legal consequences; lack of practical and psychosocial skills for IPVAW interventions; or the lack of a clear role in addressing IPVAW could pose some obstacles for PCPs to address (García-Quinto et al., 2021; Fernández, 2015; Ministerio de Salud, Servicios Sociales e Igualdad, 2015). In this sense, it is necessary to examine the variables involved in PCPs' responses to IPVAW to direct intervention and prevention efforts.

Advanced policies have been supported to facilitate the approach to IPVAW in the health care sector in Spain. Specifically, *Ley Orgánica* 1/2004 established measures of

awareness and intervention for early detection of IPVAW and women's care in the health care sector, as well as the implementation of protocols to attend IPVAW. Consequently, national and autonomic protocols were developed in Spain as fundamental tools to respond to IPVAW from the health care perspective. The first national protocol was published in 2007 by the Spanish Gender Violence Commission of the Council, considering the advice of numerous experts in the field. It also formed the reference for the rest of the autonomic protocols, and this version was upgraded in 2012 (Ministerio de Salud, Servicios Sociales e Igualdad, 2012). Likewise, the WHO (2013) developed a reference guide entitled "Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guidelines" that includes evidence-based recommendations to improve IPVAW response from health care centers. In this sense, to ensure an adequate approach to mitigating IPVAW from health care centers, Spanish protocols should comply with these recommendations.

Protocols should define and systematize detection and intervention actions from health care centers, but they should also be practical and useful to PCPs (Fernández, 2015). Despite this knowledge, no studies have synthetized and analyze the procedure described in the protocols, including Spanish PCPs' perspectives. To address this gap, the purpose of this study was to explore how health care centers in Spain address IPVAW. The work was conducted in two studies. Study 1 involved examining the protocols available in Spain via autonomous communities to check their homogeneity and whether they comply with the WHO guidelines. In Study 2, a focus group explored PCPs' perspectives on (a) their role in addressing IPVAW, (b) the use and usefulness of health care protocols to address IPVAW, (c) their experiences in IPVAW care, and (d) the obstacles to and requirements for addressing IPVAW in consultations.

STUDY 1

Method

A comprehensive search was done using the reference website of the Spanish government's Ministerio de Salud y Minsiterio de Igualdad to locate the protocols relevant to attending IPVAW victims in health care centers in Spain, as well as in each autonomous community. The protocols were included if they (a) provide information for health professionals to address IPVAW in health care centers and (b) were the latest version available. Lastly, 18 protocols were included in the study, one national and one per autonomous community. Ceuta and Melilla were not incorporated because they do not have autonomic protocols; theirs are based on the general protocol in Spain.

Data Extraction and Analysis

A coding protocol was developed to determine if the Spanish protocols to address IPVAW in health care centers were in accordance with WHO guidelines. To this end, two independent coders (M.B. and A.B.) conducted the data extraction, solving disagreements by discussion and, when required, through a consensus with a third researcher (F.E.).

Specifically, the WHO guidelines included six dimensions that were analyzed: (a) women-centered care, (b) identification and care for survivors of intimate partner violence, (c) clinical care for survivors of sexual assault, (d) training of health care professionals on intimate partner violence and sexual violence, (e) health care policy and provision, and (f) mandatory reporting of intimate partner violence. The process used in the development of these guidelines is outlined in the WHO handbook for guideline development (WHO, 2010). Additionally, the Spanish protocol to address IPVAW in health care centers points out that it is essential to include information on the detection, risk assessment, and prevention of IPVAW (Ministerio de Salud, Servicios Sociales e Igualdad, 2012). Therefore, in the present study, the six

dimensions described by the WHO guidelines and the obstacles to detection, risk assessment, and IPVAW intervention included in the Spanish reference protocol were analyzed.

Extracted data included protocol title, autonomous community of destination, year of publication (last version), the six WHO guideline dimensions, detection procedure, risk assessment, and intervention. Lastly, the percentage of intercoder agreement was calculated, and data registered were analyzed according to whether the protocols complied with WHO guidelines, summarizing each recommendation.

Results

Initially, a kappa coefficient was calculated to determine agreement between coders. According to x, a very good intercoder reliability was obtained (0.8–1.0). Specifically, the first and second coders showed a high level of agreement for the inclusion of protocols ($\kappa = 0.94$) and data registered about the compliance or noncompliance with the six dimensions of the WHO guidelines, as well as the detection, assessment, and intervention sections for the 18 protocols assessed ($\kappa > 0.85$).

Table 1 contains the main characteristics of the protocols included in the study. The protocols' years of publication ranged from 2003 to 2020, 22.22% of them having been published in the last 5 years of the review. The autonomous community of Navarra had interdisciplinary coordination protocols, but it did not have a specific protocol to attend IPVAW victims in health care centers. The Galician protocol was also included in the analysis, despite not being available in Spanish.

Table 1

Main Characteristics of the Protocols to Attend IPVAW in Spain

			Protocol includes procedure for IPVAW…		
Protocol title	**Autonomous community of destination**	**Year of publication** (last version)	**Detection**	**Risk assessment**	**Intervention**
"Protocolo andaluz para la actuación sanitaria ante la violencia de género" 3ª Edición [Andalusian protocol for health action in the face of gender violence. 3rd Edition]	Andalucia	2020	Yes	Yes	Yes
"Guía de atención sanitaria a la víctima de violencia doméstica" [Guide to health care for victims of domestic violence]	Aragon	2005	Yes	Yes	Yes
"Protocolo sanitario para mejorar la atención a las mujeres que sufren violencia" [Health care protocol to improve care for women who suffer from violence]	Asturias	2016	Yes	Yes	Yes
"Protocolo de actuación sanitaria ante la violencia machista en las Illes Balears" [Protocol for health action in the face of male violence in the Balearic Islands]	Baelaric Islands	2017	Yes	Yes	Yes
"Guía de actuación para profesionales de la salud ante la violencia de género y las agresiones sexuales en Euskadi" [Action guide for health professionals on gender violence and sexual aggressions in the Basque Country]	Basque Country	2019	Yes	Yes	Yes

"Protocolo de actuación ante la violencia de género en el ámbito doméstico" [Protocol of action against gender-based violence in the domestic sphere]	Canarias	2003	Yes	Yes	Yes
"Violencia contra las mujeres. Protocolo de actuación sanitaria ante los malos tratos" [Violence against women. Protocol for health action in the face of abuse]	*Cantabria	2007	Yes	Yes	Yes
"Protocolo de actuación en atención primaria para mujeres víctimas de malos tratos" [Protocol of action in primary care for women victims of maltreatment]	*Castilla-La-Mancha	2005	Yes	Yes	Yes
"Guía clínica de actuación sanitaria ante la violencia de género" [Clinical guide for health action in the face of gender violence]	Castilla-Leon	2019	Yes	Yes	Yes
"Protocolo para el abordaje de la violencia machista en el ámbito de la salud en Cataluña. Violencia en el ámbito familiar y de la pareja" [Protocol for the approach to male violence in the health care setting in Catalonia. Domestic and intimate partner violence]	Catalonia	2009	Yes	Yes	Yes
"Protocolo para la atención sanitaria de la violencia de género" [Protocol for the Health Care of Gender Violence]	*Valencian Community	2009	Yes	Yes	Yes
"Protocolo actuación sanitaria ante la violencia de género en Extremadura" [Health action protocol for gender violence in Extremadura]	Extremadura	2016	Yes	Yes	Yes
"Guía técnica do proceso de atención ás mulleres en situación de violencia de xénero" [Technical guide of the process of attention to women in situations of gender violence]	Galicia	2009	Yes	Yes	Yes

"Protocolo de actuación sanitaria ante la violencia contra las mujeres" [Protocol for health action in the event of violence against women]	La Rioja	2010	Yes	Yes	Yes
"Guía de actuación en atención especializada para abordar la violencia de pareja hacia las mujeres" [Specialized care action guide to address intimate partner violence against women]	Madrid	2011	Yes	Yes	Yes
"Protocolo para la detección y atención de la violencia de género en atención primaria" [Protocol for the detection and care of gender-based violence in primary care]	Murcia	2007	Yes	Yes	Yes
"Guía para profesionales. Protocolo de actuación conjunta ante la violencia contra las mujeres en Navarra" [Guide for professionals. Protocol for joint action against violence against women in Navarra]	Navarra	2018	Yes	Yes	Yes
"Protocolo común para la actuación sanitaria ante la violencia de género" [Common protocol for health action in the face of gender violence]	Spain	2012	Yes	Yes	Yes

Note. IPVAW = Intimate partner violence against women. * = Cantabria published updated protocol only for sexual assaults in 2017; Castilla-La-Mancha published a general guide intended for all types of professionals in 2009; Valencian Community published updated protocol only for emergencies in 2020.

Regarding the WHO guidelines, six dimensions were required in any protocol to address IPVAW in health care centers: (a) women-centered care, (b) identification and care for survivors of intimate partner violence, (c) clinical care for survivors of sexual assault, (d) training of health care providers on intimate partner violence and sexual violence, (e) health care policy and provision, and (f) mandatory reporting of intimate partner violence.

1. Women-Centered Care

Immediate support for women reporting IPVAW should be offered. Among the indications for health professionals, they must (a) maintain an active listening attitude without prejudice and validate the woman's feelings, (b) explore the victim's background of violence, (c) provide information about useful recourses to approach violence (e.g., legal services), (d) help women to increase their safety, and (e) promote social support. Additionally, a private space and guarantee of confidentiality are required.

All the autonomous communities included some indications about women-centered care, such as recourses to address IPVAW (e.g., call center services, websites, or specialized centers), information about signs and symptoms of IPVAW, examples of questions to ask women in consultation, and examples of documents to report situations of IPVAW. It is noteworthy that the Baelaric Islands (2017), Extremadura (2016), or La Rioja protocols are complete because, among other reasons, they offer action plans according to the specific situation (e.g., whether the woman recognizes that she is suffering from IPVAW) or include most of the information in a single document. Other protocols, such as those from Aragon (2005) or Castilla-Leon (2019), are focused on how to work with women according to their stage of motivation to change. However, the Navarra protocol is incomplete and should be reviewed (e.g., it does not include examples of questions to ask IPVAW victims or documents to report it). Likewise, the Aragon protocol uses the term "domestic violence toward women" to refer to IPVAW as defined in the *Ley Orgánica 1/2004*. In this sense, although the

phenomenon is also termed “domestic violence” in other countries, it could lead to confusion in Spain.

2. Identification and Care for Survivors of Intimate Partner Violence

Detecting and responding to cases of IPVAW is necessary. Nevertheless, positions vary on the appropriateness of universal screening. Due to this controversy and based on previous scientific research, the WHO does not recommend implementing universal screening, except when there are indicators of suspected violence. The Andalusia and Vasque Country protocols clarify the existence of this controversy in their recommendations, while the Aragon, Asturias, Castilla-La-Mancha, Madrid, Murcia, and Navarra protocols do not mention it. The rest of the protocols by autonomous communities recommend universal screening, possibly because they are based on the 2012 Spanish protocol reference. In this line, the Spanish protocol must be updated because it was published before the WHO guideline recommendations (WHO, 2013), based on previous WHO reports. In turn, all the protocols strongly recommend that women suspected of being abused be asked about IPVAW. Moreover, the protocols must integrate mental health care for women with mental disorders before addressing IPVAW or its consequences. Only a few protocols address these situations (Spanish, Andalusian, Asturias, Baelaric Islands, Basque Country, Canarias, Cantabria, Valencian Community, Extremadura, Galicia, and La Rioja protocol protocols).

Concerning IPVAW interventions, it would be desirable for the protocols to indicate specific interventions depending on the situation (e.g., pregnant women or women in shelters). In general, all protocols include recommendations about the importance of intervening and attending to victims of IPVAW, as well as care for child victims of IPVAW. However, the psychotherapeutic intervention is not defined, except for in the protocol of the Balearic Islands, which includes treatments of choice according to the symptomatology (e.g., for posttraumatic

stress disorder, trauma-focused cognitive behavioral or EMDR (Eye Movement Desensitization and Reprocessing) therapy is indicated).

3. Clinical Care for Survivors of Sexual Assault

Sexual assault is a potentially traumatic experience requiring acute and, at times, long-term care due to its negative consequences for women's physical, mental, sexual, and reproductive health. The WHO recommends offering first-line support to women survivors of sexual assault by any perpetrator, providing information and comfort to reduce women's anxiety, helping victims connect to services and social support, offering practical care and support, and listening without pressuring or judging. All the protocols analyzed include these recommendations.

Another important point is avoiding the risk of unwanted pregnancy. In this regard, offering emergency contraception to survivors of sexual assault as soon as possible to maximize effectiveness was a strong recommendation by the WHO, and all the protocols analyzed include it. However, most of them do not indicate the type of medication and recommended dosage. The WHO recommends that health care professionals should offer a single 1.5-mg dose of Levonorgestrel (if available), because it is as effective as two doses of 0.75 mg given 12–24 hours apart. Nevertheless, only the Cantabria, Castilla-La-Macha, Castilla-Leon, Valensian Community, and Extremadure protocols specify this. Although the Basque Country protocol does not specifically indicate the use of Levonorgestrel, it includes a wide range of information on how to deal with various cases of sexual aggression, recommending similar pills such as Norgestrel.

As a result of sexual assault, women may contract sexually transmitted diseases such as HIV. Hence, some of the WHO's recommendations include offering HIV post-exposure prophylaxis within 72 hours of a sexual assault and discussing HIV risk to determine the use of the prophylaxis. If a woman decides to use it, she should start the regimen as soon as possible

(before 72 hours), receive testing and counselling at the initial consultation, adhere to counselling, and be provided medicaments and vaccines for Hepatitis B. All protocols provide information about these aspects at various levels of depth, except for those from the Balearic Islands and Canarias, which do not report any information about medical treatment (e.g., prophylaxis or vaccinations for Hepatitis B) recommended in cases of sexual assault as indicated by the WHO.

Additionally, some autonomous communities, such as the Balearic Islands, x, and Cantabria, Catalonia, and Valencian Community, provide specific documents to address attending survivors of sexual assault in greater depth.

4.Training for Health Care Providers on Intimate Partner Violence and Sexual Violence

Health care professionals should be prepared to care for victims of IPVAW and have basic knowledge about violence, existing services that might offer support to victims, inappropriate attitudes among health care professionals (e.g., blaming women for violence) their own experiences of IPVAW, and various aspects of responding to this problem (e.g., identification, safety assessment and planning, communication and clinical skills, documentation, and provision of referral pathways). The protocols analyzed align with WHO recommendations; they all reflect the importance of training health professionals in IPVAW. The protocols include examples of questions to ask women depending on their situation (suspected IPVAW, injuries, etc.). Additionally, if possible, the WHO recommends integrating all these aspects into existing health services rather than providing them as stand-alone services, given the overlap between IPVAW and sexual assault. However, this information is not included in most of the protocols, perhaps because it is understood that training health care professionals in IPVAW includes addressing physical as well as psychological and sexual violence.

5. Health Care Policy and Provision

IPVAW victims should obtain health care at any time they require it. The WHO guidelines state that a health care center should have a health care professional who is trained in IPVAW care and is always available. This point is very clear in all the protocols analyzed. To the extent possible, it is recommended that care for IPVAW victims be integrated into existing health services (not as separate services), prioritizing training and provision of services in primary care. These points are reflected in the development of protocols to respond to IPVAW in primary care, highlighting the importance of health professionals in the detection of and care for this problem. Conversely, the Navarra protocol does not comply with this recommendation. In fact, it is incomplete from the perspective of responding to IPVAW in health care facilities. On the contrary, it includes brief outlines on the actions to be taken in various areas (e.g., police or health).

6. Mandatory Reporting of Intimate Partner Violence

The WHO does not recommend that health care professionals report IPVAW to police unless provided by law. Reporting IPVAW is mandatory in Spain, having both positive and negative implications from the point of view of health care professionals and IPVAW victims. Hence, health care professionals need to understand their legal obligations (if any) and their professional codes of practice to ensure that women are informed fully about their choices and limitations of confidentiality. In this line, the analyzed protocols show clear and concrete information about mandatory reporting of intimate partner violence to the police by health care professionals (depending on the situation), as well as of child maltreatment and life-threatening incidents. Likewise, most of them include examples of documents for filling out injury reports or complaints.

Detection, Risk Assessment, and Intervention

The Spanish protocol to attend victims of IPVAW in health care centers includes detection, risk assessment, and intervention as three essential blocks to be addressed. Particularly, the section on detection includes (a) information about IPVAW (e.g., definition, consequences, or myths about violence among others), (b) indicators of suspicion of or vulnerability to IPVAW (e.g., anxiety or injuries), (c) instructions and examples on how to do an interview to identify IPVAW in case of suspicion (e.g., "Many times women who have problems like yours, such as [refer to some of the most significant ones] are experiencing some type of partner abuse. Does it happen to you?"), and (d) tips on what not to do during the interview and how to care for women (e.g., not to doubt the woman's story).

Then, when professionals have the necessary information to take an active role in detecting IPVAW in consultation, an adequate risk assessment for women is necessary. In this regard, the risk assessment section contains information about how to (a) make a comprehensive assessment of the biopsychosocial factors, women's situations, type of violence, safety, and danger (e.g., women's coping strategies) and b) coordinate with other professional teams (e.g., social workers). Finally, the intervention section involves various forms of action (e.g., derivation or to report injuries) depending on the assessment previously carried out, considering the risk and awareness of the woman's problem. Although the protocols differ in their levels of development and specification, all the autonomous communities address detection, risk assessment, and intervention in their protocols. Additionally, even though the protocols are focused on attending women from health care centers, they also provide guidelines for action in other settings such as emergency or specialized care services.

