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Experiences of women with disabilities in Lithuania when their gender, disability, domestic violence, and mental health services intertwine

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ABSTRACT

Background: Women with disabilities are two to five times more likely to experience domestic violence (DV), including intimate partner violence (IPV), when compared with women without disabilities. Survivors of DV and IPV are around three times more likely than women without this life experience to develop mental health conditions or a psychosocial disability.

Objective: To explore the perspectives of women with disabilities who are survivors of DV and IPV about their help-seeking experiences and their use of mental health services in Lithuania.

Methods: A qualitative explorative study was implemented within an experiential framework. Semi-structured interviews (n = 15) were conducted with women-survivors of DV who have sensory, physical, psychosocial, and intellectual disabilities. Audio recordings were transcribed verbatim and analysed thematically using MAXQDA software.

Results: The key findings highlight the complex intersection between gender, disability, and DV, including IPV. Women with disabilities may be extremely dependent on their abusers for daily individual support and may also experience disability-based violence as a result of this situation. Societal stigma and victim-blaming attitudes, as well as the lack of community-based services, may prevent survivors from seeking help. However, those who do may benefit greatly from support provided by mental health services.

Conclusions: Further qualitative and quantitative research concerning the interlink between the areas of gender, disability, DV and IPV, and the provision of mental health services is needed, especially about what interventions might be the most effective for this particular population.

1. Introduction

Violence against women (VAW) is a major public health and gender inequality problem and a violation of women's human rights. The most prevalent expression of VAW is intimate partner violence (IPV), which is a form of domestic violence (DV): at least one in three women experience IPV at some point in their life.^{1,2,3,4,5,6,7}

DV can be described as a broad range of abusive behaviours experienced at one's own home; it may involve parents, children, siblings, and roommates, among other persons you might be living with. More specifically IPV includes psychological, economic, physical and/or sexual abuse, coercive and controlling behaviours (i.e., coercive control) by a former or current intimate partner, such as marital, co-habiting or dating partners.^{3,8} IPV is usually systemic, which refers to the fact that

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most often IPV is a long-term continuous and complex abuse, which manifests as various strategic demonstrations of power and control through manipulations: threats, intimidation, undermining, destroying of the abused person's self-confidence, and making them increasingly dependent on their partner. The disproportionate majority of victims and survivors of DV and IPV are women, and abusers are mostly men, which makes it a form of gender-based violence.³

Global evidence shows that women with disabilities are affected by this public health problem disproportionately: they are two to five times more likely to experience DV, including IPV, when compared with women without disabilities.^{9, 10, 11, 12} The most vulnerable to this risk are women with mental health conditions, psychosocial, and intellectual disabilities.^{9, 13, 14, 15}

The definition of 'disability' referred to in this article is based on Article 1 of the UN Convention of the Rights of Persons with Disabilities: "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others".¹⁶

The interlink between gender, disability, and violence is complex: women with disabilities face multiple and intersectional discrimination both because of their gender and their disability (and any other ground for discrimination relevant to their individual situation). According to McGowan and Elliott (2019), women with disabilities are often: "met with prejudice that casts the lives of people with disability as less worthy (...). In the absence of a shared understanding of these crimes, disablist norms prevail, exposing women to ongoing violence and limiting access to justice". This not only creates an environment that enables DV but can also prevent survivors with disabilities from seeking help.¹⁷

Studies show that female survivors of DV/IPV with disabilities are socially, culturally, and demographically diverse.¹⁸ Nevertheless, it has been established that generally, women with disabilities experience severe forms of physical DV/IPV more often,¹⁹ and are more likely to be abused and for longer periods than both women without disabilities and men with disabilities.^{20, 21, 22} They also may be exploited due to certain aspects concerning their disability, such as denying the needed individual support and withholding their medication.²³

Moreover, women who survive DV, including IPV, are around three times more likely than women without this life experience to develop mental health difficulties.²⁴ Experiences of this type of violence may often lead to serious physical and mental health conditions and disability.³ Hence, mental health services and professionals have a crucial role to play in supporting survivors of DV and IPV on their recovery journey.²⁵ For example, mental health professionals can make a significant difference by screening for DV and IPV, ensuring safety, person-centred care, and providing trauma- and violence-informed support.^{26, 27}

In Lithuania, a victimology study²⁸ conducted in 2021–2022 showed that women with disabilities experience various types of violence, including high levels of DV and IPV. More than half of the study's participants with disabilities experienced IPV and around one-third experienced DV perpetrated by their guardians, parents or step-parents, siblings, and children. The victimology study also confirmed the latency of these crimes of DV: one-third of the study participants did not tell anyone about their situation, and less than 20 % reported it to the police. The study also indicated that for those survivors who did seek help (e.g., consultations by various professionals), their expectations for support were often unmet. For example, services did not foster their independence and did not provide comprehensive assistance or complex support throughout the process, nor ensured a safe environment.²⁸

To find out more about the nuanced circumstances of their unmet expectations and needs for support when seeking help, this qualitative study was conducted. The main objective of the current study is to hear

and highlight the perspectives of women with disabilities who are survivors of DV and IPV about their help-seeking experiences and their use of mental health services in Lithuania.

2. Methods

2.1. Study design

This is a qualitative explorative study conducted within an experiential framework.²⁹ It is part of a broader observational cross-sectional mixed-methods study titled 'Responses to Mental Health Care Needs of Survivors of Intimate Partner Violence by Mental Health Services in Lithuania and Portugal'. Qualitative methods were chosen due to the sensitive and personal nature of the topic and to allow for an in-depth discussion of the issue. The current study aims to capture and better understand the perspectives of women with disabilities who are survivors of DV and IPV about their help-seeking experiences and specifically their use of mental health services in Lithuania.

