

La estabilidad emocional y su relación con el daño psíquico en mujeres españolas víctimas de violencia de género

Emotional stability and its relationship with the psychic damage among spanish victims of gender violence

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Resumen

Introducción: La violencia contra la mujer constituye un problema de salud pública y se ha convertido en una de las principales causas de problemas de salud en las víctimas que la sufren. Se conoce poco sobre los factores de vulnerabilidad ante estas experiencias.

El **objetivo** de este estudio es analizar la estabilidad/inestabilidad emocional como factor clave en la capacidad de afrontar una situación de violencia de género y sus consecuencias sobre la salud física y psíquica de las víctimas.

Métodos: Se trata de un estudio trasversal realizado sobre una muestra de 151 mujeres españolas. Las mujeres fueron evaluadas mediante el Cuestionario de Salud General de Goldberg y el Inventario de Personalidad 16PF de Cattell.

Resultados: Encontramos una relación significativa entre la estabilidad emocional y la puntuación total del Goldberg y sus cuatro subescalas de síntomas somáticos, ansiedad, adaptación socio-laboral y depresión ($p < 0.001$).

Conclusión: Niveles altos de estabilidad emocional podrían indicar fortaleza psicológica y menor vulnerabilidad, pudiendo favorecer que el daño psicológico en la mujer víctima sea menor.

Abstract

Introduction: Violence against women is a public health problem and has become one of the main causes of health problems in the victims who suffer. Little is known about the factors of vulnerability to these experiences.

Objective: The aim of this study is to analyze the emotional stability/instability as the key factor for coping with a gender violence situation and its effects on the physical and psychic health of the victims.

Methods: It's a cross-sectional study conducted on a sample of 151 spanish women. The women were evaluated using the Goldberg General Health Questionnaire and Cattells 16PF Inventory.

Results: Emotional stability was found to have a significant correlation with the Total Goldberg score and with its four subscales of symptoms, anxiety, withdrawal and depression ($p < .001$).

Conclusion: A high emotional stability can be seen as an indicator of psychological strength and less vulnerability, hence less psychological damage of the victim.

Palabras clave: Violencia de género. Mujeres maltratadas. Daño psíquico. Estabilidad emocional. Vulnerabilidad psicológica. Violencia familiar.

Keywords: Gender violence. Battered women. Phychic damage. Emotional stability. Psychological vulnerability. Family violence.

INTRODUCTION

Gender violence is one of the most important violations of the rights of women, including the right to health. It is worldwide health problem (1).

Spanish laws regarding violence in the family setting (e.g.

2,3,4), and specifically violence against women (e.g. 5), increased the number of reports in Courts. In all cases a medical-forensic evaluation is required as the basis of judicial decisions (6).

The psychic damage made manifest by the victim is a deed which justifies the judicial appraisal of the facts and the seriousness of the crime. Nonetheless, not all women offer the

same response to violence of similar characteristics (7). Acute psychic damage or damage manifested in the form of emotional sequelae also varies in the case of chronic psychic damage (8). Studies have demonstrated the association between the violence against women, in all its different forms, and physical and mental health (9,10,11,12). Moreover, it has been extensively shown that there are great individual differences in the means of coping a stressful situation, and that these differences in response will determine the effects of such experiences, both in the short-term response and in the long-term effects upon the health (13). Therefore, the personal manners of coping largely determine the individual differences in the psychological responses in stressful contexts (14).

The emotional stability of women sums up their capacity to cope with emotions, the level of tolerance to frustration, and their tendency to experience anxiety. When this stability remains at medium-high levels, it indicates a greater capacity to better face the traumatic events which we interpret as a lesser psychological vulnerability. In exploring these differences in response, we found studies about the influence of factors such as age (15); personality (16); the type of violence (17,11); the relationship between the victim and the aggressor (18); the duration (17); the frequency (19), among others.

In the present contribution, we study the relationship between the emotional stability of a non-clinical sample of women who suffered violence and the psychic damage, as measured by the GHQ-28. We considered additional factors such as age, the relationship between the victim and the aggressor, the type and the persistence of the violence.

