RESPONSES TO MENTAL HEALTH CARE NEEDS OF SURVIVORS OF INTIMATE PARTNER VIOLENCE BY MENTAL HEALTH SERVICES IN LITHUANIA AND PORTUGAL

UGNĖ GRIGAITĖ

A thesis submitted in fulfilment of the requirements for the Doctoral Degree in Global Public Health

(in association between the National School of Public Health, the Institute of Hygiene and Tropical Health and NOVA Medical School of NOVA University of Lisbon, and the Institute of Public Health of the University of Porto)

September, 2024

Campo Mártires da Pátria, 130
1169-056 Lisboa · Portugal

www.nms.unl.pt

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Ugnė Grigaitė

Supervisor: José Miguel Caldas de Almeida, PhD, Emeritus Full Professor at the Lisbon Institute of Global Mental Health, Comprehensive Health Research Centre, NOVA Medical School of the NOVA University of Lisbon.

Co-Supervisor: Jaime Manuel Novo Grácio, PhD, Invited Assistant Professor at the NOVA Medical School of the NOVA University of Lisbon.

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Most of all, I dedicate this achievement to my late grandad (skiriu Seleniui) Jonas Anatolijus Pocius who would have been so proud…

Sincerely, Ugnė Grigaitė
grigaiteu@gmail.com

List of Publications

Scientific Paper No. 1:

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Scientific Paper No. 3:

Grigaitė, U., Azeredo-Lopes, S., Žeimė, E., Yamin-Slotkus, P., Heitmayer, M., Aluh, D.O., Pedrosa, B., Silva, M., Santos-Dias, M., Cardoso, G., Caldas-de-Almeida, J.M. (2024) **Prevalence and Acceptability of Psychological and/or Economic Intimate Partner Violence, and Utilization of Mental Health Services by its Survivors in Lithuania**. *Journal of Public Health, Oxford University Press*. https://doi.org/10.1093/pubmed/fdae015	*Journal of Public Health* Q1 Impact Factor: 4.7

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Grigaitė, U., Klidziūtė, G., Aluh, D.O., Pedrosa, B., Santos-Dias, M., Silva, M., Cardoso, G., Caldas-de-Almeida, J.M. (2024) **Responding to the Needs of Survivors of Intimate Partner Violence in Lithuania: Perceptions of Mental Health and Social Care Professionals**. *Women & Health.* https://doi.org/10.1080/03630242.2024.2382419	*Women & Health* Q2 Impact Factor: 1.6

Scientific Paper No. 5:

Grigaitė, U., Azeredo-Lopes, S., Aluh, D.O., Pedrosa, B., Santos-Dias, M., Silva, M., Cardoso, G., Caldas-de-Almeida, J.M. (2024) **Use of Mental Health Services by Survivors of Intimate Partner Violence in Lithuania: A Mixed-Methods Study**.	UNDER PEER-REVIEW *Social Psychiatry and Psychiatric Epidemiology* Q1 Impact Factor: 3.6

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Grigaitė, U., Aginskaitė, S., Pedrosa, B., Aluh, D.O., Santos-Dias, M., Silva, M., Cardoso, G., Caldas-de-Almeida, J.M. (2024) **When Gender, Disability, Domestic Violence, and Mental Health Services Intertwine: Experiences of Women with Disabilities in Lithuania**.	UNDER PEER-REVIEW *Disability & Health Journal* Q1 Impact Factor: 3.7

Abstract

Background:

Intimate partner violence (IPV) is the most prevalent expression of violence against women, with at least one in three women experiencing it at some point in their lives. IPV is a type of gender-based violence which is a major global public health problem due to its high prevalence and profound impact on the health and well-being of not only individuals but also local and global communities. Survivors of IPV are at a higher risk of poor health outcomes compared to those who have not experienced IPV, and they are at least three times more likely to have mental health conditions. The public health approach to IPV by no means replaces the human rights and criminal justice responses to violence: instead, it highlights the complexity of the problem and complements them by offering additional understanding, perspectives, evidence, tools, and sources of collaboration.