STUDY 2

Method

Design and Procedure

A qualitative study using an in-depth interview with a focus group was performed to explore PCPs' perspectives on (a) their role in addressing IPVAW, (b) the use and usefulness of health care protocols to attend IPVAW victims, (c) their experiences in IPVAW care, and (d) the obstacles to and requirements for addressing IPVAW in consultation. Before data collection and analysis, the researchers carried out a reflexive dialogue to establish the categories to explore. Then, based on previous literature (Badenes-Sastre et al., 2021; Coll-Vinent et al., 2008; Diéguez & Rodríguez, 2021; Fernández, 2015; González et al., 2019; Ruiz-Pérez et al., 2004; Saletti-Cuesta et al., 2018; Taft et al., 2013; Valdés et al., 2016; Williams et al., 2016), the objectives of the study were defined, including the research questions for the interview (see Table 2).

The focus group interview was conducted after obtaining acceptance from the ethics committee of the University of [blinded for authors]. Firstly, a message announcing the study was diffused by institutional mail and social networks to collect PCPs to participate in a focus group. PCPs interested in participating were called via the telephone numbers provided and were informed of the study's objective and procedure, inviting them to enroll. Then, they signed informed consent according to the Helsinki Declaration, guaranteeing the anonymity and confidentiality of the participants' data. No monetary incentives were provided for participation.

Lastly, the focus group interview was conducted online using the Google Meet application. A researcher (M.B.) moderated an interview about the participants' perspectives on their role in addressing IPVAW, the use and usefulness of health care protocols to attend IPVAW, experiences in IPVAW care, and the obstacles to and requirements for addressing

IPVAW in consultations. All the PCPs participated actively in the interview, which was video and audio recorded for subsequent transcription. To minimize the social desirability bias in qualitative research, the focus group interview was conducted according to the recommendations of Bergen and Labonté (2020).

Table 2

Interview Questions for Focus Group

1. Primary care physician's role to address IPVAW	*1.1. What do you think is your role to attend the IPVAW from consultation?* *1.2. How do you think you can contribute to the IPVAW approach from healthcare centers?* *1.3. How do you think you can detect the hidden reason for consultation behind the symptoms presented by women victims of IPVAW?*
2. Use and usefulness of healthcare protocols to attend IPVAW	*2.1. What tools do you have available to address IPVAW?* *2.2. Do you know the protocols to attend IPVAW from healthcare centers?* *2.3. What do you think about the protocols to attend IPVAW from healthcare centers?* *2.4. Do you consider the protocols to attend IPVAW from healthcare centers useful? Why (not)?*
3. Experiences in IPVAW care	*3.1. How could you detect, assess, and intervene in cases of IPVAW?* *3.2. Have you ever attend women victims of IPVAW? How did you do it?* *3.3. Would you know how to act in case of IPVAW?* *3.4. Do you consider the possibility of IPVAW when you attend women in consultation?* *3.5. Do you ask IPVAW screening questions in consultation?*
4. Obstacles and needs for addressing IPVAW in consultation	*4.1. What obstacles do you find in your workplace to address IPVAW in consultation?* *4.2. What would you need to adequately address IPVAW in consultation?* *4.3. Do you think it would be necessary to train healthcare professionals on IPVAW, avoiding its normalization?*

Note. IPVAW = Intimate partner violence against women.

Participants

A focus group is an appropriate method to collect information about attitudes, knowledge, and experiences in health care fields (Kitzinger, 1995; Myers, 1988; Nyumba et al., 2018). According to Myers' recommendations (1998) for conducting focus groups, seven PCPs were selected via incidental sampling to participate. In this sense, previous studies (Fernández et al., 2022; Nyumba et al., 2018) support the use of a single focus group to conduct research.

The inclusion criterion for participation in the focus group was working as a PCP in the Spanish public health system. To recruit participants, a message was disseminated over the course of 2 months informing PCPs about the study through social networks (WhatsApp, Facebook, and Instagram) and institutional mail. Seven PCPs were willing to participate freely in the study, being informed of the research objectives and signing the informed consent according to the Helsinki Declaration. The confidentiality and anonymity of their answers were guaranteed, and no monetary incentives were provided for their participation. Table 3 shows the characteristics of the sample.

Table 3

Main Characteristics of Focus Group Participants

	Sex	Age	Work Position	Localization	Experience (years)	Specific Training in IPVAW
1	M	59	Primary Care Physician	Jaen	21	No
2	M	33	Primary Care Physician	Cordoba	8	Yes
3	M	30	Resident Medical Intern	Ciudad Real	4	No
4	W	56	Primary Care Physician	Malaga	30	Yes
5	M	30	Resident Medical Intern	Granada	5	No
6	W	28	Resident Medical Intern	Granada	2	No
7	W	27	Resident Medical Intern	Alicante	2	No
Mean		37.57			10.29	
SD		13.77			10.90	

Note. IPVAW = intimate partner violence against women; M = man; W = woman; *SD* = Standard Deviation.

Data Extraction and Analysis

The study was approved by the ethics committee of the x. Before data collection and analysis, the researchers carried out a reflexive dialogue. Then, based on previous literature (Badenes-Sastre et al., 2021; Coll-Vinent et al., 2008; Diéguez & Rodríguez, 2021; Fernández, 2015; González et al., 2019; Ruiz-Pérez et al., 2004; Saletti-Cuesta et al., 2018; Siendones et al., 2002; Taft et al., 2013; Valdés et al., 2016; Williams et al., 2016), the objectives of the study and the research questions for the interview were set (see Table 2).

The focus group interview was conducted in December 2021, lasting 1 hour and 23 minutes. To obtain the data, the focus group was audio and video recorded with the participants' consent and then transcribed into text. Then, according to previous literature (Hsieh & Shannon, 2005; Navarro-Carrillo et al., 2017; Zeighami et al., 2022), a content analysis was performed to explore PCPs' perspectives on (a) their roles in addressing IPVAW, (b) the use and usefulness of health care protocols to attend IPVAW victims, (c) their experiences in IPVAW care, and (d) obstacles to and requirements for addressing IPVAW in consultations.

Two independent coders (x) encoded the citations of the participants in each category using the following procedure. Initially, they independently conducted a first reading of the interview transcript, and after that, the two coders independently encoded the citations of the participants in each category. Subsequently, the coders shared the coded citations for each category, indicating which citations were included and discussing discrepancies with a third coder. A kappa agreement index was obtained for the inclusion of citations in each category: (a) role in addressing IPVAW ($\kappa = 1$), (b) use and usefulness of health care protocols to attend IPVAW victims ($\kappa = 0.87$), (c) their experiences in IPVAW care ($\kappa = 0.85$), and (d) obstacles to and requirements for addressing IPVAW in consultation ($\kappa = 0.81$). Finally, discrepancies between the two coders regarding whether the protocols complied with the six dimensions of

the WHO guidelines as well as the detection procedure, risk assessment, and intervention sections were discussed and resolved with the help of a third coder, resulting in full agreement to analyze the data found in this study.

Results

At the beginning of the interview, the participants introduced themselves, indicating their age, work position, years of work experience, and specific training in IPVAW (see Table 3). Then, information was obtained on the various research objectives (see Table 4). The main results showed that, although the use of health care protocols among PCPs was not so evident due to the lack of knowledge about their existence, localization, or practice, most participants considered their roles essential in attending to IPVAW victims (detecting and exploring the covert demand for consultation by victims) in health care centers. Additionally, from the PCPs' perspective, the usefulness of the protocols was doubtful, and they acknowledged the controversy in the application of universal screening for IPVAW. PCPs recognized the need to depoliticize IPVAW and respond to victims, paying attention to indicators of abuse in women and not overlooking the issue. However, they admitted that victims of IPVAW are not always attended to as they should be. Lastly, PCPs indicated IPVAW training; the lack of time and coordinated multidisciplinary teams; cultural and educational factors; and the presence of feelings such as fear, frustration, or impotence as some of the main obstacles to addressing IPVAW.

Table 4

Primary Care Physicians Perspective on Research Objectives

Dimensions	**PCP citations**
1. Role to address IPVAW	
The participants agreed that their role as PCP is fundamental to approach and detect IPVAW, exploring the covert demand for consultation by victims.	P2: *"Healthcare centers are the main gateway to anything in the current healthcare system because we are going to work on different psychopathologies. We are going to meet their families. In this aspect, we are fundamental and privileged for the recruitment, follow-up and well-being of women"*. (C1) P3: *"We are essential because we are the gateway for victims"*. (C2) P4: *"When you already know a little bit about the confidentiality that patients may have with you or because of the ability you may have to read a hidden demand from a patient that you may already know in some way and know if something is happening to her"*. (C3)
2. Use and usefulness of healthcare protocols to attend IPVAW	P1: "*I do not know any, at least here, no protocol about IPVAW"*. (C4) P6: *"I don't know the protocol"*. (C5)
The use of healthcare protocols among PCP is not so evident due to the lack of knowledge about their existence, localization, or practice.	P2: *"A very high percentage of healthcare professionals were unaware of the existence of the protocol or where it was located"*. (C6) P7: *"You may know that an IPVAW protocol exists, but where is that protocol in your consultation? Is this protocol avoidable? Is it updated?"* (C7)
From the perspective of the PCPs, the usefulness of the protocols was doubtful.	P1: *"I believe that if the protocol is there and has proven its usefulness, then we have no reason not to use it, except for the typical reason of lack of time, lack of prioritization, lack of resources or being overwhelmed for other reasons"*. *"It is*

	true that, like other protocols, they are just filled-in pages that do not have a practical, concise and, above all, effective or efficient translation". (C8) P4: *"The protocol is not a comfortable document to read"*. (C9)
To facilitate the accessibility, information, and use of the protocols to attend IPVAW, Participant 2 informed about creating a mobile health app which synthesizes the Andalusian protocol information, including a section for general population. More, app can be used to national level because it is based on the Spanish protocol to attend victims of IPVAW from healthcare centers.	P2: *"We observed that they did not know the protocol and did not even know where it was. This gave rise to the idea of adapting the Andalusian protocol to a mobile app, which could be feasible at the national level since the Andalusian protocol is based on the Ministry's protocol adapted to Andalusian resources which, although with nuances, are very similar to those of other communities"*. (C10) P3: *"In the app there is a summary of the protocol. It explains very briefly each of the branches, depending on whether you are in the emergency department, primary care, if there are indicators of suspicion, etc. In short, the app guides and orients you"*. (C11)
3. Experiences in IPVAW care	
Controversy in the application of universal screening for IPVAW among participants was obtained.	P3: *If she doesn't tell you anything, you can't tell her directly, are you a victim of violence or have you been beaten? The patient has to trust you"*. (C12) P7: *"Whoever we least expect it may have lived IPVAW or is in it. If we never ask, we will never know"*. (C13) P2: *"We should have the glasses of the active search for indicators of suspected abuse. And then, track the woman"*. (C14)
Participants pointed that PCP must always respond to the victims, paying attention to indicators of abuse in	P1: *"The woman unburdens herself to me but then I don't know what to do with so much. So I have to find someone to help me. I have always turned to a social worker"*. (C15)

women, and not look the other way. However, from their experience, it is not always the case.	P4: *"You have to know at least a little bit how to act but if you don't know how to act you can get help from a partner, social worker, etc." "In my case, I asked the social worker".* (C16) P7: *"I am not very familiar with the protocol. In cases of GBV I always turned to the social worker who was the one who helped me".* (C17) P3: *"As Resident Medical Intern, when I have taken an interest in cases of IPVAW, my work partners have told me -not to get involved in this problem- or -report injuries and forget about it-."* (C18)
4. Obstacles and needs for addressing IPVAW in consultation	
Participants manifested IPVAW training, the lack of time and coordinated multidisciplinary teams, cultural and educational factors, as well as the presence of feelings like fear, frustration, or impotence as some of the main obstacles to address IPVAW.	P3: *"Training. To have a training that will help us in our medical criteria to decide whether a patient is a victim of IPVAW or not".* (C19) P5: *"An obstacle would be the lack of training in the educational field. Insist and put more emphasis on the education of young people, adolescents and children. The best way to combat IPVAW is to give children a different source of education than what they see at home. I would insist on that as a long-term tool to try to reduce IPVAW".* (C20) P1: *"To attend IPVAW in consultation, our cancer is time"* (the rest of the participants subscribed to this perspective). (C21) P2: *"We don't even have time to detect the COVID-19, imagine stopping for half an hour to attend to a woman suffering IPVAW".* (C22) P3: *"You have very little time per patient. You have to ask a series of questions to the woman that you don't have time for in the consultation". "We are seeing an average of 50 patients per visit in primary care on average. This generates*

	anxiety for the physician, not because you don't want to follow up with that woman or interview her, but because you don't have time. Sometimes you neglect something that may be essential at that moment but because of work issues you can't do it". (C23) P1: *"I completely agree. You ultimately normalize what you have been taught to normalize. It's as simple as that".* (C24) P2: *"I was giving an IPVAW training talk to healthcare professionals and I get to the third slide and a professional gets up, slams the door and leaves the room. Imagine that talking about another medical topic such as hypertension, diabetes or heart insufficiency".* (C25) P4: *"I went to give an IPVAW talk at a high school, and I had to go up to six times because every day there were excuses. Parents had to give consent for their children to attend the conference. By the sixth time I went I was able to talk about IPVAW, but the parents and the institute put up all kinds of problems".* (C26) P7: *"We should address IPVAW through different plans such as going to schools, making IPVAW visible..."* (C27) P3: *"IPVAW is an emotional impact".* (C28) P1: *"You feel powerless and even overwhelmed". "It is a bit frustrating".* (C29) P2: *"Many times it is also very complicated. I understand the colleagues who are often afraid to get involved and take action. Fear and lack of knowledge. They don't act because they haven't been given information, not because they don't want to. You feel helpless and even overwhelmed".* (C30) P4: "*I think that many times we detect IPVAW but for fear of not knowing how to continue, we try not to ask the woman too much". "Unfortunately, in IPVAW they don't pay attention to us because they can't. It is very difficult. It is very difficult. I*

Also, the need to depoliticize IPVAW was expressed by the participants.	*wish we could say "Take this pill and the problem will be solved". It's a frustration".* (C31) P5: *"Team building, perhaps a session with the social worker in consultation, so that the patient feels a little more accompanied, or more supported by the health center".* (C32) P4: *"Unfortunately, victims of IPVAW do not pay attention to us because they cannot. It is very difficult, but we cannot feel frustrated for it. We must accompany them, and they have to know that we are there, that if they need to tell us something we are there, because we cannot do anything else".* (C33) P2: *"As with any health intervention, it would also be important to depoliticize it. It should be approached as a health problem, the IPVAW budget or the training plan, or the intervention plan should not change every four years depending on who governs at the regional or central level. Unfortunately, gender violence is a political bargaining chip and until we improve it, we will continue to face many obstacles".* (C34)

Note. IPVAW = Intimate partner violence against women; PCP = Primary Care Physicians; P = participant; C = Citation.

Discussion

Having homogeneous tools and professionals trained to approach IPVAW in health care centers is essential for victims' care. This study analyzed the available protocols in Spain, considering the WHO's recommendations for attending IPVAW, the PCPs' perspectives on the use and usefulness of these protocols, and the obstacles and requirements to respond to IPVAW adequately in consultations.

In general, national, and autonomic protocols in Spain were in accordance with WHO recommendations, showing homogeneity among them. However, it is insufficient to respond to IPVAW as a health problem; it is not enough to indicate what should be done. PCPs need to know how to respond appropriately to IPVAW. Otherwise, women may continue to be exposed to IPVAW, showing chronic physical and psychological symptomatology (Lorente, 2008; 2020).

All protocols encompassed the six main dimensions indicated in the WHO guideline to various extents (WHO, 2013), except in the community of Navarre, which includes several documents to address IPVAW but has no specific, detailed protocol for addressing IPVAW in health care centers. Additionally, controversy among protocols exists regarding universal screening. this controversy could be explained by the fact that the "Protocolo común para la actuación sanitaria ante la violencia de género (2012)" recommended universal screening to all women in consultation, but the WHO (2013) stated that it should only be applied in cases of suspicion. The recommendation for universal screening depends on the guide on which the autonomic protocols have been based. In this regard, a proactive attitude is required to detect IPVAW and act accordingly, without waiting passively for the woman or the symptoms she presents to reveal that she is experiencing IPVAW.

Likewise, though the Aragon protocol (2005) defines various types of violence (e.g., in the family context or by the partner) correctly, it uses the term "domestic violence toward

women" to refer to any abuse by a partner or former partner. In the Spanish context, and in accordance with *Ley Orgánica1/2004*, the term[1] "gender violence" should be used, avoiding confusion due to the use of terms that refer to a different type of problem in Spain, which is not the objective of the protocols for addressing IPVAW in health care centers (Ministerio de Salud, Servicios Sociales e Igualdad, 2012). Finally, it is noteworthy that the national protocol has not been updated since 2012. In this regard, it would be advisable to consider updating it due to the evolution of IPVAW manifestations, for example, through new technologies (Sánchez-Hernández et al., 2020). Additionally, efforts to unify information on IPVAW reporting by PCPs are needed, considering WHO recommendations and Spanish legislation for PCPs, providing a clear idea of what their actions should be in the face of this problem.