We hope to determine that the greater emotional stability of the woman is associated with a greater level of psychic resistance to violence, manifesting lesser psychic damage and a better preparation to overcome the vital traumatic event successfully. Psychic vulnerability expresses a lesser degree of psychological resistance of the individual in the face of traumatic events; it coincides with a reduced capacity to cope and elaborate the experiences that represent suffering.

MATERIALS AND METHODS

2.1. Sample.

The population of study consisted of 151 women who had reported intimate partner aggressions (aged 18-75 years; mean = 38.5 ± 10.64). All the women had presented a criminal court accusation, in the judicial area of Eastern Andalucía (Spain) of gender violence. Previous to our study there was no clinical intervention or specific protection of any sort.

2.2. Instruments and Evaluative Measures.

The data were processed by the Unit of Medical-forensic Evaluation of Family Violence of the Department of Legal Medicine, University of Granada (Spain) between 2002 and 2008.

By means of a semi-structured survey and psycho-diagnostic examination, we obtained data relative to medical, psychological and psychiatric aspects. In all the cases, the assessment was requested by a court Judge. We obtained the written consent of the victim, and to carry it out we went to the family setting to obtain information in the family context most immediate.

2.2.1. Psychological-Psychiatric Variables.

2.2.1.1. Emotional stability.

This was evaluated using the Questionnaire of 16 personality factors (16PF), version C (20), adapted to Spanish population (21). This tool is designed to evaluate the personality profile. The items are grouped into 16 factors of the first order: Affectivity, Intelligence, Emotional Stability, Dominance, Impulsivity, Conformity to the

Group, Sensitivity, Mistrust, Imagination, Cleverness, Apprehension, Openness to change, Self-sufficiency, Self-control, and Anxiety; and four of the second order (Anxiety, Extraversion, Control of Socialization and Independence). The factors were scored on a Likert scale from 1 to 10. "Emotional stability" is understood to express maturity, a good management of emotions, feelings and impulses, with a low tendency toward anxiety and good tolerance in the face of adverse situations. We considered "emotional stability" from two standpoints: as a independent and unique factor, and in association with the rest of the factors of the PF16; in this sense we refer to it as "associated factors". We grouped the women as either "emotionally stable" (ES) or "emotionally unstable" (EU).

"Emotional stability" as a single factor was assigned a score from 0 to 10. A score of 5-6 would be considered mid-range, ≤ 4 indicative of emotional instability and a score of ≥ 7 is indicative of emotional stability.

Given that the focus was emotional stability, any further information provided by the 16PF was not analyzed.

2.2.1.2. General health.

Evaluated using the Goldberg General Health Questionnaire (GHQ-28), abbreviated version (22), validated for Spanish population (23). This tool was originally designed to measure the risk of developing non-psychotic psychiatric disorders, and was later applied for the detection of psychosocial problems in the general population. It has four subscales: GHQ-A (somatic symptoms), GHQ-B (anxiety), GHQ-C (withdrawal) and GHQ-D (depression), which are scored binomially (0 = no symptoms; 1 = symptoms). The maximum score of each one of the subscales is 7 points, > 4 points the need for pharmacological treatments is considered necessary. The T-GHQ gathers the total score of the four subscales, meaning a maximum of 28 points. Up to 8 points is considered to be an "acceptable" level of general health; 9-16 points is "moderately affected"; and ≥ 17 points signals that the level of health is "substantially affected", in which case pharmacological treatment is deemed necessary.

2.2.2. Epidemiological variables.

We consider the following information: 1) **Age** (at the time of the accusation); 2) **Type of violence**, either "psychic violence", when consisting of insults, contempt, coercion, threats, or control behaviors; and "complex violence", when, in addition to the above, there was physical abuse entailing blows of different intensity, the use of weapons, or sexual violence; 3) **Relationship with the aggressor**, which we classified as either "stable", when the couple was legally bound or persistently living together, or "transitory" for couples who were together occasionally; 4) **Persistence of violence**, categorized as "habitual" or "not habitual", these terms used in following the judicial criteria of Spain of the severity of criminal behavior, whereby more than three aggressions constitute "habitual" conduct.