Objectives:

The main objectives of this study are to assess the prevalence of IPV and mental health conditions among IPV survivors in Portugal and Lithuania; and to analyse and compare responses to the mental health needs of IPV survivors within the existing mental healthcare systems in both countries.

Methods:

This cross-sectional study employed a mixed-methods approach. Nationally representative data from two surveys was analysed: one survey conducted in Portugal (n=3849) and another in Lithuania (n=1001). Additionally, two online surveys were designed and conducted in both countries (n=92 and n=134): both quantitative and qualitative data were collected in these online surveys. Qualitative data was also collected through a total of 6 focus groups with mental health and social care professionals and 28 semi-structured interviews with IPV survivors, including those with disabilities. Statistical analysis included logistic regression models and was conducted using the *R* software. Qualitative data was analysed thematically with the aid of the MAXQDA software.

Results:

The study resulted in 6 scientific papers, two focusing on the situation in Portugal and four in Lithuania. Study findings highlight and confirm the importance of mental health support for IPV survivors' recovery. The needed complex approaches include trauma- and violence-informed care, holistic, multi-disciplinary, and inter-sectoral efforts.

The study shows that the current profile, organisation, and provision of mental healthcare services in Portugal and Lithuania generally have significant gaps when it comes to addressing such a complex public mental health concern as IPV. Most of the studied mental healthcare services in these two countries are not equipped well enough to effectively and appropriately respond to the individual needs of IPV survivors. The only exception is the unique mental healthcare unit in the Portuguese region of Coimbra, which specialises in providing mental health support specifically to survivors and perpetrators of domestic violence, including IPV.

Apart from this one mental healthcare unit, which is unique not only in Portugal but also in Europe, many of the generic mental healthcare services and professionals in both countries often demonstrate a lack of recognition that IPV is a public mental health concern: it is regularly perceived as more of a "social problem", which is then not necessarily recognised as being relevant to the provision of mental healthcare services. Generally, a lack of effective interventions has been observed. Trauma- and violence-informed care approaches are often missing, and both countries would benefit from a better inclusion of IPV survivors with lived experiences of mental health conditions into the related policy and practice planning and implementation.

Conclusions:

Further quantitative and qualitative research is needed to explore the specificities of the utilisation of mental healthcare services by IPV survivors, as well as determine what interventions might be the most effective for this population, in different geographical and cultural contexts. Implications for the public health policy and practice include the need for mainstreaming of IPV-related knowledge and skills among professionals in mental healthcare services; elimination of both the mental health and IPV stigma and victim-blaming attitudes in society; ensuring multi-disciplinary and inter-sectoral working models between the mental healthcare sector, social care services, law enforcement, judiciary, and other relevant stakeholders.

Resumo

Contexto: A violência por parceiro íntimo (VPI) é a forma mais prevalente de violência contra as mulheres, com pelo menos uma em cada três mulheres a experienciá-la em algum momento ao longo da sua vida. A VPI, um tipo de violência baseada no género, é um problema major de saúde pública global devido à sua elevada prevalência e ao profundo impacto na saúde e bem-estar, não só dos indivíduos, mas também das comunidades locais e globais. Sobreviventes de VPI têm um maior risco de sofrer consequências negativas para a saúde, comparativamente àqueles que não experienciaram VPI, sendo pelo menos três vezes mais propensos a ter problemas associados à saúde mental. A abordagem de saúde pública à VPI não substitui em caso algum as respostas focadas nos direitos humanos e na justiça criminal à violência: em vez disso, reforça o nível de complexidade do problema e complementa estas respostas, adicionando uma nova camada de conhecimento e compreensão, novas perspectivas, evidência científica, ferramentas e fontes de colaboração.