2.2. Research team and reflexivity

All co-authors have many years of personal and professional experience in the fields of disability, mental health, public health, human rights, civic activism, and gender-based violence. This is seen as a valuable asset and is in line with the values of qualitative research: using and valuing the subjectivity of each researcher as a resource, which may shape the research process in various ways.^{30, 31, 32} The research team fully acknowledges the subjective influence of every researcher's assumptions and the way that knowledge in this qualitative study is created. It is a strength due to the co-authors' extensive knowledge and passion about the topic in question, and invaluable professional, as well as personal experiences of each member of the research team.

2.3. Study setting, measures, and participants

The research team developed a protocol for semi-structured interviews.³³ The semi-structured interview guide aimed to explore the following data categories and questions:

- 1) Socio-demographic characteristics (type of disability of the participant; current age of the participant; their age when they experienced DV/IPV for the first time; their age when they sought help/used mental health services for the first time; place of residence; place where they sought help/used mental health services; gender of the abuser).
- 2) Experiences of either seeking help in Lithuania or not, especially for their mental health needs or emotional state due to or as a result of having experienced DV/IPV. Participants were asked to describe in their own words: 1) Their encounters with various professionals, including mental health services; 2) What support they needed the most at the time; 3) How those needs were met; 4) What the professionals had to offer in response; 5) How helpful it was; 6) What the most positive and negative aspects of this experience were; 7) what barriers (if any) they faced when seeking this support; 8) What they would have liked the professional(s) to have done differently; and 9) How they found their situation affected (or not) by their gender, as well as disability.
- 3) In cases where the answer to the question about seeking any type of help was negative, the study participants were asked to describe the reasons for not seeking help.

For the selection of research participants, convenience sampling and 'snowball' methods were used.

Fifteen semi-structured interviews were conducted with women with disabilities in Lithuania between July and December 2023. They lasted an average of 60 min. The interviews were organised in collaboration

with a local non-governmental organisation Mental Health Perspectives and the Lithuanian Disability Forum.

Most of the interviews were conducted online either using Zoom or the Microsoft Teams Platform, one interview was conducted in person, and one via telephone. The in-person interview took place in a location chosen by the participant, where she felt most comfortable.

All study participants signed informed consent forms before each interview. Interviews were conducted by the first and second authors of this article and other members of the wider research team (see the Acknowledgements section of this article). The confidentiality and anonymity of participants were ensured.

2.4. Data analysis

All audio recordings of interviews were transcribed verbatim and analysed thematically according to the recommendations of Braun and Clarke.^{30,34} Transcripts were read and re-read, and parts of the text were coded, synthesised, and divided into categories. The first author of this article used an inductive approach to code the data and coding continued until no new concepts emerged from the collected data. Themes were created by the first author and then reviewed, discussed, and finalised by co-authors, taking into account patterns both inside and between the thematic categories.

The thematic analysis^{34,35} was conducted using MAXQDA software.³⁶ The reporting of the findings of this study followed the SRQR³⁷ and COREQ³⁸ standards for reporting qualitative studies.

2.5. Research ethics

All study participants signed informed consent forms before each interview. During all the stages of research design, implementation and analysis, the main principles of ethics in research with mental health service users,^{39,40,41} as well as within the field of DV and VAW^{42,43,44} were considered. For example, it was important to be aware of potential emotional distress and impact on both research participants,⁴⁵ and researchers⁴³; the sensitive nature of both the topic of violence and that of mental health difficulties and disabilities; the importance of ensuring safety⁴⁵; and support for all involved throughout the lifespan of the study. This was fostered by talking with the participants about how they felt and offering information (during and after the interviews) about where they could find help or support if needed. Moreover, accessible and ongoing support and supervision were available to members of the research team both at the Lithuanian Disability Forum and at the Lisbon Institute of Global Mental Health.

The study was approved by the Research Ethics Committee of NOVA Medical School, NOVA University of Lisbon (Ref. No. 171/2021/CEFCM).

3. Results

3.1. Details of interviews

Fifteen women with hearing, vision, physical, psychosocial and intellectual disabilities from five different geographical areas of Lithuania participated in this study (n = 15). Some of them had more than one type of disability. The study participants were both employed and unemployed, with various levels of education, and different romantic relationship statuses or living situations.

Some of the women have experienced DV since early childhood, others only after they reached adulthood. Violent situations included DV from their mother, father, step-father, brother, cousin, and intimate partners. As described in Table 1, participants' age varied between women in their early twenties and late fifties (mean age being 36.6 years).

Table 1

Sociodemographic characteristics of the participants of semi-structured interviews (n = 15).

Age category	Women with disabilities who experienced DV/IPV (n = 15)	
	n	%
18–24	1	7
25–34	7	47
35–44	3	20
44–57	4	27
Highest achieved education	n	%
Secondary School	4	27
Occupational training	2	13
College	2	13
University	7	47
Employment status	n	%
Employed	8	53
Unemployed	4	27
Studying	4	27
Living situation	n	%
Living with a partner	5	33
Living with relatives	4	27
Living in supported accommodation	1	7
Living alone	5	33
Residence	n	%
City	12	80
Town/village	3	20
Disability	n	%
Intellectual	1	7
Psychosocial	8	53
Physical	5	33
Sensory	3	20
Age of first experience of DV/IPV	Median (Min;Max)	
	8 (4; 30)	
Gender of the abuser	n	%
Only female	0	0
Only male	12	80
Both	3	20
Relationship with the abuser	n	%
Mother	3	20
Father	3	20
Step-father	1	7
Sibling and cousin	1	7
Intimate partner	10	67
Type of DV/IPV	n	%
Psychological	15	100
Economic	2	13
Physical	10	67
Sexual	7	47
Age when using any support services for the first time (n=12)	Median (Min;Max)	
	23 (8; 53)	
Place where used support services (n=12)	n	%
City	10	67
Town/village	2	13

3.2. Themes

The data analysis resulted in five main themes, as follows: 1) The intersection of gender, violence, and disability; 2) "It's just like everyday life"; 3) "Who else is going to look after me?"; 4) The survivors' own 'fault'; 5) Mental health services as a vital but deficient resource (see Tables 2–6).