2.2.3. Statistical method.

Descriptive analysis of the epidemiological data, to "emotional stability", and the scores of the four subscales and T-GHQ. This study considered the distribution of frequencies when the variables were qualitative. In the case of quantitative variables, other basic means of summing up were added to the distribution of frequencies.

The women were grouped using the conglomerated k-means method, determining the number by means of the Calinski methodology. The variable that we denominated "associated factor" characterized quite precisely these two groups of women in terms of the association of "emotional stability" with the rest of the 16PF factors.

Bivariate analysis, through simple linear regression, was applied to the following correlations:

a) Between the epidemiological variables and the score of the GHQ-28; b) Between the score in "emotional stability" and the

score of the GHQ-28; these, in both cases, as indicators of the psychic damage; and c) In turn, these GHQ scores were studied according to the distribution of the women into the two groups of ES or EU.

The statistical software package used was STATA-12-1.

RESULTS

3.1. Descriptive analysis of the epidemiological variables.

3.1.1. Age.

The age range was found to be 31-40 years old, with 59 cases (39.1%), followed by 41-50 years old, with 38 cases (25.2%) and 18 to 30 years old, with 34 cases (22.5%).

3.1.2. Type of Violence.

We found that 31 (20.53%) of the study population had reported insults, coercion, contempt, personal control, etc.; and additionally there was physical or sexual abuse or use of arms in the case of 120 women (79.47%).

3.1.3. Relationship with the aggressor.

The number of women who had a stable relationship with the aggressor was 118 (78.50%), as opposed to 22 (14.57%) who had a transitory relationship; the remaining 11 women responded to other types of relationships.

3.1.4. Persistence of violence (duration and frequency).

The results show that 108 (71.52%) women suffered repeated aggressions, whereas 43 (28.48%) reported an isolated event.

3.2. Descriptive analysis of the psychological variables.

3.2.1. "Emotional stability" and its "associated factors".

The scores obtained are as follows: With > 4 points, indicating EU there were 73 women (48.34%). There were 51 women (43.58%) who obtained intermediate scores of 5-6; and 23 (8.08%) scored ≥ 7 , indicating "high emotional stability".

According to the grouping for "associated factors", the group of ES women comprised 72 individuals (47.68%), and the group of EU women

was somewhat greater, 79 (52.32%).

3.2.2. Goldberg's General Health Questionnaire-28.

3.2.2.1. T-GHQ.

Our results gave a mean GHQ-T of 10.5 points ($SD = 7.35$). The 25 percentile was established at 5 points, percentile 50 at 9 points, and percentile 75 at 16 points. The mode was the scores of 7 and 8, with 11 cases each. The second most frequent value was a score of 0, in ten cases. The cutoff for necessitating treatment is 17 points.

The frequencies grouped according to the level of health were: 115 women (76.16%) scored ≤ 16 , while 36 (23.84%) scored ≥ 17 .

A score of ≤ 8 indicates an "acceptable" level of health in 73 women (48.34%). There were 42 women (27.81%) who obtained a score between 9-16 points, corresponding to "moderate deterioration"; and 36 women (23.84%) scored from 17-28 points.

Pharmacological treatment was indicated in at least 36 women scoring over 17.

3.2.2.2. Score on GHQ-28 sub-scales.

GHQ-A: The mean score was 3.1 ($SD = 2.2$). The number of women who scored ≤ 4 was 106 (70.2%); 45 (29.8%) presented scores 5-7; these women manifested psychic illness calling for treatment.

GHQ-B: The mean score was 3.5 ($SD = 2.15$). Whereas 104 women (68.87%) obtained scores from 0 to 4 points, indicating a moderate level of anxiety, the remaining 47 (31.13%) scored 5-7, indicating a high level of anxiety requiring treatment.

GHQ-C: The mean score was 1.8 ($SD = 1.95$). It is noteworthy that 135 (89.4%) of the women scored ≤ 4 , indicating an acceptable level of social/work adaptation. In turn, just 16 (10.60%) had scores that signaled *withdrawal*.