Objetivos: Os principais objetivos deste estudo são avaliar a prevalência de VPI e de problemas de saúde mental entre sobreviventes de VPI em Portugal e na Lituânia; e analisar e comparar as respostas às necessidades de saúde mental dos sobreviventes de VPI dos sistemas de saúde mental existentes em ambos os países.

Métodos: Este estudo transversal utilizou uma abordagem de métodos mistos. Foram analisados dados representativos a nível nacional de dois inquéritos: um inquérito realizado em Portugal (n=3849) e outro na Lituânia (n=1001). Além disso, foram concebidos e realizados dois inquéritos *online* em ambos os países (n=92 e n=134): nestes inquéritos foram recolhidos tanto dados quantitativos como qualitativos. Dados qualitativos foram ainda recolhidos através de 6 grupos focais com profissionais de saúde mental e serviço social, bem como 28 entrevistas semiestruturadas com sobreviventes de VPI, incluindo de pessoas com deficiência. A análise estatística incluiu modelos de regressão logística e foi conduzida utilizando o *software* R. Os dados qualitativos foram analisados tematicamente com a ajuda do *software* MAXQDA.

Resultados: Deste estudo resultaram em 6 artigos científicos, sendo dois focados na situação em Portugal e quatro na Lituânia. Estes resultados destacam e confirmam a importância que o apoio à saúde mental tem no processo de recuperação das sobreviventes de VPI. As abordagens necessárias são complexas, e incluem cuidados

informados por trauma e violência, e esforços abrangentes, multidisciplinares e intersectoriais.

O estudo demonstra que os atuais perfis, organização e prestação de serviços de saúde mental em Portugal e na Lituânia apresentam de uma maneira geral lacunas significativas quando se trata de abordar um problema tão complexo de saúde mental pública como a VPI. A maioria dos serviços de saúde mental estudados nesses dois países não está suficientemente equipada para responder de forma eficaz e apropriada às necessidades individuais dos sobreviventes de VPI. A única excepção encontrada foi a singular unidade de saúde mental na região de Coimbra, Portugal, que se especializa em prestar apoio de saúde mental especificamente a sobreviventes de violência doméstica e agressores, incluindo a VPI.

À excepção desta unidade de saúde mental, que é única não apenas em Portugal mas também na Europa, muitos dos serviços gerais e profissionais de saúde mental em ambos os países frequentemente demonstram falta de reconhecimento de que a VPI é uma questão de saúde mental pública: é frequentemente entendida como um "problema social", o que pode levar a não ser tida como relevante na prestação de serviços de saúde mental. Em geral, observa-se uma falta de intervenções eficazes. Abordagens de cuidados informados por trauma e violência frequentemente estão ausentes, e ambos os países beneficiariam de uma maior inclusão de sobreviventes de VPI com experiência de problemas de saúde mental no planeamento e implementação de práticas e políticas sobre este tema.

Conclusões: É necessária mais investigação quantitativa e qualitativa para explorar as especificidades da utilização dos serviços de saúde mental por parte de sobreviventes de VPI, bem como determinar quais as intervenções que podem ser mais eficazes para esta população, em diferentes contextos geográficos e culturais. As implicações para políticas de saúde pública e prestação de cuidados incluem a necessidade de disseminar e incluir o conhecimento e as competências relacionadas à VPI entre os profissionais dos serviços de saúde mental; eliminar o estigma, tanto relacionado com a saúde mental quanto com a VPI, bem como as atitudes de culpabilização da vítima, presente na sociedade; garantir modelos de trabalho multidisciplinares e intersectoriais entre o setor de saúde mental, os serviços sociais, o setor legal e judiciário, e outros actores relevantes.