The intersection of gender, violence, and disability

Both gender and disability aspects influenced the research participants' experiences of violence and their help-seeking behaviour. Women cited sexism, misogyny, socially constructed 'norms', and stereotypes (both about gender and disability) as having influenced their

Table 2
Quotes from semi-structured interviews: Theme 1.

Theme	Selected Quotes
1) <i>The intersection of gender, violence, and disability</i>	<p>“I think that this man had such an upbringing that a woman equals zero. She is only to give birth to children and to cook food. And nothing more, no opinion, no freedom of speech, nothing. Well, yes, as a slave. (...) They [intimate partners] looked at me more either as merely a friend or as a physical body. Not like a lady, in that sense, but just like that. (...) I have also experienced sexual violence because of this.” – Woman with a physical disability</p> <p>“The fact that I am a woman determined a lot. It had an impact on everything, everywhere. In cases of sexual violence, it was harassment based on gender alone. And for gynaecologists, a woman with a disability is not a woman. For the abuser, on the contrary, it is an easier prey. If I were a man, I give you one hundred percent that none of this would have happened.” – Woman with a physical disability</p> <p>“I feel like a very, very big part of my experience is due to the fact that I’m a woman. (...) And now I feel very insecure [in my body], at work, and on the street. It’s just constant paranoia that someone is going to attack because harassment is so common. Well, that’s just the way it is. I almost always have it in my mind that I’m a woman, it’s very hard to forget that.” – Woman with a psychosocial disability</p> <p>“Actually, I’m afraid [to seek help]. When you have a disability, you are very vulnerable. And when they tell you they’re going to take your child away ... And he [ex-husband] keeps saying that. (...) I’ve been told all kinds of things: “How is it that you are blind and raising children, how were you allowed to give birth?” and the like.” – Woman with a sensory disability</p>

Table 3
Quotes from semi-structured interviews: Theme 2.

Theme	Selected Quotes
2) <i>“It’s just like everyday life”</i>	<p>“It was perceived both from my side and from his side – just like everyday life. (...) I had no relatives, all my relatives were abroad, so I was alone. I had neither parents nor relatives. And it’s like everyday life here. I accepted this thing as such. That it probably has to be this way and that it’s my fault.” – Woman with a physical and psychosocial disability</p> <p>“For a long time, I kind of denied it, (...) I said that there is no violence at all. Somehow, it was more accepted that violence can basically be called violence, if it is, let’s say, physical, right?” – Woman with a sensory disability</p> <p>“I don’t understand myself, how I could have allowed so much done to myself. I didn’t see it as violence, I saw it, maybe in some way, that it was an explanation of the relationship. That it is normal, natural. That people somehow justify it. I accepted it naturally, that it had to be like this.” – Woman with a physical disability</p> <p>“I then realised that it was violence. That there was indeed already sadism, a sadist, but I could not escape. I couldn’t escape. I tried to escape once and I was beaten up. All the clothes I had put into a bag to run away were scattered in the fields, and after this, I was beaten up again just because I dared to try to run away.” – Woman with a physical and psychosocial disability</p> <p>“I would take it that the person who abused me knew that I was a vulnerable person because the anti-depressants were found and he knew very well that they were drugs for the treatment of mental health conditions. It was stigmatised. I was called a ‘psycho’ and stuff like that.” – Woman with a psychosocial disability</p>

Table 4
Quotes from semi-structured interviews: Theme 3.

Theme	Selected Quotes
3) <i>“Who else is going to look after me?”</i>	<p>“Because, who will replace diapers, who will go to the store? Support services and a psychologist are needed. (...) It is necessary to react differently [to DV] when there is a disability. [Due to the lack of available community services] I would begin to think about whether I should stay with the abuser or instead sit alone in the dark and ‘rot’. Everything is connected.” – Woman with a physical disability</p> <p>“Hypercare. I think this is one of the types of violence. When they say: you can’t, I’ll do it for you ... It’s an understatement. I became completely dependent [on the abusers]. I basically started lying in bed all the time. At home, nothing was adjusted for me. I was lying in bed and everything was handed to me. Neither a bath, nor a toilet, nor a cupboard were accessible. The parents did as they saw fit. It was more convenient for them. I felt worthless, hopeless, incapable of anything.” – Woman with a physical disability</p> <p>“He would sit me on the bed and force me to confess something that he had imagined to be true. For as long as I wouldn’t admit his ‘truth’, I wasn’t going to get my wheelchair back. One time, I was left to sit on the bed for three days.” – Woman with a physical disability</p>

Table 5
Quotes from semi-structured interviews: Theme 4.

Theme	Selected Quotes
4) <i>The survivors’ own “fault”</i>	<p>“I think it was with the social educator, it seems to me, or maybe with children’s rights professionals, that they saw everything to be my fault. It’s supposedly my fault that I said something wrong to someone as if I made things up, as if I talk back to people, manipulate and so on.” – Woman with a physical and psychosocial disability</p> <p>“Maybe it’s not the breakup itself that hurts the most, you know, but the fact that I was terrorised, then there was an attempt to break into my apartment and the reaction of the neighbours ... And the reaction of the neighbours was that: “It’s your own fault – why did you let [him] in.” – Woman with a psychosocial disability</p> <p>“The pressure from my grandmother was like ‘What will we do without him’, that we have to reconcile ... Let’s start with the fact that my grandmother was ashamed of the fact that I was an educated, intelligent woman, but that now I was in a wheelchair.” – Woman with a physical disability</p>

experiences. Women shared that their intimate partners often had ‘traditionalist’ attitudes towards them, reducing them to ‘housewives’: “This man had such an upbringing that a woman equals zero. She is only to give birth to children and cook food. And nothing more, no opinion, no freedom of speech. Well, yes, as a slave” (woman with a physical disability). Some also felt they were seen and treated merely as ‘sex objects’ due to their disability: “They looked at me more either as merely a friend or as a physical body. Not like a lady, in that sense” (woman with a physical disability) (See Table 2).