GHQ-D: The mean score was 2.4 ($SD = 2.38$). In this indicator, 127 women (77.48%) scored ≤ 4 ; 34 women (22.52%) scored 5-7, indicating a need for treatment.

3.3. Bivariate analysis of the epidemiological and psychological variables.

The statistically significant correlations are presented in Table 1.

Variables	GHQ-28 scores											
			GHQ-A		GHQ-B		GHQ-C		GHQ-D		T-GHQ	
	Reference	Risk	b	p	b	p	b	p	b	p	b	p
C Factor			-.541	<.001	-.590	<.001	-.363	<.001	-.574	<.001	-2.062	<.001
Associated factors	ES	EU	1.355	<.001	1.651	<.001	1.084	.001	1.675	<.001	5.471	<.001
Relationship with aggressor	Stable	Transitory					.881	.052				
Type of violence	Psychic	Complex	.930	.038	.853	.049			.914	.056	2.916	.049

Table 1 Bivariate analysis of the variables chosen in view of GHQ-28 scores.

3.3.1. Correlation of epidemiological variables and GHQ-28.

The age of the women and the persistence of the violence showed no correlation with the GHQ-28. The type of relationship showed signs of statistical significance with the GHQ-B.

In contrast, when the type of violence is "complex", it is directly correlated with the following variables: T-GHQ; GHQ-A; GHQ-B. The type of violence showed no correlation with GHQ-C. There were indications of its association with GHQ-D that did not reach the level of significance.

3.3.2. Correlations between emotional stability and GHQ-28.

We analyzed the scores on the GHQ-28 with regard to ES or Factor C as a trait.

GHQ-A: The correlation between Factor C and "somatic symptoms" proved to be significant and inverse, fewer emotional stability is associated with a greater GHQ-A value. When we focus on the variable "associated factors" a direct and significant association is also found with the somatic symptoms. The correlation evidences that the mean score obtained for the GHQ-A by the EU women of study was 1.355 points greater than the mean score obtained by the ES group. In short, the group EU expresses a greater number of somatic symptoms when exposed to violence.

GHQ-B: We arrived at an significant inverse association between the score in anxiety and factor C. The results obtained for this subscale showed a significant direct association with the variable "associated factors". This indicates that the mean scores for GHQ-B among the EU women is 1.651 points higher than for the ES ones. Group EU expresses greater levels of anxiety when exposed to gender violence.

GHQ-C: The score obtained for GHQ-C manifests a significant inverse correlation with factor C. The results relating withdrawal with the variable "associated factors" also establish a direct and significant association between the two. The mean score obtained for GHQ-C by the group EU is 1.084 points higher than that of the group ES. The group EU is the one exhibiting more withdrawal in the workplace or the social realm as a result of gender violence.

GHQ-D: The evaluation of depression on this subscale also leads to a significant inverse correlation with factor C. This subscale is found to have a direct and significant association with the variable "associated factors". The mean score obtained for the evaluation of depression among the group of EU women was 1.675 points higher than that of the ES women. The group EU is the one expressing greater levels of depression when exposed to violence.

T-GHQ: The correlation between the GHQ-Total score and Factor C proved to be inversely significant. Correlating the GHQ-T score with the variable "associated factors" led to a direct and significant association. The mean scores obtained in the GHQ-T by group EU is 5.471 points higher than the mean of the ES women.

Thus, the ES women can be said to suffer lesser deterioration of their state of psychophysical health and can resist better despite the loss of their emotional well-being.

DISCUSSION

The present study was conducted to examine the relationship between the psychic damage of women who suffered gender violence and the emotional stability and factors such as age, the relationship with the aggressor, the type and the persistence of the violence.