Otherwise, the focus group allowed the researchers to explore the perspective of a PCP group on their roles in addressing IPVAW, the use and usefulness of health care protocols to attend IPVAW, their experiences in IPVAW care, and their perceptions about the obstacles to and requirements for addressing IPVAW in consultation. The participants' discourse was consistent with previous literature (García-Díaz et al., 2020) that pointed out that PCPs play an essential role in detecting and addressing IPVAW. IPVAW victims using health care centers share this view (Ministerio de Salud, Servicios Sociales e Igualdad, 2015). The participants agreed that their roles as health care professionals are fundamental to approach IPVAW ([2]C1 P2, P2 C2). Particularly, as Participant 4 indicated (C3), IPVAW victims frequently go to health care centers with a covert reason for consultation, making PCPs' essential to identifying the problem (Coll-Vinent et al., 2008; Ruiz-Pérez et al., 2004; WHO, 2022).

Regarding the use and usefulness of the protocols, their use among this group of PCPs is not so evident. Specifically, some participants reported a lack of knowledge about the

[1] In Spain, the term "gender violence" has the same meaning as the term IPVAW, used by the WHO to define physical, psychological, or sexual abuse as well as control behaviors by a current or former intimate partner.
[2] C = Citation; P = Participant

existence of these protocols (P1 C4, P6 C5, P2 C6). Others, although they could recognize the protocols, did not know where to find and how to use them (P7 C7, P1 C8) or did not consider them practical (P4 C9). Consequently, to facilitate accessibility, information, and use of the protocols to address IPVAW, PCPs were informed about a mobile health app that guides PCPs and synthesizes the Andalusian protocol information, including a section for the general population; it can be used at the national level because it is based on the Spanish protocol to attend victims of IPVAW in health care centers (P2 C10, P4 C11). In this sense, the dissemination of updated information regarding the approach to IPVAW in health care centers will be key to offering an optimal response to victims. To this end, as established in the *Ley Orgánica 1/2004*, implementing awareness-raising and continuing education programs among PCPs is required.

PCPs should adopt an attitude of alertness in consultations to identify IPVAW, because many medical consultations for women's health problems are associated with its presence (Riggs et al., 2000). In this regard, controversy exists regarding the application of universal screening for IPVAW in health care centers (Castañeda et al., 2020; Plazaola-Castaño, et al. 2008; Taft et al., 2013), also reflected in the participants' perspectives (P3 C12, P7 C13, P1 C14). It seems surprising that, in the face of such a serious problem as IPVAW, one could consider adopting a passive attitude instead of being proactive, as in other types of health problems.

Further, when PCPs observe indicators of abuse in women, the problem should be addressed, and action in cases of suspected or confirmed IPVAW should not be restricted to reporting injuries. A comprehensive intervention should take place in which women are offered information and support, including follow-up to support victims' full recovery (Diéguez & Rodríguez, 2021). Unfortunately, some PCPs still do not give the issue the attention it requires (P3 C18). Even if PCPs do not know how to address IPVAW, they must always respond to

victims and not ignore the issue. In this sense, PCPs often ask social workers who are not recognized as health professionals for help (P2 C15, P4 C16, P7 C17), which, together with the lack of interdisciplinary teams, could affect the approach to IPVAW (García-Quinto et al., 2021), requiring multidisciplinary teams (P5 C32).

It is worth highlighting the obstacles that this group of PCPs encounters in responding adequately to IPVAW in consultations. According to previous literature (Diéguez & Rodríguez, 2021; Ministerio de Salud, Servicios Sociales e Igualdad, 2015), IPVAW training, the lack of time and coordinated multidisciplinary teams, IPVAW normalization, or cultural and educational factors were some of the main obstacles mentioned by participants (P3 C19, P5 C20, P1 C21, P2 C22, P3 C23), requiring changes such as training teams of health care professionals with the knowledge and skills to respond to IPVAW effectively (Bacchus et al. 2003; Waalen et al., 2000), so the normalization of IPVAW may determine the responses to this problem (Waltermaurer, 2012). PCPs also expressed the need to depoliticize IPVAW (P2 C34), approaching IPVAW as what it is—a public health and social responsibility problem (WHO, 2022). In this respect, the health system should offer a strong, clear response to IPVAW, providing recourses (e.g., training, or multidisciplinary teams) to resolve the personal situation in each case.

Moreover, PCPs discussed feelings such as fear, frustration, or impotence as obstacles to addressing this problem (P1 C24, P2 C25, P4 C26, P7 C27, P3 C28, P1 C29, P2 C30, P4 C31). According to Participant 4 (C33), an adequate understanding of IPVAW as well as the internal and external barriers in which IPVAW victims are involved will be the first step in helping them (Author, Forthcoming), and it could minimize PCPs' emotional distress rooted in victims' decisions. In turn, the impact of the obstacles (e.g., lack of training and multidisciplinary teams) on PCPs' emotional responses may have a negative influence on their care for women suffering from IPVAW, requiring actions in this regard.

Implications for research, practice, and policy

Concerning research implications, the researchers synthesized Spanish protocols' content and analyzed their usefulness by conducting a focus group with PCPs. The obtained information provides a starting point for future research and contributes to advancing scientific knowledge on the approach to IPVAW in health care centers in Spain.

Greater efforts are needed to ensure the practical implementation of the Spanish protocols, considering their limitations and the main obstacles cited by this group of PCPs, such as lack of time and training in IPVAW; feelings of fear, frustration, or impotence; and cultural, educational, and political factors. In this regard, the health system needs to enable conditions for providers to address IPVAW, including good coordination, referral networks, or IPVAW training programs for PCPs, focusing on what puts victims at risk for IPVAW, how to approach it in a consultation, and where PCPs can access recourses to care for victims of IPVAW (García-Moreno et al., 2014).

Specifically, training health care professionals in IPVAW to understand its origin and maintenance will be the first step to adopt a nonjudgmental attitude, avoiding the emergence of emotions such as fear, impotence, or frustration. For PCPs, these feelings could affect the quality of their interventions with IPVAW victims. Therefore, the need to establish self-care guidelines to reduce or prevent effects on these professionals' health is important, which in turn would improve the quality of the intervention (Alonso-Ferres et al., 2022).

In addition to these aspects, it is vital to work on the beliefs and attitudes shown by PCPs, because IPVAW training alone could be insufficient to respond adequately to this problem. In particular, Badenes-Sastre et al. (2023) found that sexist ideology and favorable attitudes toward IPVAW influence future health professionals' response to IPVAW cases. However, the training does not have a significant influence on willingness to intervene. In this

sense, cultural, educational, and political factors may also hinder the response to IPVAW, requiring appropriate measures to address them.

To avoid normalization and passivity towards IPVAW, efforts should be directed toward educating about equality from an early age. It is necessary to create a more egalitarian society, which in turn translates into a proactive response to IPVAW from health care centers. Furthermore, during university training of health professionals, work should continue from a gender perspective and emphasize their roles in relation to IPVAW, thus creating professionals prepared to respond actively to cases of IPVAW.

Likewise, the problem of PCPs' lack of time to detect and intervene in cases of IPVAW must be solved; otherwise, women will not receive the quality care they need. In this regard, organizational changes are required, reducing the number of patients to be attended by each professional and hiring more PCPs in primary care centers so that time can be dedicated to the detection of and intervention in IPVAW cases.

Regarding political implications, addressing IPVAW in health care centers should be a priority and not depend on the political party in power. All victims should be cared for equally, irrespective of the country or autonomous community in which they are located. As indicated by the WHO (2022), IPVAW is a global public health problem that affects women worldwide. In this sense, there have been social and legislative changes in Spain and internationally in relation to IPVAW (Ferrer-Pérez et al., 2019). However, victims are still not offered optimal responses from health care centers. To this end, attention should be paid to preventing this issue, focusing on the influence of social and cultural factors in PCPs' attitudes toward IPVAW and, consequently, their willingness to intervene in cases of IPVAW in consultation as a public health problem.

Limitations and Future Directions

This study is subject to a few limitations worth noting. First, part of the analysis of the protocols is based on the recommendations from the WHO guidelines, but some of the protocols were developed before their publication and are based in the Spanish legislation (Ley Orgánica 1/2004), without considering the global recommendations (WHO, 2013). This limitation was considered in the discussion of the results. Second, the small sample size makes it difficult to generalize the results. Notwithstanding the relatively limited sample, this qualitative work was complemented by an exhaustive analysis of the content of the protocols, providing valuable insights into their adequacy to attend IPVAW victims in health care centers. Lastly, the type of analysis carried out only allowed descriptive conclusions. It would be convenient to carry out research that makes it possible to quantify the information obtained through the focus group and to symbolize the relationship between categories through networks of cooperation, as other qualitative studies do.

Future studies would be beneficial in terms of exploring how to minimize the obstacles PCPs encounter in implementing the protocols in consultation, considering health care centers' perspectives, so the practical application of the contents of the protocols will be crucial. In this respect, it could be interesting to form more focus groups with PCPs who know and use these protocols to obtain more accurate information on the strengths and weaknesses of the tools available in Spain for attending IPVAW victims in health care centers.

Conclusion

Spanish protocols to address IPVAW in health care centers seem insufficient. Their use and practicality among PCPs are unclear, requiring training and specialization in the care of IPVAW victims. Participants considered that the practical application of these tools could be beneficial for attending IPVAW victims if the above-mentioned obstacles (e.g., lack of time, feelings toward victims, or IPVAW normalization) were addressed. In this sense, promoting structural and organizational changes in health care centers as well as training for PCPs in understanding IPVAW and the application of the protocols in consultations are needed to improve the care for victims.

Estudio 8

Study 8

Future Health-Professionals: Attitudes, Perceived Severity, and Willingness to Intervene in Intimate Partner Violence Cases

Futuros Profesionales Sanitarios: Actitudes, Gravedad Percibida y Voluntad de Intervención en Casos de Violencia de Género

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Resumen

La violencia de género (VG) es un problema de salud pública por el que muchas víctimas acuden a los centros de salud para aliviar las consecuencias de la violencia. El presente estudio tuvo como objetivo explorar la relación entre las actitudes hacia la VG y la voluntad de intervención en casos de VG por parte de futuros profesionales sanitarios, considerando la influencia de la gravedad percibida de la VG en esta relación. La muestra estuvo compuesta por 432 estudiantes (M = 22,89, DT = 6,36) de psicología (52,60%), enfermería (26,20%) y medicina (21,20%). Se evaluaron el sexismo, la aceptación de la VG, la gravedad percibida y la voluntad de intervención en casos de VG. Los resultados mostraron bajo sexismo (M = 0,61, DT = 0,59) y aceptación de la VG (M = 1,05, DT = 0,06), así como alta percepción de gravedad (M = 9,62, DT = 0,60) y moderada voluntad de intervención en casos de VG (M = 5,20, DT = 1,16). Además, el modelo conceptual testado mostró que a más actitudes sexistas, mayor aceptación de la VG, menor percepción de la gravedad de la VG y, en consecuencia, menor voluntad de intervención en casos de VG. Estos hallazgos destacan la importancia de abordar las barreras actitudinales y perceptivas de los futuros profesionales sanitarios para detectar y atender la VG precozmente desde los centros sanitarios.

Palabras clave: violencia hacia las mujeres, barreras de respuesta, sexismo, aceptación, rol de los profesionales sanitarios

Abstract

Intimate partner violence (IPV) is a public health problem for which many victims attend to healthcare centers to alleviate the results of violence. The present study aimed to explore the relation between IPV attitudes and willingness to intervene in cases of IPV by future health professionals, considering the influence of perceived severity of IPV in this relation. The sample was composed of 432 students (M = 22.89, SD = 6.36) of psychology (52.60%), nursing (26.20%), and medicine (21.20%). Sexism, IPV acceptance, perceived severity, and willingness to intervene in IPV cases were assessed. The results displayed low sexism (M = 0.61, SD = 0.59) and acceptance of IPV (M = 1.05, SD = 0.06), high perceived severity (M = 9.62, SD = 0.60), and moderate willingness to intervene in cases of IPV (M = 5.20, SD = 1.16). Moreover, a conceptual model showed that more sexist attitudes were related to more acceptance of IPV, decreased perceived severity of IPV, and consequently, the willingness to intervene in cases of IPV. These findings highlight the importance of addressing the attitudinal and perceptive barriers of future healthcare professionals to detect and attend early to IPV from healthcare centers.

Keywords: violence against women, barriers to response, sexism, acceptance, health professionals' role

Future Health-Professionals: Attitudes, Perceived Severity, and Willingness to Intervene in Intimate Partner Violence Cases

Intimate partner violence (IPV) is a major public health problem that involves behaviors by partner or former partners that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors (World Health Organization [WHO], 2022). Specifically, one in three women in the world suffered IPV, which causes physical and mental health deterioration, including fractures and other injuries, gastrointestinal issues, chronic pain, depression, or anxiety (Campbell, 2002; Wang, 2016, WHO, 2022). Consequently, victims of IPV frequently visit healthcare centers such as primary care, mental health, or emergency services with a covert reason for consultation, and health professionals' roles are essential in detecting IPV (Campbell, 2002; Coll-Vinent et al., 2008; Ruiz-Pérez et al., 2004; WHO, 2022). However, health professionals may encounter barriers to identifying and responding to IPV, such as time constraints, lack of information, attitudes toward IPV (e.g., not considering IPV a health problem), or failing to identify IPV as the origin of the patient's signs and symptoms (Blanco et al., 2004; Coll-Vinent et al., 2008; Goicolea et al., 2019). In this regard, it is necessary to examine the variables involved in health professionals' responses to IPV to direct intervention and prevention efforts.

Theoretical Framework

Feminist theory is focused on exploring gender relations based on the social construction of gender, describing IPV as a consequence of gender inequality on the societal level (Bograd, 1988; West & Zimmerman, 1987). In this theoretical context, gender-related norms, and attitudes such as acceptance and justification of violence are the main causes of IPV and impact public and professional responses to it (Ferrer et al., 2020; Flood & Pease, 2009). Likewise, attitudes toward IPV could influence its perceived severity as well as help-seeking and reporting behaviors (Herrera et al., 2014; Kuijpers et al., 2021). To mitigate the

issue, it is necessary to explore the relation between attitudes and perceptions of IPV as well as their effect on responses to IPV.

Attitudes, Perceived Severity, and Willingness to Intervene in Cases of IPV

Attitudes toward IPV reveal social norms regarding the acceptance or non-acceptance of IPV and influence professionals who attend victims of violence such as health professionals (Gracia et al., 2020). Specifically, sexism is an ideology that involves attitudes and stereotypes of a gender, considering specific roles appropriate or not depending on gender (Expósito et al., 1998). According to the theory of ambivalent sexism (Glick & Fiske, 1996), sexism is multidimensional and encompasses ambivalence between genders; it can be divided into hostile sexism and benevolent sexism. Sexism has been positively related to attitudes of acceptance of IPV, and both types, have been negatively linked to the perceived severity of IPV (Martín-Fernández et al., 2018; Sánchez-Hernández et al., 2020; Yamawaki et al., 2009), which reflects the significance or magnitude assigned to IPV threats (Riddle & Di, 2020; Witte, 1994). In this regard, attitudes toward IPV may mean that some perceive IPV as normal, determining the social response to this problem (Waltermaurer, 2012).

In general, tolerant attitudes toward IPV as well as victim blaming continue to be present in Spanish society (Centro de Investigaciones Sociológicas, 2012; 2013; Rodríguez et al., 2021), also reflected in healthcare professionals. In particular, health professionals' willingness to intervene in cases of IPV decreases when they display more sexist attitudes (Noriega et al., 2020). Also, Torrecilla (2016) founded that more than 28% of health professionals justified physical violence, blaming women and minimizing IPV, more than 17% did not strongly refuse psychological violence, and more than 5% did not totally reject sexual violence. Likewise, highly sexist attitudes and tolerance of IPV were found among students intending to work as health professionals caring for potential IPV victims (Diéguez et al., 2017;

García-Díaz et al., 2020). This highlights the urgency of considering multiple factors, such as perceptions and attitudes toward IPV, to minimize this problem (Ming et al., 2020).

In general, some researchers have explored health professionals' knowledge, opinions, attitudes, and perceptions of IPV (Badenes-Sastre & Expósito, 2021; Cann et al., 2001; Follingstad & DeHart, 2000; Follingstad et al., 2004; Goicolea et al., 2017; Noriega et al., 2020) pointed out the influence of health professional's perceptions and attitudes in their response to IPV (Leung et al., 2018). Because IPV is a public health problem, and many victims attend to healthcare centers to alleviate the results of violence (WHO, 2022), it is necessary analyze the influence of these variables in future health professionals. However, no studies have explored the influence of attitudes and perceptions of severity of IPV on future health professionals' willingness to intervene in cases of IPV. Hence, addressing this gap will be essential for understanding the influence of these variables in future health professionals' responses to IPV, as they will have to detect IPV and care for potential victims when they complete their training and work in healthcare centers.