“It’s just like everyday life”

A large proportion of the research participants revealed that for a long time, they did not recognise their personal experiences and did not identify them as DV or IPV. It took them a lot of time, support from others and individual information searches to identify these experiences. Forms of violence that are more difficult to recognise are psychological violence and disability-based violence: manipulations based on the daily support they need, provision or non-provision of this support, deprivation or limitation of assistive devices, arbitrary regulation of medication doses, neglect and ignoring of individual needs.

Table 6
Quotes from semi-structured interviews: Theme 5.

Theme	Selected Quotes
5) <i>Mental health services as a vital but deficient resource</i>	<p>“Yes, my psychologist was like that, she was from the polyclinic, she sent me there and I calmed down already, I started communicating with people. I started to open up, and I just liked it, I really like psychologists.” – Woman with an intellectual disability</p> <p>“Only two psychologist consultations a week is not enough. (...) I called the helpline a couple of times, but they were not specialised, they didn’t help me.” – Woman with a physical disability</p> <p>“Once, I remember, I went to a psychologist and the psychologist said: “Well, you’re strong, keep doing it.” I even got a little irritated and angry, because at that moment I needed to be listened to and that kind of thing. (...) A traumatised person needs to be given that kind of support. But as I say, sometimes for a traumatised person there are so many nuances and how carefully you need to choose your words.” – Woman with a physical disability</p> <p>“I knew there was something wrong with me, because of the eating disorder, because I had missed my periods, I knew that there was something wrong with me. It was then that I started going to psychologists and even to a psychiatrist, and I took anti-depressants. It was really difficult for me. But at that time, maybe they might have asked me about the violence, but even if they did, they didn’t talk about it any further. We didn’t touch on this topic of violence.” – Woman with a psychosocial disability</p> <p>“Especially when I was a teenager, when I started going [to a psychologist], it [DV] should have been brought up and received more attention. Because I was growing up in extreme tension all the time. In all kinds of shame, guilt, and tension. And that was never of any interest to anyone.” – Woman with a psychosocial disability</p>

Often, women accepted the violence they experienced as a usual ‘everyday thing’, the only familiar reality based on their past experiences and social ‘norms’; thus, they were often just resigned to it: “It was perceived both from my side and from his side – just like everyday life. I accepted this thing as such” (woman with a physical and psychosocial disability). Women reported that even later, after recognizing and understanding their experiences as violence, it was not always possible for them to escape from abusive relationships or even seek help at all. This was both due to their dependence on the abuser for daily disability-related assistance and due to the risk of further physical harm from the abuser for trying to escape or seek help: “I couldn’t escape. I tried to escape once and I was beaten up” (woman with a physical and psychosocial disability). (See [Table 3](#))

“Who else is going to look after me?”

Research participants, especially those with physical, intellectual or psychosocial disabilities, named their physical, emotional, financial or other dependence on the abuser as one of the aspects that made it difficult for them to seek help or to withdraw from violent relationships in general. In some cases, this dependence arose from individual support needs, but sometimes it was subjectively imposed: for example, by constantly stating that a woman would not survive alone without the abuser: “Hypercare. I think this is one of the types of violence. When they say: you can’t, I’ll do it for you ... It’s an understatement. I became completely dependent” (woman with a physical disability). Sometimes the same thing was repeated to them not only by the abusers but also by a wider circle of relatives.

Moreover, the examples provided by the women illustrated how the abusers tended to use this situation to intensify and maintain their coercive control, namely by manipulating the withholding of the

help and support they most needed: “He would sit me on the bed and force me to confess something that he had imagined to be true. For as long as I wouldn’t admit his ‘truth’, I wasn’t going to get my wheelchair back. One time, I was left to sit on the bed for three days” (woman with a physical disability). The women stated that the fear of seeking help was increased by the knowledge of the systemic problems existing in the country and the lack of support services provided in the community to meet both their physical and mental health needs: “I would begin to think about whether I should stay with the abuser or instead sit alone in the dark and ‘rot’” (woman with a physical disability). (See [Table 4](#))

The survivors’ own ‘fault’

Survivors of DV who did not seek help or delayed seeking it named various attitudes related to their disbelief that help might be possible at all. Women shared that their experiences often remained a secret, behind closed doors, because society’s attitudes, indifference, disability stigma and blaming the victims for the violence they have experienced encouraged them to remain silent: “And the reaction of the neighbours was that: ‘It’s your own fault – why did you let [him] in’” (woman with a psychosocial disability). The research participants also mentioned a strong sense of shame, which prevented them from sharing their experiences with others and seeking help. A lot of women mentioned pressure from society and relatives to stay in violent relationships: “The pressure from my grandmother was like ‘What will we do without him?’” (woman with a physical disability). (See [Table 5](#))

3.2.1. *Mental health services as a vital but deficient resource*

The research participants described a great need for psychological help and mental health support and its importance: both in helping to recognise the violence they were experiencing and freeing themselves from violent relationships; and in dealing with the mental health consequences of the psychological trauma they have experienced and on their recovery journey: “At that moment I needed to be listened to and that kind of thing. A traumatised person needs to be given that kind of support. But as I say, sometimes for a traumatised person there are so many nuances and how carefully you need to choose your words” (woman with a physical disability).

As a positive experience, women identified those cases of encounters with mental health professionals, when professionals paid more time and attention to listening to their personal stories; put more effort into finding out the reasons for certain behaviours and mental health conditions of women who have experienced DV, and recognised their specific experiences of DV/IPV; as well as related maltreatment and psychological trauma, and the consequences for their mental health.