Regarding the age of the victims, the figures coincide with other studies; concluding that the greatest prevalence of gender violence involved women in the age range of 31-40 years (24). This would suggest that violence is consecutive with the initial period of living together, when the compatibility of characters and vital

projects is tested. Also noteworthy is the elevated prevalence of gender violence among the youngest age bracket studied here, 18 to 30 years of age (22.5%). These are early relationships, and it would be logical to assume that the education of the persons involved is less patriarchal and more based on respect and equality. This social influence on the attitudes of gender violence has been explored by a number of studies (25), previous authors observed violence and lack of equality in the secondary school setting (26) and the university (27), making these populations at a risk to be addressed by preventive studies.

Further, the results of this study come to underline that physical damage most often accompanies the attitude of disrespect and humiliation, experiences that are very damaging to the psychophysical health (28). Our findings are in line with the results of studies that report that "complex violence" appears with high frequency in the cases of violence against women who file in court (24,15). Accusations of violence in the family setting in Spain were traditionally dealt with as general misdemeanors of lesions. In the Penal Code reform of 1989 and 1995, the misdemeanor of family violence was typified, considering only physical violence. Then psychic violence was added with the same consideration of seriousness in the Penal Code reform of 1999. This made it necessary to evaluate the psychic damage of victims in order to prosecute in court according to the real seriousness. Among women reporting that they were the victims of violence, the percentage of complex violence is greater, and this may be due to the fact that there are more evident lesions, which makes prosecution somewhat easier (15). Nonetheless, we also find studies that indicate that the percentage of psychological violence is on the rise (29). Similarly, studies show that among young couples there is increasing psychological violence, however, when the relationship is more stable, physical violence increases (30).

The findings indicate that the situation of greater stability in the relationship prevailed, and violence arose when there was a stronger link. Similar findings are reported in studies that conclude that a high percentage of stable relations are found in the cases of violence in intimate relationships (24). It may also be true that it is more difficult to break off a relationship of greater stability, whether legal or affective, as it is complicated to arrive at agreements about common goods, the children, etc. (31,32,15).

In line with previous research, most women endure psychic and physical violence that is persistent, before reporting the incidents to the police or judge (31). These authors associate the frequency of the aggressions with their duration over time, considering that before a formal accusation the woman has suffered the violent conduct frequently, over a long period.

Notwithstanding, the fact that abuse can involve women with very different types of personality makes come to show that, even though emotional stability has an important influence in the process, other factors may be equally important. Thus, although personality traits bear an influence, at the same time they can be modulated by extreme or continuous events (33,19) that may appear in the victims as new forms of adapting. Relating these affirmations with our own results, the 52.32% of women found to be unstable according to the "associated factors" would have reflected the group EU; and the 47.68% of the women who were found to be ES may have been influenced by other factors while experiencing and enduring a relationship based on violence. This does not contradict the role of emotional stability in coping with the damaging effects violence.

On the other hand, we should stress that the evaluation using the T-GHQ must be done on an individual basis, as the score on some of the subscales may suffice to prescribe treatment. Of all the women, just over half (51.65%) showed a general deterioration in their health, yet pharmacological treatment was indicated for just 23.84%. Therefore, nearly half the women (48.34%) can be said to have an acceptable health. These results highlight the inconsistency when different studies explore the damage deriving from violence against women, and point to the need for further research into the factors that facilitate and protect against this traumatic experience. Golding (10) arrived at

results very similar to ours. One finding upheld by the literature consulted is that women victims of gender violence show an association between the traumatic experience and its effect on mental health (9,11). Other studies aiming to determine the time of response between the onset of violence and the time of appearance of symptoms came to the conclusion that the symptoms in women with no previous mental disorder tended to appear within the range 1-5 years (12); our future research efforts will take into account this "window" for the appearance of symptoms.