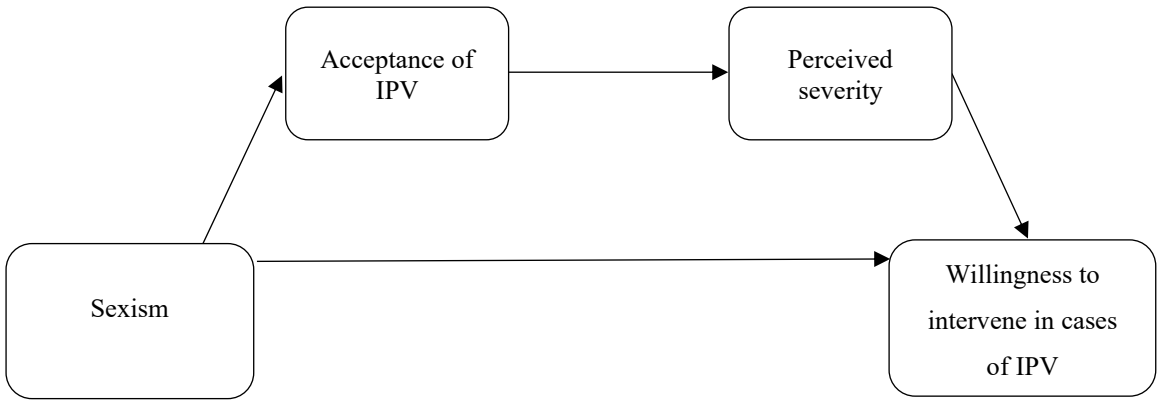
The Present Research

Based on the considerations the purpose of the present study was to explore the relation between IPV attitudes and willingness to intervene in cases of IPV by future health professionals such as physicians, nurses, and psychologists, considering the influence of perceived severity of IPV in this relation. A conceptual model (Figure 1) analyzing the mediating effect of IPV acceptance and perceived severity in the relationship between health professionals' sexism and willingness to intervene in cases of IPV was tested. Initially, scores and correlations among future health professionals' sexist attitudes, acceptance of IPV, perceived severity, and willingness to intervene in cases of IPV were explored. Specifically, we estimated that the willingness to intervene in cases of IPV would correlate negatively with sexism (Hypothesis 1a) and acceptance of IPV (Hypothesis 1b) and positively with perceived

severity (Hypothesis 1c). Then, we expected that more sexist attitudes would be related to more acceptance of IPV, decreasing the perception of severity of IPV and, consequently, the willingness to intervene in cases of IPV (Hypothesis 2).

Figure 1

Conceptual Model Showing the Proposed Relationship Between Sexism and Willingness to Intervene in cases of IPV Mediated by Acceptance of IPV and Perceived Severity



Method

Participants

The sample was composed of 432 participants (88% women); 52.6% were psychology students, 26.2% were in nursing, and 21.2% in medicine. The age of the participants ranged from 18 to 65 years (M = 22.89, SD = 6.36). Of the total sample, 75.7% had received training in IPV and 24.3% had not. Specifically, 53.7% of them had specific training in attending victims of IPV from a healthcare center. Concerning previous IPV experiences, 78.0% of the participants reported experiencing or knowing about IPV cases.

Instruments

Ambivalent Sexism Inventory (ASI; Glick & Fiske, 1996). The Spanish version of the ASI was applied (Expósito et al., 1998). It assesses ambivalent sexism and was composed of 22 items rated in a 6-point response format ranging from 0 (totally disagree) to 5 (totally agree). Of the 22 items, 11 were related to hostile sexism (e.g., “Women are very easily offended”),

and 11 were related to benevolent sexism (e.g., “The man is incomplete without the woman”). Higher scores revealed more sexist attitudes. In the present study, the alpha coefficient of ambivalent sexism was .89.

Acceptability of IPV against Women (A-IPVAW; Martín-Fernández et al., 2018). The A-IPVAW measured the acceptability of a set of men’s behaviors towards their female partners. This scale includes 20 items (e. g., “I think it is acceptable for a man to control where their partner goes”), with a response format range from 1 (not acceptable) to 4 (very acceptable). High scores on the scale indicated more acceptability of IPV. In this study, the Cronbach’s alpha for the scale was .53.

Perceived Severity of IPV (PS-IPV; Gracia et al., 2009). The scale presents eight hypothetical scenarios (e.g., “A couple is fighting; he insults her and threatens to hit her”) to assess the perceived severity of IPV incidents. The participants had to rate the scenarios on a 10-point response scale (ranging from 1, not severe at all, to 10, extremely severe). In this study, the scale showed good internal consistency ($\alpha = .83$).

Willingness to Intervene in Cases of Intimate Partner Violence against Women (WI-IPVAW short version; Gracia et al., 2018). A shorter version of the initial WI-IPVAW scale (five items) was created, including five items that assess calling the police (e.g., “If I found out that a woman neighbor of mine had been beaten by her husband, I would advise her to report it”), personal involvement (e.g., “In a bar, if a man started screaming at his partner, I would stand between them to help the woman”), and not my business (e.g., “If an immigrant couple or a couple from another culture were fighting on the street, I would ignore it and keep walking”). The participants responded in a 7-point response format from 1 (not likely) to 7 (extremely likely) to rate the probability that they would intervene in the situation presented. The Cronbach’s alpha for this study was .79.

Socio-demographic information. Data regarding participants' sex, age, degree, IPV training, specific training to attend IPV from healthcare centers, and previous experiences with IPV victims were measured at the end of the questionnaire.

Design and Procedure

A no-experimental associative study was performed.

Through intentional sampling, the participants were included in the study if they were studying for a degree in psychology, nursing, or medicine in Spain. First, an online survey was developed using the LimeSurvey research platform. Next, the survey was disseminated on social networks (Instagram, Facebook, WhatsApp, and institutional mail). All of the participants were informed about study's purpose and volunteered to participate, providing their informed consent in accordance with the Helsinki Declaration, and the anonymity and confidentiality of their responses was guaranteed. No monetary incentives were provided for participation. The study was developed with the approval of the ethics committee of the University of Granada.

Data Analysis

The data were analyzed using the SPSS Program, version 23. First, descriptive statistics (mean and standard deviation) were conducted to explore the participants' scores on sexism, acceptance of IPV, perceived severity, and willingness to intervene in cases of IPV. Then, a Pearson correlation analysis was carried out to analyze how the willingness to intervene in cases of IPV is related to the attitudes and perceptions assessed. Last, a multiple serial mediation analysis was performed using model 6 of the PROCESS program described by Hayes (2013). This analysis was intended to explore an explanatory model in which the acceptance of IPV and the perceived severity of IPV mediated the relationship between sexism and willingness to intervene in cases of IPV. The analyses were controlled for age, sex, degree,

IPV training, specific training to attend IPV victims from healthcare centers, and previous IPV experience.

Results

Sexism, Acceptance of IPV, Perceived Severity, and Willingness to Intervene in Cases of IPV

Table 1 shows descriptive statistics regarding the main variables used in this study according to degree and the correlations between variables. The results obtained in the descriptive analysis show that future health professionals present low sexist attitudes (M = 0.61, SD = 0.59) and acceptance of IPV (M = 1.05, SD = 0.06), as well as high perception of severity of IPV (M = 9.62, SD = 0.60). However, participants' willingness to intervene in cases of IPV was moderate (M = 5.20, SD = 1.16). The Pearson correlation analysis revealed significant correlations between willingness to intervene in cases of IPV and the rest of variables analyzed: sexism (r = -.170, p < .001), acceptance of IPV (r = -.276, p < .001), and perceived severity (r = .249, p < .001). These results confirm Hypotheses 1a, 1b, and 1c.

Table 1

Correlation Analysis among Willingness to Intervene in Cases of IPV, Attitudes and Perceptions and Means According to degree

					Psychology (*n* = 228)	**Nursing (*n* = 113)**	**Medicine (*n* = 91)**
	1	2	3	4	*M*(*SD*)	*M*(*SD*)	*M*(*SD*)
1. Willingness to Intervene in cases of IPV	-				5.16(1.13)	5.47(1.10)	4.95(1.21)
2. Sexism	-.170***	-			0.58(0.57)	0.59(0.59)	0.69(0.62)
3. Acceptance of IPV	-.276***	.248***	-		1.05(0.07)	1.04(0.06)	1.04(0.06)
4. Perceived severity	.249***	-.223***	-.302***	-	9.60(0.64)	9.71(0.47)	9.60(0.65)

Note. IPV = intimate partner violence; *$p < .05$; **$p < .01$; ***$p < .001$.

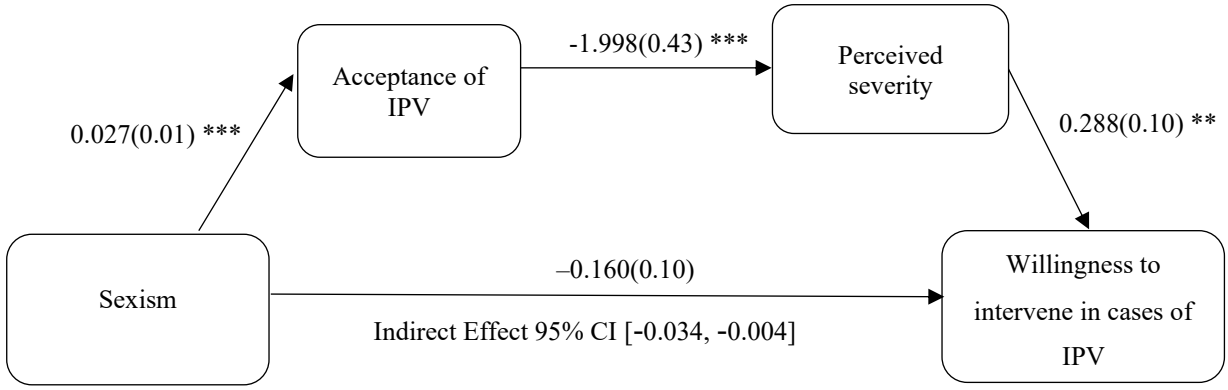
Mediating Effect of Acceptance of IPV and Perceived Severity on the Relationship between Sexism and Willingness to Intervene in Cases of IPV

To test Hypothesis 2 ("More sexist attitudes would be related to more acceptance of IPV, decreasing the perception of severity of IPV and consequently, the willingness to intervene in cases of IPV"), model 6 of a multiple serial mediation of the PROCESS macro (Hayes, 2013) was applied.

[1]As shown in Figure 2 and Table 2, higher scores in acceptance of IPV and lower scores in perceived severity predicted less willingness to intervene in cases of IPV in people with more sexist attitudes (indirect effect = -0.016, *SE* = 0.01, 95% CI[-0.034, -0.004]), confirming Hypothesis 2. Finally, the variance explained by acceptance of IPV and perceived severity variables included in the model predicted a total of 14.36% of the willingness to intervene in cases of IPV according to sexism attitudes.

Figure 2

Conceptual Model Showing the Relationship Between Sexism and Willingness to Intervene in cases of IPV Mediated by Acceptance of IPV and Perceived Severity



Note. Unstandardized beta coefficients reported, with standard errors within parentheses; **p* < .05; ***p* <.01; ****p* < .001.

[1] The analyses were controlled by age, sex, degree, IPV training, specific training to attend IPV victims from healthcare centers, and having previous IPV experiences, finding significant results in age (p < .01) and sexism related to acceptance of IPV and acceptance of IPV to perceived severity (p < .01); in sex (p < .01) related to sexism in acceptance of IPV and acceptance of IPV to perceived severity (p < .01); in medicine degree (p < .05) related to sexism in acceptance of IPV; and having previous IPV experiences (p < .05) related to sexism in acceptance of IPV, as well as sexism related to willingness to intervene in cases of IPV (p < .05).

Table 2

Mediating Effect of Acceptance of IPV and Perceived Severity on the Relationship Between Sexism and Willingness to Intervene in Cases of IPV

	Acceptance of IPV		Perceived Severity		Willingness to Intervene in Cases of IPV	
Background	*Coeff.*	Symmetric BCI	*Coeff.*	Symmetric BCI	*Coeff.*	Symmetric BCI
Constant	1.064***	[1.001, 1.118]	10.924***	[9.895, 11.952]	6.493***	[3.625, 9.362]
Sexism	0.027***	[0.017, 0.038]	–0.137*	[-0.231, –0.042]	-0.160	[–0.247, 0.027]
Acceptance of IPV			–1.998***	[–2.852, -1.145]	–3.370***	[–5.081, –1.659]
Perceived Severity					0.288**	[0.101, 0.476]
Age	–0.002***	[–0.003, –0.001]	0.011**	[0.003, 0.020]	0.006	[–0.011, 0.023]
Sex	–0.020*	[–0.039, –0.001]	0.343***	[0.173, 0.512]	–0.099	[–0.437, 0.067]
Degree 1	–0.018*	[–0.034, –0.003]	–0.012	[–0.150, 0.127]	–0.203	[–0.473, 0.067]
Degree 2	–0.003	[–0.018, 0.012]	0.096	[–0.041, 0.232]	0.256	[–0.377, 0.210]
IPV training	0.012	[–0.005, 0.028]	0.117	[–0.032, 0.266]	–0.082	[–0.243, 0.281]
Specific training to attend IPV from healthcare centers	0.012	[–0.003, 0.026]	–0.021	[–0.155, 0.113]	0.019	[–0.243, 0.281]
Having previous IPV experiences	0.016*	[0.001, 0.030]	–0.126	[–0.256, 0.001]	–0.274	[–0.527, 0.021]
	$R^2 = .137$ $F(8, 423) = 8.45, p < .001$		$R^2 = .177$ $F(9, 422) = 10.09, p < .001$		$R^2 = .143$ $F(10, 421) = 7.06, p < .001$	

Indirect Effects	Effects	Symmetric BCI
Total	–0.147	[–0.239, –0.074]
I1	–0.092	[–0.165, – 0.037]
I2	–0.039	[–0.087, –0.006]
I3	–0.016	[–0.034, –0.004]

Note. IPV = intimate partner violence against women; Degree 1 = condition 1 medicine; condition 0 = nursing and psychology; Degree 2 = condition 1 nursing; condition 0 = medicine and psychology; I1 = Sexism → Acceptance of IPV → Willingness to Intervene in Cases of IPV; I2 = Sexism → Perceived Severity → Willingness to Intervene in Cases of IPV; I3 = Sexism → Acceptance of IPV → Perceived Severity → Willingness to Intervene in Cases of IPV; Symmetric BCI: Symmetric Bootstrapping Confidence Interval. The indirect effects are significant where the Bootstrap Confidence Interval does not include the value 0. *p < .05, **p < .01, ***p < .001.

Discussion

Addressing IPV in healthcare centers is critical to detect this problem and support victims. Knowing about future health professionals' attitudes and perceptions about IPV is the first step in understanding how they respond to it. In this regard, changing the perspective of IPV from a private issue to a social problem has involved better knowledge of the problem and legislative changes to address IPV (Bosch & Ferrer, 2000). Likewise, IPV is recognized as a major public health problem (WHO, 2022), however, it is not always addressed as such. Sexist ideology can influence attitudes and perceptions toward IPV and determine responses to this issue, which may cause health professionals to underestimate the severity of IPV in consultation, interfering in their willingness to intervene.

This study is one of the first to test a conceptual model assessing the mediating effect of IPV acceptance and perceived severity on the relationship between sexism and willingness to intervene in cases of IPV by future health professionals. The results confirmed Hypothesis 2: "More sexist attitudes would be related to more acceptance of IPV, decreasing the perception of severity of IPV and, consequently, the willingness to intervene in cases of IPV." These novel findings are key to identifying the obstacles presented to attend to IPV victims in healthcare centers as well as directing efforts to raise future health professionals' awareness about IPV. Moreover, although it was not the main objective of the study, IPV training and specific training to attend IPV victims from healthcare centers were controlled to test the conceptual model, with no significant results. In this regard, the despite the fact that a lack of training in IPV is recognized as an obstacle (Coll-Vinent et al., 2007; Shearer et al., 2006), our outcomes may suggest that IPV training is not sufficient to generate willingness to intervene in IPV cases for future health professionals, requiring a focus on attitudinal and perceptual variables. Considering this will be essential so, despite victims frequently going to healthcare centers due to the health problems caused by IPV, the responses from health professionals (e.g., injury

reports) reflect only 9.6% of the total number of complaints, showing a possible lack of involvement in helping victims to get out of violent relationships (Consejo General Poder Judicial, 2019; Lorente, 2020).

Other important findings were scores obtained by future health professionals on sexist attitudes, acceptance, perceived severity and willingness to intervene in IPV cases. In general, low levels of sexism and acceptance of IPV were found in our sample, which was composed mainly of women. These outcomes are contrary to that of García-Díaz et al. (2020), who found high tolerance of IPV and sexist attitudes among psychology, nursing, and medicine students. However, although Rodríguez and Ballesteros (2019) also encountered medium or high percentages of acceptance of IPV behaviors among young people as well as low gender equality attitudes, it was more pronounced in men than women. As a result of these differences, considering variables such as gender or universities' commitment will be important to consider in transmitting favorable attitudes toward the IPV approach from healthcare centers.

Otherwise, although previous studies assessed the perceived severity of IPV in the general population, aggressors, victims, or police (e.g., Gilbert & Gordon, 2017; Gracia et al., 2008; Guerrero-Molina et al., 2017; Herzog, 2004), to date, no previous studies have explored it in a sample of future health professionals. In this study, participants showed a high perception of severity of IPV, making an important contribution to the current literature; being aware of the magnitude and severity of IPV is necessary in order to confront it (Badenes-Sastre & Expósito, 2021). Last, our sample had medium scores in willingness to intervene in cases of IPV. This outcome is striking—although IPV is recognized as a public health and social responsibility issue (WHO, 2022), the willingness to intervene helping women victims of IPV might not be enough. In this regard, in addition to adopting a favorable attitude in the fight against IPV, health professionals must act and help the victims because, according to Parker et

al. (2020), when victims of IPV perceive social support, the likelihood of victimization decreases.