On the other hand, it was evident from the stories of the research participants that mental health professionals often tend not to recognise the need to assess the experience of DV/IPV in their work as an important factor in the mental health status of their service users. The women said that they encountered the often-dismissive behaviour and attitudes of professionals, sometimes even stigmatisation and victim-blaming attitudes.

When research participants approached mental healthcare services, they felt that the professionals did not pay enough attention to the topic of violence, which was a fundamental trauma in their lives: “Especially when I was a teenager, when I started going [to a psychologist], it [DV] should have been brought up and received more attention. Because I was growing up in extreme tension all the time. In all kinds of shame, guilt, and tension. And that was never of any interest to anyone” (woman with a psychosocial disability). Many of them mentioned that they felt misunderstood by professionals, and they were not listened to. Moreover, mental health professionals

often considered DV/IPV to be a ‘social problem’ as if seemingly irrelevant to their mental health care, treatment, and recovery.

The research participants identified the importance of psychological help and other mental healthcare services but highlighted its general unavailability as one of the systemic gaps. Also, gaps were described in the education of professionals, their frequent lack of knowledge and skills in working with cases of DV/IPV, as well as in the context of the intersection of gender, violence, and disability. The women’s narratives also echoed issues of financial access to services due to differences in the quality of mental healthcare in the public and private sectors. They also described disability-related accessibility issues, for example, inaccessible infrastructure, communicational, informational and attitudinal barriers, and stigma (See Table 6).

4. Discussion

This study qualitatively explores the perspectives of women with disabilities who have experienced DV and IPV in Lithuania and analyses their help-seeking experiences, especially in the mental healthcare sector. The study highlights that women with disabilities may be abused by their parents, guardians, relatives, and intimate partners. The forms of DV/IPV can be very diverse: physical, sexual, psychological, economic violence, coercive control, and disability-based violence.

The results correspond to and reproduce the trends examined and identified in the global scientific literature. First, it often takes time for women who experience DV, and especially IPV, to recognise and identify these experiences as violence: this may require the help of those around them, especially various professionals.^{26, 46, 47} It is particularly difficult to recognise psychological violence, including economic violence and coercive control, given the different definitions and concepts of these forms of violence in different countries, societies, and communities.⁴⁸ Also, in cases of DV/IPV, the risk of violence intensifying may increase when the victim-survivor tries to escape from such a relationship, and the abuse may continue even in cases of separation.^{49, 50}

These results are typical of many cases of DV/IPV, regardless of the presence or absence of a disability. However, concerning women with disabilities, two specific results of this study are particularly important to note. First, the women’s experiences related to DV when the abuser manipulates the (non)providing of the necessary daily support to a woman with a disability warrant attention. This can be identified as a separate form of violence, i.e., disability-based violence.^{51, 52} Secondly, due to the need for support, women with disabilities can often be deeply dependent on their abusers in their daily lives: the abuser can also be the primary source of vital day-to-day support. In such cases, women with disabilities may feel deeply dependent on the abuser both physically, emotionally, and financially.⁵³ This dependence may lead to feelings of helplessness and disbelief that there is a way out of the present situation.

Systemic problems of the lack and inaccessibility of individual support and community-based services may contribute to this problem. Research participants mentioned various doubts and fears about such situations as, for example, if the abuser was to be separated from the survivor after seeking help, and evicted from their home, the woman would be left without vital daily individual support. The lack of such community support services that could replace the daily care provided by the abusers in Lithuania, especially in the context of mental healthcare, is also documented in the international literature.⁵⁴

The current study has shown that the intersection of gender, disability and violence in the intimate environment, related societal attitudes and prevailing socially constructed ‘norms’ influence both the seeking and receiving of help, as well as the violence itself. Women with disabilities who experience DV/IPV face multiple forms of discrimination, both because of their gender and disability. On the one hand, society’s attitude is based on gender stereotypes and traditional expectations for women regarding their behaviour and responsibilities in life. On the other hand, women with disabilities are often humiliated because

of their disability and are not valued as ‘women enough’. Degrading attitudes towards women due to their gender and disability and related harmful trends not only create an environment that enables DV/IPV but can also prevent survivors from seeking help in time (or at all).¹⁷

Moreover, not only the related public stigma and widespread blaming of the victims of DV/IPV but also the self-stigma are highlighted in international literature.⁵⁵ Public stigma is often based on various negative and unfounded myths about DV and survivors of DV may internalise and believe these myths. This may result in women’s feelings of shame, self-blame, distance, alienation, and self-isolation.⁵⁵ Additionally, the research participants named negative experiences due to the existing stigma and stereotypes in society, not only because of DV/IPV,⁵⁵ but also due to disability and mental health conditions.^{56, 57} This problem was also mentioned when talking about mental health professionals and their attitudes towards people with disabilities.

In cases when women with disabilities who have experienced violence seek help, mental healthcare services are significantly important. Women who experience DV/IPV are at a high risk of various physical and mental health conditions.^{3, 58, 59} For this reason, professionals need to have sufficient knowledge and skills to work with persons who have experienced DV/IPV: to recognise the violence they have experienced, help them identify it, respond to related health problems and refer them to other professionals for the necessary legal, psychological or other help.⁴⁷ However, the testimonies of the research participants reveal quite the opposite picture: their negative experiences when using mental health services were often determined by negative stereotypes prevailing in society, the mental healthcare professional’s indifference, as well as a lack of specific knowledge and skills about both DV/IPV and disability.