Specifically, the scores on GHQ-28 sub-scales indicate that the poor health and the need for medication appear in roughly 30% of the women regarding both psychosomatic symptoms and anxiety. Just over 20% required treatment for depression. Only 10% presented a pathological situation in terms of their social/work environment. In general, a moderate effect is seen for the scales A, B and D. This result is in line with the findings of other studies in that a moderate-serious association exists between gender violence and depression, anxiety and stress (9,11). This could be attributed to the high percentage of women who exhibited good social/work adaptation. In this case, work is experienced as a positive force, providing security and self-esteem. It therefore facilitates a proper management of the stress that violence may generate. Studies show that one socio-demographic variable characterizing battered women is the prolonged relationship with the aggressor, with the additional circumstance of the woman's not having a job (34). Accordingly, having a job and economic autonomy favors decision-making and can help lead the way out of the situation of abuse. Furthermore, work can "counter-act" the negative symptoms in these women, serving as an escape valve. Rothman et al. (35) confirmed how important having a job can be for women who are victims of gender violence. Among the benefits, they found improved self-esteem, increased social contact, "breathing room", and a vital objective.

As indicated, neither age nor the persistence of violence, nor the type of relationship with the aggressor had a correlation with the general state of health of the woman victim. There was a correlation between the scores in somatic symptoms, anxiety, withdrawal, depression and T-GHQ score and the "complex violence", the combination of physical and psychic violence that is known to cause greater damage to the general health. These data support the findings of previous authors, who affirm that undergoing complex violence increases the symptoms of deterioration of mental health (17,10,11). In our review of the literature addressing the duration and frequency of aggressions, we encountered different terms used as synonyms. We chose to denominate the existence of violence over time and occurring frequently as "persistence of violence". The studies consulted reflect some disparity in results when there are correlations of the duration and/or frequency of the violence and the damage for the health. Golding (10) refers to a dose-response relationship between violence and depression. Bonomi et al. (17) also found an association between the duration of abuse and the affectation of the health of women. Nonetheless, Beydoun et al. (9) found that only a small proportion of women who had been exposed to gender violence for a long time suffered from depressive symptoms. Patró Hernández et al. (16) likewise found no relationship between the duration of abuse and the levels of depression in victims of gender violence, but conclude there is a relationship with the frequency of the episodes of abuse. Nonetheless, various studies have demonstrated a connection between exposure to violence and stressors (9). We found no significant correlation between the age and the general state of health. Other authors arrive at a significant association, the younger women presenting more depressive symptoms and a greater deterioration of self-esteem (15). Regarding the type of relationship between the victim and the aggressor, there was no statistically significant association with the health. This result coincided with the findings reported by Stewart (36).

Finally, the results give a significant association between "emotional stability" and psychic damage in the women suffering gender violence. This correlation is even greater when the

"emotional stability" is studied as a trait within the variable "associated factors". Comparatively, the results obtained on the GHQ subscales offer scores that double or triple the effect of abuse when the emotional stability is associated with the rest of the 16PF factors.

Generally speaking, we may affirm that our results point to emotional stability as a protecting factor for the health of women subjected to gender violence. These results are in line with previous reports. Lazenbatt et al. (37) studied the means of coping with gender violence among a population of women over 50 years of age, as well as the consequences for their health. Their results point to the existence of pathological mechanisms of adaptation such as the abuse of alcohol and self-medication, concluding that their state of health was at an elevated risk. Although the concept of *coping* may not mean exactly the same thing to everyone who uses the term (13), it can be said in general that *coping focused on the emotional* is less effective as a procedure in order to minimize the negative emotions. Proving more effective would be *coping focused on the problem*, whose objective is to influence and eliminate the source of stress (33). In the context of gender violence, these findings have been confirmed. It is our understanding that the means of avoiding this situation by focusing on emotional aspects and resorting to avoidance behaviors bears a relation with a profile of emotional instability. Thus, Lilly and Graham-Bermann (38) report that women using a coping mechanism based on emotion showed more symptoms of post-traumatic stress and were more likely to expose themselves to situations of violence again. Similarly, studies involving other populations, such as Viet Nam veterans, revealed that the individuals who scored low in emotional stability (measured using the 16PF) developed more post-traumatic stress symptoms (39).

CONCLUSIONS

In this article "emotional stability" is dealt with as a specific trait having a particularly important influence on the response of the women who suffer from gender violence. Our main conclusion is that there is a strong statistical correlation between emotional instability and the psychic damage to women. This allows us to identify the more vulnerable women who require attention, to approach them in a preventive stage.

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