In accordance with previous literature (Diéguez et al., 2017; García-Díaz et al., 2020; Martín-Fernández et al., 2018; Noriega et al., 2020; Waltermaurer, 2012; Yamawaki et al., 2009), strong correlations among target variables (attitudes, perceived severity, and willingness to intervene in cases of IPV) were found. Particularly, willingness to intervene in cases of IPV was negatively associated with sexism (Hypothesis 1a) and acceptance of IPV (Hypothesis 1b), while perceived severity was positively related to it (Hypothesis 1c), confirming the initial hypothesis. Findings from the present study gave empirical support to the idea that future health professionals' attitudes and perceptions about IPV influence their willingness to intervene in cases of IPV. It is necessary to work on these aspects during training for psychologists, nurses, and medical physicians, emphasizing the consequences of IPV for women's health.

In sum, given the extent and potential dangerousness of IPV, systematic screening and assessment from healthcare centers should be considered. Specifically, health professionals should be aware that many medical consultations for health problems by women are associated with the presence of IPV (Riggs et al., 2000), and it is essential to adopt an attitude of alertness for the early detection of IPV.

Limitations and Future Directions

The findings obtained in the conceptual model allow sequential testing of sexism as related to willingness to intervene in cases of IPV through acceptance of IPV and perceived severity. Notwithstanding, these data must be interpreted with caution. First, significant effects in age, sex, degree, and previous experiences of IPV were founded in some relationships between variables. Given the imbalance of participants in these categories, it was not possible to analyze the differences among them in attitudes, perceptions, and willingness to intervene in cases of IPV. In this line, accumulated empirical evidence suggests that men show sexism

and acceptance of IPV, as well as perceiving less severity of IPV than women (Diéguez et al., 2020; Lelaurain, et al., 2018). Further, García-Díaz et al. (2020) studied a sample of health science students, finding higher levels of sexism and tolerance of IPV in psychology students than medicine or nursing students as well as less sexism and IPV tolerance in students in their last courses than those in their first courses. Testing the present conceptual model differentiating according to sex, degree and course would be interesting for future research.

Additionally, due to the low Cronbach's alpha obtained for the acceptability of IPV scale, results should not be generalized, requiring further research. Finally, this study assessed the social response in terms of intervening in cases of IPV by future health professionals, but not specifically the response in their workplace, as they were still students. Other studies should explore their responses and/or willingness to intervene in these cases in consultation settings. In spite of these limitations, the study certainly adds to our understanding of the obstacles to intervening in cases of IPV. It would be interesting for future studies to test this conceptual model with health professionals, taking into account their actions in consultation beyond their willingness to intervene.

Implications for Practice and Policy

The aforementioned findings elucidate important practical and policy implications. First, the conceptual model suggests the need to direct efforts to reduce favorable attitudes toward IPV that make it difficult to perceive the severity of this problem, consequently decreasing willingness to respond to IPV. Preventing IPV through transversal education in gender equality will help generate a social change that does not accept or normalize IPV. Additionally, working IPV attitudes and perceptions in future health professionals during their university training, including gender perspectives, will encourage them to take an active role in the detection of IPV when they are working in healthcare centers. Lastly, health professionals must understand IPV (WHO, 2013). In this regard, health professionals can benefit from the

implementation of specific programs to attend IPV victims in consultation to understand the nature of the issue—a public health problem that does not consider political ideologies.

In terms of policy implications, IPV prevention campaigns should continue to be implemented to promote social awareness and the perception of severity of IPV. Likewise, the effectiveness of these campaigns should be evaluated regularly. As this study has shown, perceived severity of IPV and willingness to intervene in cases of IPV, may vary depending on attitudes towards this problem. These data are alarming; the response to IPV, unlike other health problems, will depend on the cultural context including beliefs, attitudes, and laws (Spencer et al., 2020). IPV will need to be depoliticized, and institutions should make efforts to address IPV as a public health problem, adopting general governmental commitments that do not depend on the ideologies of the political group in power.

Finally, health professionals are in a unique position to ask women about IPV during routine or annual consultations and, although there is a general awareness of the importance of IPV screening from healthcare centers, wide variation also exists depending on the site and the way IPV detection is applied (Shearer et al., 2006; Williams et al., 2016). Similarly, based on the results obtained in this study, it can be concluded that attitudinal and perceptual obstacles in future health professionals' responses to IPV require prevention programming and intervention work.

Conclusion

Healthcare centers' responses to IPV are essential, requiring a commitment among health professionals caring for victims. This study concluded that greater sexist attitudes in future health professionals are related to lower willingness to intervene in cases of IPV, and this relationship is mediated by higher attitudes of acceptance of IPV and lower perceived severity. Although the future health professionals showed low levels of sexist attitudes and acceptance of IPV as well as high perceived severity of IPV, their willingness to intervene in IPV cases was not high. In this regard, promoting a cultural and attitudinal change among health science students from early stages at universities will be a crucial element in acting against IPV.

CAPÍTULO 5: Discusión general

CHAPTER 5: General discussion

En esta tesis doctoral se ha estudiado la relevancia de diferentes variables individuales y relacionales en las respuestas ante la VG por parte de las víctimas y de los y las profesionales del ámbito sanitario que las atienden. Concretamente, se ha centrado en investigar el papel de la percepción de gravedad y valoración del riesgo de la VG en la toma de decisión, teniendo en cuenta su relevancia y la escasa literatura previa en esta línea. Para abordar estas cuestiones se han llevado a cabo ocho estudios empíricos recogidos en tres bloques: **Capítulo 1** "Revisión bibliográfica" (*Estudios 1* y *2*), **Capítulo 2** "Víctimas de violencia de género" (*Estudios 3, 4, 5,* y *6*), y **Capítulo 3** "Profesionales del ámbito sanitario" (*Estudios 7* y *8*). Los resultados obtenidos contribuyen al avance científico en esta temática y responden al objetivo general de la tesis doctoral "obtener evidencia empírica respecto a las variables implicadas en el proceso de toma de decisión en situaciones de VG", así como a los objetivos específicos: 1) conocer el estado del arte con relación a la percepción de gravedad de la VG y variables relacionadas; 2) examinar las variables implicadas en la decisión de dejar la relación o buscar ayuda en víctimas de VG; y 3) explorar las variables implicadas en la voluntad de intervención en casos de VG por parte de los y las profesionales del ámbito sanitario que las atienden.

A continuación, se discuten los principales hallazgos y las contribuciones al campo de la ciencia de los estudios empíricos que conforman la tesis. Con la finalidad de facilitar la claridad y comprensión de las investigaciones, se analizan los resultados por apartados que recogen las principales aportaciones de esta tesis al proceso de toma de decisión de dejar la relación violenta, buscar ayuda e intervenir en casos de VG. Seguidamente, se mencionan las principales limitaciones de la tesis doctoral, proponiendo futuras líneas de investigación que puedan subsanarlas o corregirlas, y que permitan avanzar en el estudio del complejo proceso de toma de decisión, teniendo en cuenta la información obtenida en este trabajo. Asimismo, se describen las implicaciones de esta tesis doctoral para la investigación, la práctica profesional

y la política social. Por último, se incluye un apartado de conclusiones que recoge las aportaciones más relevantes de la tesis doctoral.

Percepción de la gravedad de la VG y variables relacionadas

Como novedad, esta tesis doctoral profundizó en la percepción de gravedad de la VG y, para ello, se llevó a cabo una revisión exhaustiva de esta variable mediante el *Estudio 1* "Perception and Detection of Gender Violence, and Identification as Victims: A Bibliometric Study" y el *Estudio 2* "How Severity of Intimate Partner Violence is Perceived and Related to Attitudinal Variables? A Systematic Review and Meta-Analysis" que conforman este capítulo. Ambos estudios permitieron determinar la literatura disponible sobre la percepción de gravedad de la VG y variables relacionadas. Los hallazgos obtenidos fijan el punto de partida de futuras investigaciones y, en particular, han sido fundamentales para guiar los estudios de esta tesis doctoral.

Por un lado, en el *Estudio 1* se analizaron 974 documentos—la mayoría artículos originales— obtenidos en la base de datos Scopus y publicados entre 1984-2019. Se recogió información cuantitativa sobre el tipo de documentos, procedencia, producción anual, campo de estudio, contribuciones por año y revista, autorías más prolíficas, coautorías, instituciones donde se realizan las investigaciones, las palabras clave más frecuentes, la interacción por países y los 25 artículos más citados. De acuerdo con López y Osca-Lluch (2009), estos indicadores bibliométricos han permitido evaluar la producción científica y conocer tanto la historia como el presente de la investigación en el campo de la VG, concretamente en la percepción de gravedad e identificación como víctimas.

A modo general, los resultados son esperanzadores dado que reflejan un aumento de investigaciones sobre la temática en los últimos años, además de la implicación de un elevado número de países (n = 79), instituciones (n = 159) y profesionales (n = 2.758) en la producción científica del tema. Entre los artículos más citados destacan los que investigan acerca de las

percepciones y las actitudes hacia la VG por parte de diferentes actores (p.ej., víctimas, agresores, personal sanitario o estudiantes), y sobre la importancia de detectar la VG desde el ámbito sanitario.

Este estudio también puso en relieve la gran cantidad de nomenclaturas empleadas mundialmente para referirse a una misma problemática, la VG. Esto supone una desventaja considerable para el abordaje de esta ya que, la naturaleza de la VG, a diferencia de otro tipo de violencias como la doméstica o la familiar, parte de la desigualdad de género que da lugar al establecimiento de relaciones de poder del hombre sobre la mujer (Lorente et al., 2022). Asimismo, la VG supone un problema de salud pública y responsabilidad social reconocido mundialmente (OMS, 2022) y que, por tanto, debe ser denominado, identificado y abordado unilateralmente, teniendo en cuenta los aspectos diferenciales con otras violencias y garantizando la igualdad de oportunidades de ayuda a las mujeres independientemente del país en el que se encuentren.

La diversidad de nomenclaturas también podría afectar a los resultados de investigación, siendo recomendable fomentar la colaboración entre investigadoras e investigadores con la finalidad de debatir y consensuar el estudio de la VG y posteriormente, poder establecer comparaciones y avanzar hacia una misma dirección. En este sentido, los resultados del *Estudio 1* reflejaron una baja colaboración internacional, pudiendo afectar al impacto y visibilidad de las publicaciones científicas sobre la temática (Alonso-Arroyo et al., 2005) y, por tanto, a la lucha contra la VG. En definitiva, el análisis bibliométrico ha contribuido al conocimiento de la actividad científica referida a la percepción de gravedad de la VG e identificación de las mujeres como víctimas, analizando las tendencias actuales en esta área de estudio y estableciendo las bases para posteriores investigaciones.

Por otro lado, en el *Estudio 2* se sintetizó y analizó la información disponible sobre la percepción de gravedad de la VG, a la vez que se halló evidencia empírica respecto a la

influencia de otras variables (sexismo, roles tradicionales de género, culpar a la víctima, exonerar al agresor y aceptación de mitos de violación) en dicha percepción. Este estudio puso en manifiesto la limitada investigación disponible en esta línea. Específicamente, la revisión sistemática tan solo incluyó 27 estudios que evaluaban la percepción de gravedad de la VG en diferentes muestras como población general (*n* = 32.234; incluyendo 2.273 mujeres; 1.347 hombres; 5 transexuales; y 28.609 no indicado), adolescentes (*n* = 146), estudiantes (*n* = 1.427), víctimas de VG (*n* = 158), agresores (*n* = 129); inmigrantes (*n* = 350), policías (*n* = 143), psicólogos/as (*n* = 449), abogadas/os (*n* = 800), y personas mayores de 65 años (*n* = 110). A pesar de la variedad de la muestra, en el *Estudio 2* no se halló ninguna investigación que evaluase la percepción de gravedad de la VG por parte de los y las profesionales del ámbito sanitario. Este vacío de conocimiento fue cubierto mediante el *Estudio 8* de esta tesis doctoral dado que, estos y estas profesionales resultan cruciales para la posible detección y respuesta ante la VG (Heron y Eisma, 2020; Shearer et al., 2006) y, el hecho de no percibir la problemática como grave cuando se enfrentan a ella en consulta, dificulta un diagnóstico ajustado a la realidad en la que se encuentran las víctimas, ofreciendo en ocasiones tratamientos que solo enmascaran los síntomas pero no abordan la causa ni ofrecen la ayuda que las mujeres necesitan. De esta manera, la VG podría mantenerse invisibilizada, reconociendo un porcentaje de casos muy inferior al real, y demorando la atención a las mujeres víctimas (Ministerio de Sanidad, 2021).

Asimismo, en el meta-análisis únicamente pudieron ser incluidos 12 estudios. Los resultados mostraron una menor percepción de gravedad de la VG en hombres que en mujeres, así como una relación negativa entre la percepción de gravedad de la VG y las actitudes favorables hacia esta, como son, creencias sexistas, la asunción de roles de género tradicionales, la culpabilización de las víctimas, la exoneración del agresor o la aceptación de mitos de la violación. Estos hallazgos ponen en relieve la importancia de adoptar una

perspectiva feminista que rompa con el androcentrismo tradicional, mitigando los factores de riesgo socioculturales como son las actitudes y creencias patriarcales que explican la VG y crean un entorno de aceptación y tolerancia (Eguiluz et al., 2011; Expósito, 2022; Ferrer y Bosch, 2005; Ferrer et al., 2020). Como se ha probado en los **Capítulos 3** y **4** de esta tesis doctoral, todo ello puede minimizar la percepción de gravedad de la VG tanto en las víctimas como en los y las profesionales del ámbito sanitario que las atienden.

En resumen, con el *Estudio 1* y *2* de este capítulo se obtuvo información precisa acerca de la cantidad y contenido de la investigación disponible respecto a la percepción de gravedad de la VG. Los resultados evidencian la necesidad de continuar investigando en esta dirección pues, aunque la producción científica de artículos originales sobre la percepción de gravedad de la VG e identificación como víctimas parecería estar en aumento en los últimos años, los estudios que han profundizado en ello todavía son limitados (n = 27). En base a los hallazgos obtenidos en este capítulo, se orientaron los estudios empíricos posteriores incluidos en los **Capítulos 3** y **4**.

Variables implicadas en la decisión de dejar la relación o buscar ayuda en víctimas de VG

La socialización de las mujeres respecto a la importancia de mantener una relación de pareja complica el proceso de tomar la decisión de dejarla, adentrándolas fácilmente en relaciones de las que será muy difícil salir, como si de un laberinto patriarcal se tratase (Bosch et al., 2006; García-Jiménez et al., 2020; Jack, 1991). Cuando la relación implica VG, este proceso se complica todavía más, poniendo en riesgo el bienestar e integridad de las mujeres. Los factores socioculturales que se manifiestan mediante un clima de tolerancia y aceptación de la VG constituyen un riesgo para el mantenimiento en las relaciones violentas (Ferrer-Pérez et al., 2020; Gracia et al., 2020). En este sentido, será importante considerar la dificultad que encuentran las mujeres para tomar decisiones en el contexto de la pareja y abandonar de manera

precoz relaciones abusivas pues, el sistema patriarcal está diseñado para que se mantengan en relaciones de pareja como parte de su valía e identidad (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2011). En este capítulo se examinaron las variables implicadas en la decisión de dejar la relación o buscar ayuda en víctimas de VG (*objetivo específico 2*) mediante la realización de cuatro estudios con mujeres de población española. Los hallazgos obtenidos ofrecen información no explorada con anterioridad, que facilita la comprensión de los procesos mentales que se dan en las mujeres para tomar decisiones respecto a la VG, y que han dado lugar a nuevas preguntas de investigación.

En primer lugar, debido a la necesidad de disponer de un instrumento universal para detectar a mujeres que sufren VG en España, el *Estudio 3* adaptó, valido y mejoró la versión del instrumento de la OMS (2005) para detectar la VG. Para ello, se eliminaron preguntas dobles y ambiguas y se incluyeron respuestas de frecuencia, evitando la dicotomía. El instrumento mostró unas propiedades psicométricas adecuadas que, garantizan su uso en el contexto español. La versión española del instrumento de la OMS (2005) supone un avance para la identificación de la VG en España, pudiendo ser empleado en diferentes contextos (p.ej., investigación, sanidad y educación) y minimizando la infradetección de casos pues, sólo con en este estudio se halló una prevalencia del 79,7% en mujeres españolas que sufrían VG (35,7% en los últimos 12 meses). Estos datos ponen en relieve la importancia de tomar acción de manera proactiva para identificar casos de VG y no mirar hacia otro lado ya que, a pesar de los avances y esfuerzos sociopolíticos para erradicar la VG en España, las mujeres todavía están expuestas a la violencia y, el hecho de que no denuncien o verbalicen su situación, no significa que no la sufran. En los *Estudios 4, 5,* y *6* se exploraron algunas de las variables que pueden dificultar que las mujeres rompan con la relación violenta o busquen ayuda, sin perder de vista el contexto patriarcal en el que se encuentran como principal obstáculo.

En el *Estudio 4,* la dependencia emocional y el compromiso con la relación fueron variables clave para entender por qué las víctimas de VG tiene dificultades para dejar la relación. A pesar de que, en primera instancia, las víctimas de VG (en comparación con las que no informaron sufrir VG) referían utilizar la estrategia de *huida* en mayor medida, cuando se contemplaba el papel de la dependencia emocional y el compromiso con la relación de pareja, disminuía la probabilidad de utilizar esta estrategia. Del mismo modo, si bien el sexismo no tuvo un efecto moderador en esta relación, las mujeres que sufrían VG presentaban mayores niveles de sexismo benevolente, es decir, mostraban actitudes más favorables hacia la desigualdad de género, adoptando determinadas normas en la relación de pareja, a priori inofensivas, pero que justifican en cierto modo el poder del hombre frente a la mujer (Durán et al., 2014; Expósito y Herrera, 2009; Glick y Fiske, 1996; 2001; Juarros-Basterretxea et al., 2019). Pese a no haber encontrado el efecto esperado del sexismo benevolente en nuestros estudios, podemos afirmar que éste podría suponer un riesgo para continuar en la relación violenta debido a su contribución en la justificación de la violencia ampliamente constatada (Expósito et al., 2010; 2022).