Globally, there is still little evidence of effective mental health interventions for survivors of violence who have disabilities.⁶⁰ Often, in practice, the psychological trauma of a violent experience may not be recognised and effectively responded to, even though the world is increasingly recognising the need for trauma- and violence-informed care and the importance of related methodologies and practices in providing mental health support to survivors of DV/IPV, including those with disabilities.^{26, 27, 61, 62}

5. Strengths and limitations

The study has provided a more comprehensive and nuanced understanding of how gender, disability, experiences of DV and IPV, and mental health difficulties intersect. Shedding light on this major public health concern and identifying these multiple dimensions of inequalities can inform more effective and equitable policies and interventions that address the complex realities of people’s lives. On the other hand, this study provides the experiences of only a limited number of participants. Therefore, and due to its qualitative nature, is not possible to generalise the findings of this study. In addition, participants came mostly from large cities and it was not feasible to reach those living in the more rural communities during this study. This was mostly due to time and funding constraints.

6. Conclusion

The study findings contribute to sparse literature concerning women with disabilities who experience DV/IPV, their help-seeking experiences, and their use of mental health services. The key findings highlight the complex intersection between gender, disability and DV, including IPV. Women with disabilities may be extremely dependent on their abusers for daily individual support and also may experience disability-based violence as a result of this situation. Societal stigma and victim-blaming attitudes, as well as the lack of community-based support services, may prevent survivors from seeking help; however, those who do,

may benefit greatly from support provided by mental health services. Further qualitative and quantitative research concerning the interlink between the areas of gender, disability, DV and IPV, and the provision of mental healthcare is needed, especially about what interventions might be the most effective for this particular population.

CRedit authorship contribution statement

Ugnė Grigaitė: Writing – original draft, Software, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Simona Aginskaitė:** Writing – review & editing, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Bárbara Pedrosa:** Writing – review & editing, Methodology. **Deborah Oyine Aluh:** Writing – review & editing, Methodology. **Margarida Santos-Dias:** Writing – review & editing, Methodology. **Manuela Silva:** Writing – review & editing, Methodology. **Graça Cardoso:** Writing – review & editing, Methodology. **José Miguel Caldas-de-Almeida:** Writing – review & editing, Supervision, Methodology.

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The co-authors declare that there is no conflict of interest.

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References

- Garcia-Moreno Claudia, Jansen Henrica, Ellsberg Mary, Heise Lori, Watts Charlotte. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *Lancet*. 2006;368(9543). [https://doi.org/10.1016/S0140-6736\(06\)69523-8](https://doi.org/10.1016/S0140-6736(06)69523-8).
- European Union Agency for Fundamental Rights. Violence against women: an EU-wide survey [Online]. Available: https://staging.fra.europa.eu/sites/default/files/ra-2014-vaw-survey-factsheet_en.pdf; 2014. Accessed May 23, 2023.
- World Health Organization. "Violence against women: prevalence estimates. Global, Regional and National Prevalence Estimates for Intimate Partner Violence against Women and Regional Prevalence Estimates for Non-partner Sexual Violence against Women. World Report on Violence and Health, no. March, 2021; 2018 [Online]. Available: <https://www.who.int/publications/i/item/9789240026681>. Accessed January 3, 2024.
- Singh Chandan Joht, Thomas Tom, Bradbury-Jones Caroline, et al. Female survivors of intimate partner violence and risk of depression, anxiety and serious mental illness. *Br J Psychiatry*. 2020;217(4). <https://doi.org/10.1192/bjp.2019.124>.
- Krug Etienne, Mercy James, Dahlberg Linda, Zwi Anthony. *World Report on Violence and Health*. Geneva: World Health Organization; 2002.
- Sanz-Barbero Belén, Pereira Patricia López, Barrio Gregorio, Vives-Cases Carmen. Intimate partner violence against young women: prevalence and associated factors in Europe. *J Epidemiol Community Health*. 1978;72(7):611–616. <https://doi.org/10.1136/jech-2017-209701>. Accessed July 7, 2023.
- Barbier Alice, Chariot Patrick, Lefevre Thomas. Intimate partner violence against ever-partnered women in Europe: prevalence and associated factors—results from