Santrauka

Įvadas: Intymaus partnerio smurtas (IPS) yra labiausiai paplitusi smurto prieš moteris išraiška ir bent viena iš trijų moterų tai patiria kažkuriame savo gyvenimo etape. IPS yra laikoma viena iš smurto lyties pagrindu formų, reikšminga ir plačiai paplitusi globalios visuomenės sveikatos problema, veikianti ne tik atskirų individų, bet ir vietos bendruomenių ir visos visuomenės sveikatą ir gerovę. IPS lemia blogesnę moterų fizinę sveikatą ir bent tris kartus didesnę psichikos sveikatos sutrikimų riziką, lyginant su moterimis, kurios nepatyrė IPS. Visuomenės sveikata grindžiamas požiūris į IPS nepakeičia žmogaus teisių ar baudžiamosios justicijos atsako į smurtą, atvirkščiai, jis papildo ir pabrėžia problemos sudėtingumą bei kompleksiškumą, siūlydamas naujas įžvalgas, perspektyvas, mokslu grindžiamus įrodymus, įrankius ir išteklius bendradarbiavimui.

Tikslas: Pagrindiniai šio tyrimo tikslai – įvertinti psichikos sveikatos sutrikimų paplitimą tarp IPS išgyvenusiųjų Portugalijoje ir Lietuvoje; išanalizuoti ir palyginti abiejų šalių psichikos sveikatos priežiūros sistemų atsaką į IPS išgyvenusių moterų psichikos sveikatos poreikius.

Metodai: Šiame vienmomentiniame skerspjūvio tyrime buvo derinami keli metodai. Buvo išanalizuoti reprezentatyvūs dviejų nacionaliniu mastu atliktų visuomenės apklausų duomenys, viena apklausa atlikta Portugalijoje (n=3849), kita – Lietuvoje (n=1001). Be to, abiejose šalyse buvo atliktos ir dvi internetinės IPS išgyvenusiųjų apklausos (atitinkamai n=92 ir n=134), skirtos surinkti tiek kiekybinius, tiek ir kokybinius duomenis. Buvo suorganizuotos ir šešios fokusuotos diskusijų grupės, kuriose dalyvavo psichikos sveikatos ir socialinės priežiūros specialistai, atlikti 28 pusiau struktūruoti interviu su IPS išgyvenusiomis moterimis, įskaitant moteris su negalia. Statistinė analizė apėmė logistinės regresijos modelius ir buvo atlikta naudojant R kompiuterinę programą. Kokybiniai duomenys buvo analizuojami atliekant teminę analizę, naudojant MAXQDA kompiuterinę programą.

Rezultatai: Tyrimo rezultatas – šeši moksliniai straipsniai, publikuoti tarptautiniuose mokslo žurnaluose, iš kurių du skirti situacijos Portugalijoje analizei, keturi – Lietuvos duomenims aptarti. Tyrimo duomenys, pabrėžia ir patvirtina psichikos sveikatos pagalbos ir paslaugų svarbą IPS išgyvenusių asmenų atsigavimui (angl. recovery). Atliktas tyrimas parodė kompleksinių metodų poreikį šių paslaugų teikimui, kurie apima

psichikos sveikatos paslaugų teikimą atsižvelgiant į traumos ir smurto patirtį (angl. trauma- and violence-informed care), holistines, daugiadisciplinines ir tarpsektorines pastangas.

Tyrimas parodė, kad esamas psichikos sveikatos priežiūros paslaugų profilis, organizavimas ir teikimas Portugalijoje ir Lietuvoje turi didelių spragų sprendžiant tokią sudėtingą visuomenės psichikos sveikatos problemą kaip IPS. Dauguma tirtų psichikos sveikatos priežiūros paslaugų abiejose šalyse nėra pakankamai išvystytos, kad galėtų veiksmingai ir tinkamai reaguoti į individualius IPS išgyvenusių moterų poreikius. Vienintelė išimtis yra unikalus psichikos sveikatos priežiūros skyrius Portugalijos Koimbros regione, kuris konkrečiai specializuojasi teikiant psichikos sveikatos pagalbą, skirtą asmenims, išgyvenusiesiems smurtą artimoje aplinkoje, įskaitant IPS.