En cuanto a la dependencia emocional y el compromiso con la relación, las víctimas de VG mostraran mayores niveles de dependencia emocional que las mujeres que no informaron de sufrir VG. Sin embargo, no se encontraron diferencias significativas entre los grupos de mujeres en el compromiso con la relación. Teniendo en cuenta el contexto sociocultural en el que se desarrollan las mujeres, cabría esperar que la mayoría de ellas se mostrasen comprometidas con establecer y mantener una relación de pareja ya que, se les enseña a orientar su vida en función de esos mandatos de género, dónde el compromiso con la relación es mayor que el compromiso consigo mismas (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2011). Del mismo modo, la dependencia emocional favorecería la tolerancia de la violencia y el perdón hacia la pareja agresora (Beltrán-Morillas et al., 2019; Rusbult y van Lange, 2003;

Tan et al., 2018; Valor-Segura et al., 2014), dificultando el uso de la estrategia *huida* como muestran los datos del *Estudio 4*.

Además, como una primera aproximación a la percepción del riesgo, en el *Estudio 4* también se exploró en qué medida las mujeres que informaron sufrir VG pensaban que esta violencia podría repetirse en el futuro. Los resultados obtenidos son cuanto menos preocupantes pues, el riesgo de reincidencia de violencia física y sexual sólo fue percibido entre el 3% y el 16% de las mujeres, respectivamente. De acuerdo con el ciclo de la violencia (Walker, 2009), las mujeres, erróneamente tienden a pensar que su pareja está arrepentida y que la violencia no volverá a repetirse, que se trata de algo puntual y justificado. Pero, la violencia siempre vuelve a aparecer, poniendo en riesgo la integridad de las mujeres. En cuanto a la violencia psicológica, parece que las víctimas percibían en mayor medida el riesgo de reincidencia por parte de su pareja actual que en las violencias física o sexual. En este sentido, las violencias más sutiles (p.ej., psicológica o conductas de control) son percibidas menos graves que otro tipo de violencias manifiestas (p.ej., física o sexual) (Novo et al., 2016; Yamawaki et al., 2009), pudiendo afectar del mismo modo a la percepción de riesgo de reincidencia. En este caso, a pesar de que la mayoría de las mujeres percibían el riesgo de volver a sufrir violencia psicológica en el futuro por parte de su pareja actual, parecería que existe cierto grado de tolerancia a este tipo de violencia que facilita que continúen expuestas a ella, con las consecuencias que ello conlleva.

Siguiendo el hilo del *Estudio 4*, en el *Estudio 5* se continuó explorando el papel de la dependencia emocional en la toma de decisión en mujeres. Concretamente, se testó un modelo conceptual para la violencia física, psicológica y sexual, con la finalidad de analizar los efectos mediadores de la gravedad percibida de la VG y valoración del riesgo para la vida, en la relación entre la dependencia emocional y la búsqueda de ayuda en mujeres que informaron sufrir VG. Aunque es sabido que la dependencia emocional juega un papel importante en el

mantenimiento en relaciones de VG (Rusbult y Langer, 2003; Tan et al., 2018; Valor-Segura et al., 2014), este estudio aporta resultados únicos con mujeres víctimas de VG, confirmando que mayores puntuaciones en dependencia emocional se relacionan con menor percepción de gravedad de la VG, menor valoración del riesgo para la vida y, en consecuencia, mayor dificultad para utilizar estrategias de búsqueda de ayuda. Este modelo conceptual se confirmó para los tres tipos de violencia evaluadas (física, psicológica, y sexual).

La dependencia emocional parte de un déficit afectivo que, en el caso de las mujeres, puede ser adquirido por la socialización de género, haciéndolas más vulnerables a ser víctimas de violencia por parte de los hombres. Ante situaciones de violencia, la dependencia emocional favorece la tendencia a evaluar más positivamente los comportamientos de la pareja con tal de no perder su estima y aceptación (González-Jiménez y Hernández-Romera, 2014) lo que, a su vez, puede ponerlas en riesgo. Los resultados del *Estudio 5* siguen la línea de investigaciones previas. Específicamente, Garrido-Macías et al. (2020a) hallaron que mayores niveles de dependencia en mujeres predecían menor percepción de gravedad de las transgresiones sexuales por parte de la pareja y, por tanto, menor probabilidad de dejar la relación. En este sentido, una percepción de la gravedad de la VG ajustada a la realidad será fundamental para que las mujeres tomen decisiones que las protejan de la VG.

Del mismo modo, una baja percepción de gravedad de la VG también disminuye la valoración del riesgo que las víctimas realizan de su situación y, en consecuencia, minimiza la probabilidad de buscar ayuda. En base a estos hallazgos, resulta fundamental continuar investigando la perspectiva de las víctimas ante la VG, ya que supone un factor de riesgo para la victimización sucesiva y futura (Spencer et al., 2019). Para ello, será conveniente considerar que, la exposición a la VG puede generar en las mujeres el *efecto de la luz de gas*, afectando a sus percepciones e interpretaciones de las situaciones violentas de la relación y suponiendo un obstáculo para dejarla (Spear, 2019; Sweet, 2019).

Por ello, el *Estudio 6* recogió las experiencias personales de un grupo de víctimas de VG con el fin de identificar los principales obstáculos que encontraron para romper con la relación violenta. En particular, la minimización de la gravedad de la situación, la valoración desajustada del riesgo de la VG para la vida, la justificación del agresor, la culpa, la vergüenza y el miedo, fueron los principales obstáculos que encontraron las víctimas para poner fin a la VG. De acuerdo con Heim et al. (2018), el procesamiento disfuncional de la situación puede ser crucial para la toma de decisión en el contexto de la pareja. Por tanto, a partir de los resultados obtenidos en la primera parte del *Estudio 6*, se evaluaron estos obstáculos de manera cuantitativa, comparándolos entre mujeres que informaron (vs. no) sufrir VG, a fin de identificar los efectos transformadores que conlleva la exposición a la violencia. Los resultados reflejaron que, las víctimas de VG, percibían menor gravedad de la VG, atribuían menos responsabilidad al agresor, y sentían más culpa y vergüenza que las mujeres que no informaron sufrir VG. Estas diferencias ponen en manifiesto la complejidad de la VG y cómo, la exposición a la misma genera en ellas una distorsión de la realidad como la derivada del *efecto de la luz de gas.* En este sentido, las víctimas de la VG podrían dudar de sus experiencias y sentirse impotentes para abandonar las relaciones violentas debido a la manipulación a la que estarían sometidas por parte de su pareja agresora (Dickson et al., 2022; Spear, 2019; Sweet, 2019).

El *efecto de luz de gas* tiene su origen en la desigualdad de género, lo que facilita al agresor la manipulación de la víctima, ya que, basa sus argumentos en la realidad social, haciendo uso de los estereotipos de género y las desigualdades estructurales e institucionales existentes (Sweet, 2019). En particular, en España, una parte de la población tiende a pensar que para abordar la VG se deben adoptar medidas para proteger la presunción de inocencia de los hombres y vigilar las denuncias falsas que, las mujeres, podrían interponer para obtener beneficios económicos y perjudicar a los hombres (Centro de Investigaciones Sociológicas, 2017; 2023). De este modo, las respuestas individuales de las mujeres podrían verse afectadas

por estas actitudes públicas permisivas y tolerantes hacia la VG (Gracia et al., 2020). Como resultado, el mantenimiento en la relación violenta pone a las mujeres en una situación de riesgo por todas las consecuencias que la VG conlleva para su salud física y mental (Campbell, 2002; Ellsberg et al., 2008; OMS, 2022; Sans y Sellarés, 2010; Sarasua el al., 2007; Wang, 2016). En este estudio, además, se muestra como las víctimas sienten culpa y vergüenza ante la VG, minimizan la gravedad de esta violencia y responsabilizan en menor medida al agresor por la situación. En este sentido, parecería que la exposición a la VG potenciaría los elementos dados previamente por la cultura patriarcal en la que, en cierto modo, la VG podría ser justificada en determinadas circunstancias para corregir conductas en las mujeres que rompen con el orden desigual establecido como normal (Lorente et al., 2022). La violencia que las mujeres sufren por parte de su pareja puede transformar su realidad, distorsionando sus interpretaciones y obstaculizando la toma de decisión de romper con la relación violenta (Daw et al., 2022). Por tanto, no hay un perfil determinado de mujeres que sufren VG, sino que la propia exposición a la violencia tiene un impacto en sus interpretaciones y emociones que las atrapa y les dificulta romper con ella.

En cuanto a las emociones, las víctimas de VG mostraron mayores sentimientos de culpa y vergüenza que las mujeres que no refirieron sufrir violencia por parte de su pareja o expareja. Estos resultados están en la línea de estudios previos (Cala et al., 2016; Escudero et al., 2005; Puente-Martínez et al., 2016) que señalan a ambas como emociones de riesgo para mantenerse en relaciones violentas. La culpa en las víctimas promueve pensamientos sobre que han hecho algo mal, exonerando las conductas negativas del agresor (Puente-Martínez et al., 2016; Smith et al., 2002). Igualmente, la vergüenza implica una autoevaluación negativa y está relacionada con la exposición pública (Smith et al., 2002). Es curioso que, tanto la culpa como la vergüenza implican, de un modo u otro, la interiorización por parte de las víctimas de que la VG es su responsabilidad. Esta valoración no surge de la nada, el androcentrismo social ha

invisibilizado a los agresores, considerándolos como hombres con comportamientos anormales, justificando la VG para tratar de explicar situaciones de difícil comprensión, atribuyendo a causas externas las conductas de los agresores (p.ej., alcohol) e internas a las víctimas (p.ej., conducta provocadora), y en definitiva, obviando la VG como un problema social (Centro de Investigaciones Sociológicas, 2012; 2013; Expósito, 2022; Herrera y Expósito, 2009; Lorente, 2007; 2022; Pagliaro et al., 2018). Tomar conciencia de que la VG involucra a toda la sociedad (Bosch-Fiol y Ferrer-Pérez, 2000; Expósito, 2022; Lorente, 2022) es esencial para promover el cambio en las bases que originan y mantienen la VG, evitando la ambigüedad y liberando a las víctimas de una carga de responsabilidad que no les corresponde.

Por el contrario, no se encontraron diferencias significativas en la percepción del riesgo para la vida y el miedo entre las mujeres que informaron sufrir (vs. no) VG. Respecto a la percepción del riesgo para la vida, explorar esta variable ha sido una de las principales aportaciones de esta tesis doctoral pues, hasta el momento, según nuestro conocimiento, ningún estudio había contemplado su influencia en la toma de decisiones de las mujeres. En el *Estudio 5* la valoración del riesgo para la vida se asociaba positivamente con la gravedad percibida de la VG y con la probabilidad de búsqueda de ayuda por parte de las víctimas. En el *Estudio 6*, la información obtenida en el grupo focal con víctimas de VG mostró que, cuando las mujeres estaban en la relación de violencia, no realizaban una valoración ajustada del riesgo que conlleva la VG para su vida, suponiendo un obstáculo para salir de la violencia. Sin embargo, no se hallaron diferencias en la percepción del riesgo para la vida de la VG según las mujeres informaran sufrir (vs. no) violencia por parte de su pareja o expareja. Esto apuntaría a que las mujeres en general (sean víctimas o no) tienen la capacidad de percibir el riesgo que la VG podría suponer para su vida. Sin embargo, a pesar de reconocer ese riesgo, las mujeres víctimas pueden no tomar medidas adecuadas para finalizar la relación de VG (Gondolf y Beeman, 2003) y quizá, como se ha visto en los estudios de esta tesis doctoral, esto se deba al peso que

tienen otras variables como la dependencia emocional, el compromiso con la relación, la distorsión cognitiva de la realidad (p.ej., minimización de la gravedad de la VG o de la atribución de responsabilidad al agresor), o las emociones de culpa y vergüenza en la toma de decisión de las víctimas.

Del mismo modo, independientemente de que las mujeres sufran o no VG, no se encontraron diferencias en los sentimientos de miedo ya que, posiblemente todas ellas compartan esta emoción por el mero hecho de ser mujeres. En este sentido, las mujeres mostrarían una conciencia del peligro que implica la violencia de los hombres (p.ej., daños físicos o mentales), requiriendo la construcción de una sociedad libre de violencias en la que las mujeres no necesiten estar en alerta constante por el miedo que les genera estar expuestas a diferentes violencias machistas (Brownhalls et al., 2020). Para ello, será necesario el compromiso tanto individual como colectivo de las instituciones públicas para generar una cultura de igualdad como alternativa a la misoginia (Bosch y Ferrer, 2000).

Como conclusión de este **Capítulo 3** "Víctimas de violencia de género", será importante tener en cuenta el papel de las diferentes variables exploradas en los *Estudios 4, 5,* y *6* para entender el proceso metal de las mujeres ante la toma de decisión en situaciones de VG. No se puede perder de vista los efectos transformadores que la exposición a la VG implica en la percepción de la realidad de las mujeres, así como la influencia del patriarcado en las respuestas individuales de las víctimas. Tener esto en mente, permitirá adoptar una visión más realista de las dificultades a las que se enfrentan las mujeres para romper con la relación de violencia, evitando crear juicios de valor y culpabilizar a las víctimas de una problemática social en la que la sociedad en su conjunto tiene la responsabilidad de tomar acciones encaminadas a evitar esta lacra.

Respuesta ante la VG desde el ámbito sanitario

La VG es un problema de salud pública y responsabilidad social que afecta a una de cada tres mujeres en el mundo (OMS, 2022). En España, la Ley Orgánica 1/2004, de Medidas de Protección Integral contra la Violencia de Género, ha supuesto un hito en lo que respecta a prevención, sanción y erradicación de la violencia contra las mujeres, así como a la protección y ayuda a las víctimas. A raíz de esta ley se han desarrollado protocolos nacionales y autonómicos para la atención de la VG desde sanidad pues, los y las profesionales de este ámbito son un recurso referente para que las víctimas de VG revelen su situación (Fernández, 2015; García-Moreno et al., 2014; Ruiz-Pérez et al., 2004). Por ello, el **Capítulo 4** de esta tesis doctoral tuvo como objetivo específico explorar las variables implicadas en la voluntad de intervención en casos de VG por parte de los y las profesionales del ámbito sanitario que las atienden, mediante el *Estudio 7* y el *Estudio 8.*

En el *Estudio 7* se abordaron dos objetivos. Por un lado, se sintetizó y analizó la información disponible en los protocolos españoles para atender la VG desde sanidad, comprobando su homogeneidad y si se ajustan a las directrices de la OMS (2013), cumpliendo la mayoría de ellos con estos criterios. El rango temporal de publicación de estos protocolos osciló entre 2003-2020 y, tan solo el 22,22% de ellos fueron publicados en los últimos cinco años. De hecho, algunos protocolos se publicaron antes de la Ley Orgánica 1/2004 o todavía incluyen el término de "violencia doméstica" en lugar de VG. Todo ello, denota la necesidad de actualizar dichos protocolos con la finalidad de ajustarlos a la realidad presente de la VG, teniendo en cuenta otras formas de ejercer y sufrir la violencia como son las nuevas tecnologías (Sánchez-Hernández et al., 2020).

Por otro lado, con la finalidad de comprobar si estas herramientas disponibles son puestas en práctica, se realizó un grupo focal con profesionales de atención primaria recabando información sobre su opinión acerca del rol que desempeñan ante la atención de casos de VG,

del uso y utilidad de los protocolos de atención a la VG desde el ámbito sanitario, de sus experiencias atendiendo casos de VG, y de los obstáculos y necesidades para ayudar a las víctimas de VG desde consulta. Los resultados mostraron que, a pesar de que la mayoría de los protocolos se ajustaban a las directrices de la OMS (2013), son insuficientes para abordar esta problemática, especialmente porque los y las profesionales de atención primaria desconocen su existencia o refieren falta de formación en VG y en el uso de los protocolos en consulta. Sin embargo, coincidiendo con estudios previos (Coll-Vinent et al., 2008; García-Díaz et al., 2020; OMS, 2022; Ruiz-Pérez et al., 2004), los y las profesionales de atención primaria son conscientes de la relevancia de su papel en la detección y respuesta ante casos de VG. En este sentido, será fundamental conectar a los y las profesionales del ámbito sanitario con las herramientas que tienen disponibles para atender la VG en consulta, estableciendo un procedimiento claro y accesible que les permita actuar de manera segura, evitando ambigüedades.

Para ello, ciertos aspectos deberían ser consensuados previamente. Por ejemplo, a partir del *Estudio 7*, se observó controversia respecto a la aplicación del cribado universal en consulta. Algunos protocolos recomiendan el cribado universal mientras que otros o no lo recomiendan o ni si quiera hacen referencia a este aspecto. Esta controversia procedimental también observada en estudios previos (Castañeda et al., 2020; Plazaola-Castaño, et al. 2008; Taft et al., 2013), se traduce en una confusión por parte de las y los profesionales de atención primaria, quienes no tienen claro cómo deben actuar. Es sorprendente cómo, ante un problema tan grave como es la VG, no existe un consenso total de actuación, y se considera como una opción la posibilidad de actuar pasivamente ante esta problemática, en lugar de responder activamente como se hace ante otros problemas de salud.