- the violence against women EU-wide survey. *Front Public Health*. 2022;10. <https://doi.org/10.3389/fpubh.2022.1033465>. Accessed July 7, 2023.
- World Health Organization. *Violence Against Women: Intimate partner and sexual violence against women*. 2019.
- Hughes Karen, Bellis Mark, Jones Lisa, et al. Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies. *Lancet*. 2012;379:1621–1650. <https://doi.org/10.1016/S0140>.
- United Nations Committee on the Rights of Persons with Disabilities. *General Comment No.3 on Article 6 – Women and Girls with Disabilities*. 2016.
- European Parliament. Resolution on the situation of women with disabilities. <https://oeil.secure.europarl.europa.eu/oeil/popups/printficheglobal.pdf?id=691836&l=en>; 2018. Accessed June 11, 2024.
- Gupta Jhumka, Kanselaar Samantha, Zhang Cheyu, Zaidi Jaffer. Disability and intimate partner violence in fragile states: a multi-country analysis. *Glob Public Health*. 2023;18(1). <https://doi.org/10.1080/17441692.2023.2204339>.
- Dammeyer Jesper, Chapman Madeleine. A national survey on violence and discrimination among people with disabilities. *BMC Public Health*. 2018;18(1). <https://doi.org/10.1186/s12889-018-5277-0>. Accessed: Jun. 11, 2024. [Online]. Available:.
- Hahn Josephine, McCormick Marie, Silverman Jay, Robinson Elise, Koenen Karestan. Examining the impact of disability status on intimate partner violence victimization in a population sample. *J Interpers Violence*. Nov. 2014;29(17):3063–3085. <https://doi.org/10.1177/0886260514534527>.
- Maureen Tutty Leslie, Nixon Kendra. He stole my meds to get high: the mental health and well-being of women abused by intimate partners and their disability status. *J Interpers Violence*. 2024. <https://doi.org/10.1177/08862605241243344>.
- United Nations General Assembly. Convention on the rights of persons with disabilities. <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities>; 2006. Accessed April 19, 2023.
- McGowan Jasmine, Elliott Karla. Targeted violence perpetrated against women with disability by neighbours and community members. *Womens Stud Int Forum*. 2019;76.
- Ballan Michelle, Burke Freyer Molly, Marti Nathan, Perkel Jules, Webb Katie, Romanelli Meghan. Looking beyond prevalence: a demographic profile of survivors of intimate partner violence with disabilities. *J Interpers Violence*. Nov. 2014;29(17):3167–3179. <https://doi.org/10.1177/0886260514534776>.
- Douglas Brownridge. Partner violence against women with disabilities: prevalence, risk, and explanations. *Violence Against Women*. Sep. 2006;12(9):805–822. <https://doi.org/10.1177/1077801206292681>.
- Rosemary Hughes, Lund Emily, Gabrielli Joy, Powers Laurie, Curry Mary Ann. Prevalence of Interpersonal Violence Against Community-Living Adults With Disabilities: *Lit Rev*. Nov. 2011. <https://doi.org/10.1037/a0025620>.
- Smith Diane. Disability, gender and intimate partner violence: relationships from the behavioral risk factor surveillance system. *Sex Disabil*. Mar. 2008;26(1):15–28. <https://doi.org/10.1007/s11195-007-9064-6>.
- Chirwa Esnat, Jewkes Rachel, Van Der Heijden Ingrid, Dunkle Kristin. Intimate partner violence among women with and without disabilities: a pooled analysis of baseline data from seven violence-prevention programmes. *BMJ Glob Health*. Nov. 2020;5(11). <https://doi.org/10.1136/bmjgh-2019-002156>.
- Lund Emily. Community-based services and interventions for adults with disabilities who have experienced interpersonal violence: A review of the literature. Oct. 2011. <https://doi.org/10.1177/1524838011416377>.
- Bacchus Loraine, Ranganathan Meghna, Watts Charlotte, Devries Karen. *Recent intimate partner violence against women and health: A systematic review and meta-analysis of cohort studies*. 2018. <https://doi.org/10.1136/bmjopen-2017-019995>.
- Sutton Amber, Beech Haley, Ozturk Burcu, Nelson-Gardell Debra. Preparing mental health professionals to work with survivors of intimate partner violence: a comprehensive systematic review of the literature. *Affilia - Journal of Women and Social Work*. 2020;36(3):426–440. <https://doi.org/10.1177/0886109920960827>.
- Oram Sian, Fisher Helen, Minnis Helen, et al. The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy. *Lancet Psychiatry*. 2022;9(6):487–524. [https://doi.org/10.1016/S2215-0366\(22\)00008-6](https://doi.org/10.1016/S2215-0366(22)00008-6) [Online]. Available: . Accessed June 28, 2023.
- Wathen Nadine, Mantler Tara. Trauma- and violence-informed care: orienting intimate partner violence interventions to equity. *Curr Epidemiol Rep*. 2022;9:233–244. <https://doi.org/10.1007/s40471-022-00307-7>. Accessed July 11, 2023.
- Aginskaitė Simona, Uscila Rokas. Viktimologinis tyrimas: moterų su negalia smurto patirtys. <https://www.lnf.lt/wp-content/uploads/2022/03/Viktimologinis-tyrimas-ataskaita-LNF.pdf>; 2022. Accessed June 20, 2023.
- Hall Stuart. *Representation: Cultural Representations and Signifying Practices*. Sage Publications, Inc; Open University Press; 1997 [Online]. Available: <https://psycnet.apa.org/record/1997-36930-000>. Accessed January 24, 2024.
- Braun Virginia, Clarke Victoria. Thematic analysis. In: *Encyclopedia of Quality of Life and Well-Being Research*. Springer International Publishing; 2022:1–7. https://doi.org/10.1007/978-3-319-69909-7_3470-2.
- Braun Virginia, Clarke Victoria. Reflecting on reflexive thematic analysis. 2019. <https://doi.org/10.1080/2159676X.2019.1628806>.
- Gough Brendan, Madill Anna. Subjectivity in psychological science: from problem to prospect. *Psychol Methods*. Sep. 2012;17(3):374–384. <https://doi.org/10.1037/a0029313>.
- Jacob Stacy, Ferguson Paige. Writing interview protocols and conducting interviews: tips for students new to the field of qualitative research. *Qual Rep*. 2015. <https://doi.org/10.46743/2160-3715/2012.1718>.
- Braun Virginia, Clarke Victoria. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2). <https://doi.org/10.1191/1478088706qp0630a>.

35. Braun Virginia, Clarke Victoria, Hayfield Nikki, Davey Louise, Jenkinson Elizabeth. Doing reflexive thematic analysis. In: *Supporting Research in Counselling and Psychotherapy*. 2023. https://doi.org/10.1007/978-3-031-13942-0_2.
36. *Software. MAXQDA 2022*. 2022.
37. O'Brien Bridget, Harris Ilene, Beckman Thomas, Reed Darcy, Cook David. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med*. 2014; 89(9):1245–1251. <https://doi.org/10.1097/ACM.0000000000000388>.
38. Tong Allison, Sainsbury Peter, Craig Jonathan. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. Dec. 2007;19(6):349–357. <https://doi.org/10.1093/intqhc/mzm042>.
39. Jain Shobhit, Patnaik Kuppli Pooja, Deep Pattanayak Raman, Sagar Rajesh. *Ethics in psychiatric research: Issues and recommendations*. 2017. https://doi.org/10.4103/LJPSYM.LJPSYM_131_17.
40. Keogh Brian, Daly Louise. *The ethics of conducting research with mental health service users*. 2009. <https://doi.org/10.12968/bjon.2009.18.5.40539>.
41. DuBois James. "Ethics in mental health research: principles, guidance and cases. *Oxford University Press*. 2008;193(6). <https://doi.org/10.1192/bjp.bp.108.049890>, 256pp. ISBN 9780195179934," *British Journal of Psychiatry*.
42. Ellsberg Mary, Heise Lori. *Bearing witness: Ethics in domestic violence research*. 2002. [https://doi.org/10.1016/S0140-6736\(02\)08521-5](https://doi.org/10.1016/S0140-6736(02)08521-5).
43. Aronson Fontes Lisa. *Ethics in violence against women research: The sensitive, the dangerous, and the overlooked*. 2004. https://doi.org/10.1207/s15327019eb1402_4.
44. Downes Julia, Kelly Liz, Westmarland Nicole. Ethics into violence and abuse research - a positive empowerment approach. *Sociol Res Online*. 2014;19(1). <https://doi.org/10.5153/sro.3140>.
45. World Health Organization. *Ethical and safety recommendations for intervention research on violence against women. Building on Lessons from the WHO Publication "Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women"*. 2016.
46. Gunter Jeniffer. Intimate partner violence. *Obstet Gynecol Clin N Am*. 2007;34(3): 367–388. <https://doi.org/10.1016/j.ogc.2007.06.010>. . Accessed June 19, 2024.
47. McKibbin Anne, Gill-Hopple Kathy. Intimate partner violence: what health care providers should know. *Nurs Clin*. 2018;53(2):177–188. <https://doi.org/10.1016/j.cnur.2018.01.007>. . Accessed June 28, 2023.
48. Martín-Fernández Manuel, Gracia Enrique, Lila Marisol. Psychological intimate partner violence against women in the European Union: a cross-national invariance study. *BMC Public Health*. Dec. 2019;19(1). <https://doi.org/10.1186/s12889-019-7998-0>.
49. Anyango Cartrine, Goicolea Isabel, Namatovu Fredinah. Women with disabilities' experiences of intimate partner violence: a qualitative study from Sweden. *BMC Womens Health*. Dec. 2023;23(1). <https://doi.org/10.1186/s12905-023-02524-8>.
50. Flury Marianne, Nyberg Elisabeth, Riecher-Rössler Anita. *Domestic violence against women: Definitions, epidemiology, risk factors and consequences*. 2010. <https://doi.org/10.4414/smww.2010.13099>. *SMW supporting association*.
51. United Nations Commission on the Status of Women. Fact sheet: violence against women and girls with disabilities [Online]. Available: <http://web.worldbank.org/WBSITE/EXT>; 2013.
52. McCarthy Michelle, Hunt Siobhan, Milne-Skillman Karen. I know it was every week, but I can't be sure if it was every day: domestic violence and women with learning disabilities. *J Appl Res Intellect Disabil*. Mar. 2017;30(2):269–282. <https://doi.org/10.1111/jar.12237>.
53. Sara-Beth Plummer, Findley Patricia. Women with disabilities' experience with physical and sexual abuse: a Review of the literature and implications for the field. *Trauma Violence Abuse*. Jan. 2012;13(1):15–29. <https://doi.org/10.1177/1524838011426014>.
54. Wijker Doron, Sillitti Paola, Hewlett Emily. The provision of community-based mental health care in Lithuania. *OECD Health Working Papers*. 2022;143. <https://doi.org/10.1787/18de24d5-en>. . Accessed July 7, 2023.
55. Taccini Federica, Mannarini Stefania. *An Attempt to Conceptualize the Phenomenon of Stigma toward Intimate Partner Violence Survivors: A Systematic Review*. MDP1; Mar. 01, 2023. <https://doi.org/10.3390/bs13030194>.
56. Grigutytė Neringa, Jakubauskienė Marija, Levickaitė Karilė. Stigmatizuojančios Lietuvos gyventojų nuostatos psichikos sveikatos srityje - tyrimo ataskaita. https://www.hi.lt/uploads/pdf/Psichikos_sveikatos_centras/2023/Stigmatizuojančiu_nuost_atu_psichikos_sveikatos_srityje_apklausoju_duomenu_analize.pdf; 2022. Accessed July 20, 2023.
57. Thornicroft Graham, Sunkel Charlene, Aliev Akmal Alikhon, et al. The lancet commission on ending stigma and discrimination in mental health. *The Lancet Commissions*. 2022;400(10361):1438–1480. [https://doi.org/10.1016/S0140-6736\(22\)01470-2](https://doi.org/10.1016/S0140-6736(22)01470-2). . Accessed July 21, 2023.
58. Spencer Chelsea, Keilholtz Brooke, Palmer Megan, Vail Summer. *Mental and Physical Health Correlates for Emotional Intimate Partner Violence Perpetration and Victimization: A Meta-Analysis*. *Trauma Violence Abuse*; 2022. <https://doi.org/10.1177/15248380221137686>.
59. Lohmann Susanne, Cowlshaw Sean, Ney Luke, O'Donnell Meaghan, Kim Felmingham. *The Trauma and Mental Health Impacts of Coercive Control: A Systematic Review and Meta-Analysis*; 2023. <https://doi.org/10.1177/15248380231162972>. *Trauma Violence Abuse*. . Accessed June 28, 2023.
60. Pastor-Moreno Guadalupe, Saletti-Cuesta Lorena, Henares-Montiel Jesús, Escudero-Carretero María, Higuera-Callejón Camila, Ruiz-Pérez Isabel. Systematic review of healthcare interventions for reducing gender-based violence impact on the mental health of women with disabilities. *J Nurs Scholarsh*. May 2024. <https://doi.org/10.1111/jnu.12985>.
61. Butler Lisa, Critelli Filomena, Rinfrette Elaine. *Trauma-informed care and mental health*. *Dir Psychiatr*. 2011;31(3):197–212.
62. Karakurt Günnur, Koç Esin, Katta Pranaya, Jones Nicole, Bolen Shari. "Treatments for Female Victims of Intimate Partner Violence: Systematic Review and Meta-Analysis", Feb. 04. *Frontiers Media S.A*; 2022. <https://doi.org/10.3389/fpsyg.2022.793021>.