Además, las y los profesionales de atención primaria indicaron la falta de tiempo y de equipos multidisciplinares coordinados, los factores culturales y educativos, así como la

presencia de sentimientos como el miedo, la frustración o la impotencia, como algunos de los principales obstáculos que encuentran para atender la VG en consulta. Estos datos no son nuevos, sino que vienen manifestándose con anterioridad (Diéguez & Rodríguez, 2021; García-Quinto et al., 2021; Ministerio de Salud, Servicios Sociales e Igualdad, 2015), requiriendo el establecimiento de un nexo de unión entre las medidas implementadas para responder ante la VG desde el ámbito sanitario (p.ej., protocolos o cursos de formación) y el abordaje eficaz de cada uno de los obstáculos que los y las profesionales encuentran a la hora de atender la VG en consulta (p.ej., falta de tiempo o desconocimiento procedimental). De lo contrario, será como parchear el problema perdiendo de vista lo realmente importante, poner fin a la VG y brindar a las víctimas la ayuda que necesitan. Comprender el proceso psicológico en el que se encuentran las víctimas facilitará a los y las profesionales del ámbito sanitario el acompañamiento y ayuda, evitando que ello les ocasione malestar o incomodidad (p.ej., al no entender por qué no dejan la relación de violencia) y, en consecuencia, se realice una mala praxis ante esta problemática.

Mediante el *Estudio 7* de este capítulo, se constata la necesidad de generar un mayor nivel de responsabilidad, compromiso e implicación, tanto por parte del sistema sanitario, como en las decisiones políticas, pues se ha generado un marco de esperanza y confianza social de que se está respondiendo adecuadamente a la VG cuando realmente no es del todo así. Es necesario remar en una misma dirección y abordar los obstáculos que dificultan la puesta en marcha efectiva de medidas para erradicar la VG y atender adecuadamente a las víctimas.

Por último, en el *Estudio 7* los y las participantes también reconocieron los elementos culturales y educativos como algunos de los principales obstáculos para abordar la VG en consulta. Como hemos resaltado a lo largo de esta tesis doctoral, el papel del sexismo y las actitudes hacia la violencia no puede ser obviado ya que, podrían determinar la respuesta ante la misma (Harris et al., 2005; Martínez-Fernández et al., 2018; Waltermaurer, 2012). La

presencia de actitudes sexistas en los y las profesionales del ámbito sanitario disminuye la probabilidad de intervención en casos de VG (Noriega et al., 2020); más del 28% de los y las profesionales del ámbito sanitario justifican en cierto modo la VG, y más del 17% no rechazan totalmente la violencia sexual (Torrecilla et al., 2016). Asimismo, investigaciones previas con estudiantes del ámbito sanitario (Diéguez et al., 2020; García-Díaz et al., 2020) también mostraron actitudes de tolerancia hacia la VG. En base a la relevancia de las variables actitudinales en la toma de decisión ante situaciones de VG, el **Capítulo 4** de esta tesis doctoral concluyó con el *Estudio 8* que tuvo como objetivo testar un modelo conceptual, incluyendo el efecto mediador de la percepción de gravedad de la VG como una de las principales variables de interés en esta tesis.

Concretamente, en el *Estudio 8* se testó un modelo conceptual sobre el efecto mediador de la aceptación de la VG y la percepción de gravedad de la VG en la relación entre las actitudes sexistas y la voluntad de intervención en futuras y futuros profesionales del ámbito sanitario (estudiantes de medicina, psicología y enfermería). Los resultados fueron controlados por la formación en VG. Curiosamente, esta variable no tuvo influencia en el modelo por lo que, para entender la toma de decisión de las y los profesionales del ámbito sanitario ante la VG se debe prestar atención al papel que desempeñan las variables actitudinales, dirigiendo los esfuerzos a cambiar las bases culturales que sustentan la aprobación y tolerancia de la VG.

En particular, mayores actitudes sexistas se han relacionado con la aceptación de la VG y, ambas variables, con la minimización de su gravedad (Anderson y Bushman, 2002; Martín-Fernández et al., 2018; Sánchez-Hernández et al., 2020; Yamawaki et al., 2009). A partir del *Estudio 8,* se confirma la literatura previa, añadiendo como novedad los efectos de estas variables en la voluntad de intervención ante casos de VG. Asimismo, este estudio aporta resultados sobre la percepción de la gravedad de la VG por parte de futuros y futuras profesionales del ámbito sanitario (medicina, psicología y enfermería) que, desde nuestro

conocimiento, nunca habían sido explorados. Contar con dicha información es esencial dado que, el grado en el que se perciba la magnitud de la amenaza, en este caso la VG, se podrá predecir la respuesta ante la misma (Kuijpers et al., 2021; Riddle y Di, 2020; Witte, 1994) pues, de acuerdo con estudios previos (Gracia et al., 2008; 2009; León et al., 2022; Sylaska y Walter, 2014), cuanto más grave se perciba la VG, más probable será que se intervenga ante ella.

En esta línea, contrario a lo referido en la literatura previa (Diéguez et al., 2020; García-Díaz et al., 2020; Torrecilla et al., 2015), en el *Estudio 8* los y las participantes mostraron bajas puntuaciones en sexismo y aceptación de la VG, así como una alta percepción de la gravedad que supone la VG. Estos resultados resultan prometedores ya que, cuanto menor sea la tolerancia hacia la VG por parte de las personas que se están formando para ser profesionales del ámbito sanitario, mayor será la probabilidad de que respondan eficazmente ante esta problemática en el futuro. Asimismo, estos y estas profesionales deberían adoptar respuestas proactivas ante la VG. Sin embargo, los resultados obtenidos en el *Estudio 8* reflejan puntuaciones medias en la voluntad de intervención ante situaciones de VG por parte de las y los participantes. Esta respuesta ante la VG no es suficiente y menos cuando, en un futuro, estos y estas participantes en formación se enfrenten a casos reales de VG en consulta. En este sentido, se requiere una mayor concienciación acerca de la problemática en la que no haya espacio para las dudas pues, para las víctimas de VG, percibir apoyo disminuye la probabilidad de victimización (Parker et al., 2020). Por tanto, como futuros y futuras profesionales del ámbito sanitario, al igual que en cualquier problema de salud pública, su papel ante la detección e intervención en casos de VG debe ser claro, rotundo y libre de ideologías sexistas (OMS, 2022).

Valoración global

En general, a partir de los resultados obtenidos en los estudios empíricos, cabe destacar la incongruencia entre la gravedad que implica la VG como problema social y de salud y la respuesta ante la misma. Como se ha indicado a lo largo de esta tesis doctoral, la VG supone un riesgo para la salud y la vida de las víctimas, pues tienen un 40% más de riesgo de muerte que las mujeres que no están expuestas a esta violencia y, en España, son asesinadas una media de 60 mujeres al año por parte de su pareja o expareja (Chandan et al., 2020; Ministerio de Igualdad, 2023). Además, los costes económicos que conlleva esta problemática ascienden a más de 30.000 millones de euros en España (Instituto Europeo para la Igualdad de Género, 2021). Sin embargo, la respuesta ante la VG todavía es insuficiente.

A pesar de que España es un país de referencia para el alcance de la igualdad entre hombres y mujeres, así como en la adopción de medidas para la erradicación de la VG mediante la Ley 1/2004, tan solo el 2,7% de la población considera la VG entre los principales problemas y se ha observado un aumento en la negación de la existencia de la VG, especialmente entre las y los más jóvenes pues, entorno al 20-30% argumenta que se trata de una invención ideológica (Centro de Investigaciones Sociológicas, 2023; Ministerio de Igualdad, 2019; Rodríguez et al., 2021). Este negacionismo se ha extendido llegando incluso a las instituciones españolas donde, parte de la población pretende eliminar el término de VG equiparándolo a la violencia en el contexto familiar. Asimismo, al igual que ocurre en otros países, algunos protocolos para la atención de la VG desde el ámbito sanitario continúan utilizando el término violencia doméstica para aludir a la VG. El uso de diferentes nomenclaturas para referirse a una misma problemática dificulta la identificación clara de la VG, generando confusión respecto al tipo de violencia a la que se enfrenta la sociedad e invisibilizando los elementos socioculturales que la determinan (Lorente et al., 2022).

Todo ello se ve reflejado en la respuesta de las víctimas y de los y las profesionales del ámbito sanitario ante la VG pues, en España, el 77,4% de víctimas nunca denunció a su agresor entre otros motivos, porque no consideraban la VG suficientemente grave (Ministerio de Igualdad, 2020) y, tan solo el 7,8% de las denuncias provienen de partes de lesiones por parte de los y las profesionales del ámbito sanitario (Consejo General del Poder Judicial, 2023). En esta línea, según las respuestas de las y los participantes de los estudios empíricos de esta tesis, parecería que se percibe la gravedad y el riesgo que implica la VG (*Estudios 2, 4, 5,* y *8*). Sin embargo, las respuestas de búsqueda de ayuda por parte de las víctimas, así como la voluntad de intervención ante casos de VG por parte de los y las profesionales del ámbito sanitario no son rotundas, hallando puntuaciones medias que podrían indicar cierta pasividad ante la VG debido a la valoración de las consecuencias que conllevarían sus decisiones.

En particular, mediante la información recabada en los grupos focales con víctimas y profesionales del ámbito sanitario (*Estudios 6* y *7*), se pudo concretar información en esta línea. Las víctimas referían que, cuando estaban atrapadas en la VG, encontraban una serie de obstáculos para romper con la VG como es el miedo a las consecuencias de enfrentar al agresor o poner fin a la violencia. En esos casos, aunque las mujeres pudieran percibir la gravedad de la situación en la que se encontraban, valoraban más arriesgada la toma de decisión encaminada a buscar ayuda o dejar la relación violenta. Igualmente, las consecuencias de la VG se ven reflejadas en la decisión de intervención de las y los profesionales del ámbito sanitario ante situaciones de VG, refiriendo que, en ocasiones, no actúan por miedo a empeorar la situación o buscarse problemas. En este sentido, para favorecer la adopción de actitudes proactivas ante la VG y la toma de decisiones encaminadas a poner fin a dicha violencia, será necesario ofrecer seguridad a la sociedad mediante el apoyo institucional, evitando que se valore como más arriesgada la toma de decisiones para combatir activamente la VG frente a la pasividad y tolerancia de esta. Para ello, los caminos de actuación deben ser claros y no generar confusión

pues, como se observa en los protocolos para la actuación ante la VG desde el ámbito sanitario, todavía existe controversia en cuanto a la aplicación del cribado universal para la detección de la VG desde el ámbito sanitario. Esta falta de consenso institucional se manifiesta en la respuesta de estas y estos profesionales, dificultando la erradicación de la VG.

En resumen, parecería que se aparta la mirada de la VG como problema social y estructural, situándola en lo particular y contextual. La VG agravaría o potenciaría los elementos de desigualdad ya existentes previamente por la construcción cultural que explica la VG como normal o excepcional, según las circunstancias particulares de cada caso. De este modo, la normalización de la VG y la falta de implicación podrían explicarse por argumentaos dados previamente por la cultura. En este sentido, cabría cuestionarse si la cultura patriarcal que sustenta las bases de la VG podría tener un efecto de luz de gas en los y las profesionales del ámbito sanitario, distorsionando la percepción de la realidad respecto a la VG y dificultando la toma de decisiones dirigidas a combatir esta problemática (Daw et al., 2022).

Limitaciones y futuras líneas de investigación

Esta tesis doctoral aporta datos novedosos y contribuye al avance científico respecto a la toma de decisión ante la VG por parte de las víctimas y de los y las profesionales del ámbito sanitario que las atienden. La evidencia empírica hallada da lugar a nuevas preguntas de investigación, requiriendo continuar trabajando e indagando en esta línea. Pese a ello, esta tesis doctoral no está exenta de ciertas limitaciones que deberían ser consideradas para futuras investigaciones.

En primer lugar, en el *Estudio 1*, el uso de la base de datos Scopus fue justificado para realizar el análisis bibliométrico (Bosman et al., 2006; Valderrama-Zurián et al., 2015), pero no se contempló la literatura gris o los documentos recogidos en otras bases reconocidas como Web of Science. En este sentido, aunque el objetivo del estudio fue obtener una visión general de la investigación sobre la percepción de gravedad de la VG e identificación como víctimas,

futuras investigaciones se beneficiarían de la inclusión de más bases de datos para realizar el análisis bibliométrico.

En segundo lugar, algunos de los instrumentos utilizados en esta tesis podrían suponer una limitación para la generalización de los resultados. Concretamente, en el *Estudio 3* se adaptó y validó en muestra española el instrumento para la detección de la VG de la OMS (2005), mejorando su aplicabilidad y eliminando respuestas dicotómicas y dobles preguntas. Aunque el instrumento mostró adecuadas propiedades psicométricas, la mayoría de las participantes eran menores de 30 años e indicaron un nivel educativo alto, requiriendo que, futuras investigaciones mejoren la aplicabilidad del instrumento teniendo en cuenta diferentes variables sociodemográficas. Asimismo, para la realización de los *Estudios 4, 5* y *6* no pudimos utilizar este instrumento ya que, todavía no estaba garantizada su aplicabilidad. En su caso, se tradujeron los ítems del instrumento de la OMS (2005) al español siguiendo el método de retro traducción (Cha et al.., 2007). Se aplicó el mismo procedimiento con el cuestionario "Perceived Relationships Quality Components (Fletcher et al., 2000) y la subescala del cuestionario "Seeking Social Support Subscale of the Ways of Coping Questionnaire" (Menssink, 2017), cuyas versiones en español no están disponibles. Será recomendable que futuras investigaciones adapten estos instrumentos al contexto español actual, presentando evidencias de fiabilidad y validez que avalen su uso.

En tercer lugar, para llevar a cabo los diferentes estudios se realizó un muestreo no probabilístico, requiriendo prudencia en la generalización de los resultados a toda la población. Concretamente, para los *Estudios 3, 4, 5* y *6* que se realizaron con mujeres en el contexto español, excepto las víctimas de VG del grupo focal, el resto de las participantes se reclutaron a través de las redes sociales (Facebook, Instagram o WhatsApp) o el correo institucional, cumplimentando las encuestas de manera online, lo que resultó en que, la mayoría de las muestras presentaban rangos de edad media entre 25-30 años y niveles educativos altos. En

este sentido, la brecha digital podría haber limitado la representatividad de la muestra dada la dificultad de algunas mujeres para acceder a Internet y a las Tecnologías de la Información y Comunicación. En cuanto a los grupos focales, únicamente se pudo entrevistar a un grupo de mujeres víctimas de VG y un grupo de profesionales de atención primaria debido a que, se trata de muestras muy específicas y de difícil acceso. No obstante, de acuerdo con la literatura previa (Fernández et al., 2022; Myers, 1998; Nyumba et al., 2018) un grupo focal fue suficiente para llevar a cabo los estudios. Además, la información recabada con los grupos focales se completó con otros análisis que permitieron ofrecer datos relevantes en ambos casos.

En cuarto lugar, la naturaleza correlacional de la mayoría de los estudios incluidos en esta tesis doctoral, no permiten determinar causalidad. Por ello, aunque los resultados obtenidos sugieren la dirección en la que se relacionan las variables estudiadas con la toma de decisión en mujeres y profesionales del ámbito sanitario, se necesitan diseños más robustos que permitan obtener relaciones causales.

Por último, cabe mencionar que en esta tesis doctoral se ha investigado la toma de decisión en víctimas y profesionales del ámbito sanitario teniendo en cuenta su intención de conducta, pero no la conducta real. En esta línea, sería interesante que futuras investigaciones diseñaran otro tipo de estudios que permitieran recabar información sobre la toma de decisión en contextos reales o de laboratorio, así como estudios longitudinales. Para ello, en futuros estudios con víctimas de VG, además de las variables exploradas en esta tesis doctoral, sería interesante explorar otros errores atribucionales (p.ej., esperanza al cambio o autoengaño) que las víctimas podrían realizar para evitar las disonancias cognitivas que les provocaría la VG y que influirían en la toma de decisión respecto a la relación ya que, el ciclo de la violencia produciría periodos de arrepentimiento por parte del agresor que confundirían a las mujeres y contribuirían a mantener estos errores atribucionales o distorsiones cognitivas (Echeburúa et al., 2002; Gilbert y Gordon, 2017; Heim et al., 2018; Nicholson y Lutz, 2017; Walker, 2012).

Por tanto, se deberá considerar la toma de decisión de las mujeres teniendo en cuenta que quizá deseen que la violencia finalice, pero no la relación de pareja por todo lo que conlleva para ellas.

Implicaciones para la investigación, la práctica y la política

Esta tesis doctoral presenta importantes implicaciones para la investigación, la práctica profesional y la política social, contribuyendo al avance en la comprensión de la complejidad que supone el proceso de toma de decisión para combatir la VG por parte de diferentes actores. Mediante los resultados obtenidos en la tesis doctoral, se favorece el progreso científico y se fija un punto de partida para continuar avanzando en el diseño de investigaciones e implantación de medidas que ayuden a erradicar la VG.

Como puntos fuertes de esta tesis doctoral se destaca el uso de una metodología mixta en la que se combinan análisis cualitativos y cuantitativos, permitiendo profundizar en mayor medida en la comprensión y corroboración de los resultados obtenidos y compensando las debilidades inherentes que supone el uso de cada enfoque de manera independiente. Del mismo modo, se ha obtenido información directa de muestras específicas de la población como son mujeres víctimas de VG y profesionales del ámbito sanitario, enriqueciendo enormemente los resultados. Con todo ello, se han testado diferentes modelos conceptuales que arrojan claridad a la complejidad que supone la VG, destacando el papel y la relación entre diferentes variables como son la dependencia emocional, el compromiso con la relación, las actitudes, las percepciones y las valoraciones sobre la toma de decisión de dejar la relación, buscar ayuda o la voluntad de intervención en casos de VG. Estos resultados, aunque se encuentran en la línea de investigaciones previas, van más allá de lo explorado anteriormente, mostrando la percepción de gravedad de la VG y la valoración del riesgo para la vida como variables de interés para seguir explorando dada su relevancia en la toma de decisión en situaciones de VG. Todo ello, permite avanzar en el conocimiento de este fenómeno y da lugar a nuevas incógnitas

que responder en futuras investigaciones contemplando la influencia de otras variables relevantes como pueden ser las distorsiones cognitivas (Echeburúa et al., 2002; Gilbert y Gordon, 2017; Heim et al., 2018; Nicholson y Lutz, 2017; Walker, 2012).

Además, en esta tesis doctoral se tuvo en cuenta la valoración del riesgo para la vida por parte de las mujeres como una variable que facilitaría la búsqueda de ayuda. Sin embargo, cuando la mujer se plantea la ruptura de la relación violenta o denunciar su situación y, el agresor percibe que pierde el control sobre ella, el riesgo de ser asesinada aumenta lo que, podría llevar a la mujer a mantenerse en la relación por miedo a las consecuencias letales para ella o para sus hijos e hijas (Dobash el al., 2007; 2011; Liem et al., 2009; Lorente et al., 2022; Ministerio de Igualdad, 2020). De esta manera, aunque las mujeres perciban el riesgo en el que se encuentran, podrían valorar la decisión de dejar la relación como un aumento del riesgo para su vida en lugar de una protección para ellas o sus hijas e hijos. En este sentido, resulta de interés para futuras investigaciones continuar explorando la valoración del riesgo que realizan las víctimas de su situación, teniendo en cuenta su papel ante la toma de acciones (p.ej., búsqueda de ayuda) encaminadas a romper con la relación violenta. Además de la valoración del riesgo, resulta relevante tener en cuenta el miedo que ciertas situaciones de VG generan en las mujeres y su posible influencia en el proceso de toma de decisión. En el contexto español, se ha constatado que el 14,4% de las mujeres han experimentado miedo hacia su pareja actual o pasada, llegando en ocasiones a someterse a situaciones de violencia por miedo a enfrentar consecuencias más graves al contradecir al agresor (Ministerio de Igualdad, 2020).

A pesar de la relevancia de la valoración del riesgo para la vida que realizan las víctimas para su toma de decisión, no se encontró ningún instrumento adecuado para medir esta variable. Por ello, se incluyó un ítem ad hoc para evaluarla. En este sentido, aunque sería interesante que futuras investigaciones se implicaran en el desarrollo de un instrumento adecuado para valorar la percepción del riesgo para la vida que realizan las mujeres teniendo en cuenta la VG en todas

sus formas (violencia física, psicológica, sexual, y conductas de control), el uso de un único ítem ad hoc es una alternativa válida y fiable para medir un constructo (Allen et al., 2022). Del mismo modo, aunque en España se cuenta con la escala "Percepción de gravedad de la VG" (Gracia et al., 2009a), dados los objetivos de los diferentes estudios sólo pudimos emplearla en el estudio 8. En los estudios 4, 5 y 6 que se realizaron con víctimas, la finalidad fue conocer su percepción de gravedad respecto a los ítems específicos de VG reconocidos por la OMS (2005), diferenciando en algunos casos como en el estudio 5, en función del tipo de VG (física, psicológica y sexual). Esa información tuvo que ser recabada mediante un ítem ad hoc que había sido empleado en otras publicaciones previas para evaluar la percepción de gravedad (Garrido-Macías et al., 2017; Sánchez-Hernández et al., 2020).

En cuanto a las implicaciones prácticas de esta tesis doctoral, aunque es cierto que en España se han realizado cambios sociales y legislativos para combatir la VG (Ferrer et al., 2019), la cantidad de mujeres que todavía sufren violencia por parte de sus parejas o exparejas es cuanto menos sorprendente. Concretamente, en el *Estudio 3,* el 79,7% de mujeres informaron sufrir VG (física, sexual, psicológica o conductas de control) por parte de su pareja o expareja. En este sentido, de acuerdo con los datos obtenidos en la última macroencuesta realizada en España (Ministerio de Igualdad, 2020), aunque la mayoría de las mujeres son reticentes a denunciar (sólo el 21,7% de ellas lo hizo), pueden utilizar otras formas de buscar ayuda a través de centros sanitarios (10,4%) o de su entorno (77,2%). Por tanto, el papel de la sociedad en la respuesta a las víctimas es fundamental pues, si se sienten apoyadas disminuye el riesgo de victimización (Ministerio de Igualdad, 2020; OMS, 2022; Parker et al., 2020; Yamawaki et al., 2012). Resulta imprescindible focalizar los esfuerzos en crear una sociedad consciente de la realidad, que sea capaz de percibir la gravedad que supone la VG y actuar en consecuencia. Para ello, la educación en igualdad desde edades tempranas, las campañas de sensibilización sobre la VG, así como la implantación de formaciones específicas a los y las

profesionales del ámbito sanitario, será necesario para visibilizar la VG y trabajar en conjunto para erradicarla.

En cuanto a las implicaciones políticas, a pesar de que existe una norma social de rechazo y condena de la discriminación y violencia hacia las mujeres, todavía sigue presente un clima de desigualdad social (Expósito, 2022; Ferrer et al., 2019). De hecho, en España se han consolidado partidos políticos que representan a un sector de la población y que niegan la existencia de la VG con todas las implicaciones que ello conlleva pues, pretenden borrar el origen de una realidad de violencia que sufren las mujeres por parte de los hombres y, por tanto, no abordar la problemática adecuadamente. En este escenario, es necesario evitar las polarizaciones sociales que entienden la VG como un ataque a los hombres y pierden de vista la VG como un problema que requiere modificar las circunstancias culturales de desigualdad por el conjunto de la sociedad y no sólo por la principal parte afectada, las mujeres (Lorente, 2022).

Por último, la VG debería abordarse desde el ámbito sanitario sin cuestionar la realidad de las mujeres, como se haría con cualquier otro problema de salud (p.ej., cáncer), sin que la ideología de los y las profesionales del ámbito sanitario interfiera en su respuesta de atención a las víctimas. Para ello, se precisa de un compromiso institucional donde la igualdad de género sea la principal vacuna contra esta problemática.

Conclusions

IPVAW has devastating consequences for society as a whole and for women's physical and psychological health, requiring a proactive response to combat this problem. In this doctoral thesis, the main objective was to deepen the understanding of the decision-making process regarding help-seeking or help-seeking responses in IPVAW cases by various actors. In turn, this objective was divided into three specific objectives: 1) to know the literature in relation to the perception of IPVAW's severity and related variables; 2) to examine the variables involved in the decision to leave the relationship or seek help in IPVAW victims; and 3) to explore the variables involved in the willingness of health care professionals to intervene in IPVAW cases.

Throughout the empirical studies included in this doctoral thesis, we gained the following findings.

Perception of IPVAW severity and related variables

- Regarding the available scientific activity on the perception and detection of IPVAW, as well as in its identification, victims obtained in the Scopus database showed an increase in production in recent years, highlighting the publication of original articles. Likewise, the single authorship per country predominates, being that the United States is the leading country. The main objectives of the most cited documents are detection of IPVAW by health care professionals, assessment of the risk of recidivism through the perception of the victims, and the study of various actors' perceptions and attitudes toward IPVAW.
- A total of 27 studies were included in the systematic review and 12 in the meta-analysis about the perception of IPVAW's severity and related variables. The results showed that men perceived IPVAW as less severe than women. Likewise, a negative relationship was found between perceived IPVAW severity and favorable attitudes

toward IPVAW such as sexist views, victim blaming, excusing the perpetrator, rape myths acceptance, and traditional gender roles.

Variables involved in the decision to leave the relationship or seek help in IPVAW victims

- The validation and adaptation of the World Health Organization's Violence Against Women Instrument in the Spanish population showed an adequate internal consistency through confirmatory factorial analysis for physical (α = .92), psychological (α = .91), sexual (α = .86), and control behaviors subscales (α = .91) as well as for the total scale (α = .95), justifying its use in Spain. This instrument will facilitate the detection of IPVAW in the Spanish context and comparisons between countries.
- Higher scores in dependency and commitment predicted less use of exit strategies among women who reported IPVAW. No significant results were found regarding loyalty strategy and benevolent sexism.
- Higher scores in dependency were related to the lower perceived severity of IPVAW, lower assessed levels of risk for life, and, thus, the elevated difficulty in engaging in help seeking in all types of violence (physical, psychological, and sexual).
- A focus group of IPVAW victims revealed perceptions (e.g., minimization of the situation), interpretations (e.g., justifying the aggressor), and feelings (e.g., guilt) as the main obstacles in leaving the violent relationship.
- Women who suffered IPVAW obtained lower scores in perceived severity, attribution of responsibility of the aggressor, and higher scores in feelings of embarrassment and guilt than women who had not suffered IPVAW. No significant differences were found in the risk assessed and the feelings of fear among women's group.

Health care response to IPVAW

- Protocols to attend IPVAW from healthcare centers in Spain are insufficient to adequately respond to the problem, requiring a greater commitment of the health system. Policy decisions under this strategy create a framework of hope and social confidence that the problem is being adequately responded to when it is not.
- Primary care physicians reported obstacles to attend IPVAW in consultation such as lack of time and training in IPVAW, feelings of fear, frustration, and impotence, as well as cultural, educational, and political factors.
- Low sexism and acceptance of IPVAW, high perceived severity, and moderate willingness to intervene in cases of IPVAW were found in a sample of future health care professionals (students of medicine, psychology, and nursing).
- A conceptual model was tested showing that more sexist attitudes were related to more acceptance of IPVAW, decreased perceived severity of IPVAW, and, consequently, the willingness to intervene in cases of IPVAW.

In short, combating IPVAW requires a social environment that favors help for victims, free of value judgments, in which women can be and feel safe to break with the violent relationship. To this end, it is necessary to continue working and researching on the problem, implementing appropriate and truly effective measures to promote help among victims, and the professionals who care for them. Otherwise, we will all be responsible for contributing to the maintenance of IPVAW, with all the consequences that this entails.

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Para las mujeres

"Imagina que vas paseando por la arena de la playa. Hace un sol radiante, la temperatura es agradable y se respira paz y tranquilidad. Estás ilusionada por disfrutar de ese lugar idílico para ti. Otras personas pasean a tu alrededor, parecen despreocupadas e incluso comentáis lo agradable que es el lugar. Todo parece ideal, así que decides adentrarte un poco más, acercándote a la orilla. Te encuentras a otras personas, corriendo en dirección contraria. No entiendes cómo pueden irse, si es un entorno muy agradable. Entonces, llegas más adentro, y decides sentarte a disfrutar. Parece que todo va bien, estás tranquila y no hay nadie a tu alrededor que perturbe tu bienestar. Cuando va pasando un tiempo, comienzas a sentir un poco de frío, la humedad cala en tus huesos, pero piensas, "no es nada, el sol todavía calienta". Cuando el sol se pone, ya no aguantas más el frío en tu cuerpo y decides levantarte, sin embargo, no puedes hacerlo. No entiendes qué te está pasando, empiezas a arrastrarte por la arena intentando ponerte en pie y luchas con todas tus fuerzas para poder avanzar. No puedes, con cada intento de salir, la arena te está atrapando cada vez más y te impide volver a casa. A pesar de todos tus esfuerzos por escapar, sigues hundiéndote cada vez más hasta que, te das cuenta de estás atrapada en arenas movedizas. Empiezas a ser consciente de que la arena por la que caminabas no era segura como parecía y que estás en peligro mortal, ya sea porque las arenas movedizas terminen hundiéndote o bien porque te mantengas tanto tiempo en ellas que no puedas sobrevivir. Si la arena es húmeda, controlas la respiración y adoptas una posición adecuada que te permite arrastrarte lentamente hasta salir de las arenas movedizas. Por el contrario, si la arena ya está seca, necesitas la ayuda de otras personas. Entonces gritas fuertemente y, aunque parece que no hay nadie alrededor, tus gritos pueden oírse a lo lejos pues, las personas de la zona son conscientes de los peligros que alberga en esta playa y, aunque los carteles para advertir del peligro no estaban suficientemente visibles para ti, corren a socorrerte con éxito. Cuando has logrado salir de las arenas movedizas, encuentras un cartel en el suelo, desgastado por el paso del tiempo, que incluye la advertencia de peligro. Te dices a ti misma que jamás volverás a pasar por ninguna playa, pero, recuerda, no todas las playas entrañan los peligros de las arenas movedizas, algunas playas son seguras y deberemos aprender a distinguirlas".

Las relaciones de VG son como esas arenas movedizas. Cuando se inicia una relación de pareja, lo último que esperamos es quedar atrapadas por la violencia ya que, lo que observamos es una persona que dice amarnos. Al igual que el paseo agradable en la playa, iniciamos las relaciones de pareja con la ilusión de establecer un vínculo seguro que favorezca nuestro bienestar. Cuando aparecen las incomodidades, no les damos la importancia que requieren, quizá por lo que significa para nosotras tener una relación de pareja o quizá porque no podemos llegar a entender cómo la persona que dice amarnos puede ser capaz de dañarnos intencionadamente. Sea como fuese, es en esas incomodidades donde tenemos que prestar atención y ser capaces de ver más allá, diferenciando entre lo que nos gustaría que fuera (expectativa) o fue en su momento (recuerdos), y lo que es (realidad). Ser conscientes de los peligros que entraña la VG, desde sus manifestaciones más sutiles a las más manifiestas, nos ayudará a no tolerar ningún tipo de violencia y no gastar energías en una batalla perdida. Es decir, forcejear y luchar contra las arenas movedizas sólo facilita el hundimiento. De la misma manera, esforzarnos en que el agresor cambie, normalizar la violencia, autoengañarnos, pensar que la violencia cesará y dirigir nuestra energía a alcanzar la relación que deseamos, sólo nos atrapará más en la VG, mermando nuestra salud y poniéndonos en peligro. En lugar de ello, apoyarnos en el entorno puede ayudarnos a romper con la violencia y escapar de las arenas movedizas que nos atrapan. Aunque pensemos que estamos solas y que nadie entenderá nuestras decisiones, no es así. Disponemos de recursos especializados para ayudarnos a encontrar la salida más fácilmente pues, como en las arenas movedizas cuando no podemos salir por nosotras mismas, la ayuda externa podría determinar el resultado de nuestra historia. Asimismo, cuanto más tiempo estemos expuestas a la VG más difícil será salir de ella debido a que nuestras interpretaciones, percepciones y valoraciones de la situación estarán distorsionadas, no veremos con claridad y tendremos

sentimientos desagradables hacia nosotras mismas, como la culpa o la vergüenza. Por tanto, no te desgastes en una relación de VG y, en lugar de luchar por conseguir que el agresor o vuestra relación cambie, dirige todos tus esfuerzos y energías para salir de esas arenas movedizas que te atrapan porque…

NO, el agresor no sabe amar.

NO, el agresor no cambiará con el tiempo.

NO, lo que hace el agresor no tiene justificación.

NO, no hay compromiso con la violencia.

NO, no necesitas al agresor.

NO, el agresor no es mejor que tú.

NO, no es culpa tuya.

NO, no estás sola.

NO, no se merece tu amor.

NO, no es normal lo que hace.

NO, no estarás peor sin él.

NO, no lo silencies.

SÍ, esto te puede estar pasando a ti.

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Recursos para la violencia de género en España

Resources for intimate partner violence against women in Spain

Ministerio de Igualdad, Gobierno de España

https://violenciagenero.igualdad.gob.es

La web del Ministerio de Igualdad de España contiene información para la atención de la violencia de género (entendida como malos tratos en la pareja, de acuerdo con el artículo 1 de la LO1/2004, de 28 de diciembre de Medidas de Protección Integral contra la Violencia de género), así como sobre otras formas de violencia contra la mujer, como la trata de mujeres y niñas con fines de explotación sexual o la mutilación genital femenina. Ofrece un servicio anónimo, confidencial y gratuito que está disponible 24 horas, 365 días y al que se puede acceder mediante:

- Atención telefónica: **016**
    - En caso de discapacidad auditiva el teléfono es **900 116 016**
- Email: **016-online@igualdad.gob.es**
- WhatsApp: **600 000 016**
- WhatsApp de asistencia psicológica inmediata: **682 916 136** y **682 508 507**

Tanto la web como el teléfono 016, no dejan rastro en el historial del ordenador ni en la factura telefónica. Son completamente seguros para las mujeres.

También se puede recibir atención inmediata a través de los siguientes recursos:

- Emergencias: **112**
- Policía Nacional: **091**
- Guardia Civil: **062**
- Aplicación ALERTCOPS: https://alertcops.ses.mir.es/publico/alertcops/
- Comunidades Autónomas: https://violenciagenero.igualdad.gob.es/enlaces/comunidades/home.htm