Be šio vienintelio psichikos sveikatos priežiūros skyriaus, kuris yra unikalus ne tik Portugalijoje, bet ir Europoje, daugelis bendrųjų psichikos sveikatos priežiūros paslaugų ir specialistų abiejose šalyse dažnai neatpažįsta, kad IPS yra visuomenės psichikos sveikatos problema. IPS neretai yra labiau suvokiamas kaip socialinė, o ne sveikatos problema, tokiu būdu ignoruojant jos aktualumą psichikos sveikatos priežiūros sistemai. Taip pat tyrimas leido identifikuoti veiksmingų intervencijų trūkumą: dažnai trūksta psichikos sveikatos paslaugų teikimo atsižvelgiant į traumos ir smurto patirtį (angl. trauma- and violence-informed care) bei su tuo susijusių metodų taikymo, o taip pat abiem šalims būtų naudinga nuosekliai įtraukti IPS išgyvenusius asmenis, turinčius psichikos sveikatos sutrikimų patirties, į atitinkamos politikos ir praktikos planavimą bei įgyvendinimą.

Išvados: Reikalingi tolesni kiekybiniai ir kokybiniai tyrimai, siekiant ištirti IPS išgyvenusiųjų psichikos sveikatos priežiūros paslaugų teikimo ir naudojimo ypatumus, taip pat nustatyti, kokios intervencijos galėtų būti veiksmingiausios šiai visuomenės grupei skirtinguose geografiniuose ir kultūriniuose kontekstuose. Poveikis visuomenės sveikatos politikai ir praktikai apima psichikos sveikatos priežiūros specialistų žinių apie IPS ir įgūdžių integravimą; psichikos sveikatos ir IPS stigmos bei aukas kaltinančio požiūrio panaikinimą visuomenėje; bei psichikos sveikatos priežiūros sektoriaus, socialinės priežiūros paslaugų, teisėsaugos, teismų ir kitų suinteresuotųjų šalių daugiadisciplininio ir tarpsektorinio bendradarbiavimo modelių įgyvendinimą.

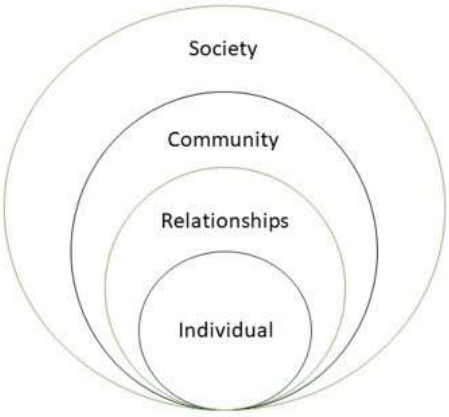
Introduction

Intimate Partner Violence as a Global Public Health Problem

Intimate partner violence (IPV) is the most prevalent expression of violence against women (WHO, 2021). IPV is globally recognised as a type of gender-based violence, a serious public health concern, and a human rights issue, with at least one in three women experiencing it at some point in their lives (Chandan et al., 2020; European Union Agency for Fundamental Rights, 2014; Garcia-Moreno et al., 2006; The European Parliament, 2024; WHO, 2018).

IPV is a major global public health problem due to its high prevalence and profound impact on the health and well-being of not only individuals but also local and global communities (Stöckl & Sorenson, 2024; World Health Organization, 2002). The public health approach to IPV by no means replaces the human rights and criminal justice responses to violence: instead, it highlights the complexity of the problem and complements them by offering additional understanding, perspectives, evidence, tools, and sources of collaboration (World Health Organization, 2002).

In line with the public health approach, IPV and its consequences can be prevented and various sociological theories of IPV engage with different levels of the social-ecological framework (Meyer et al., 2024). The social-ecological model highlights the multifaceted complexity of violence: its nature being related to both individual-, relationship-, community-, and society-level factors, which intersect and overlap with each other (World Health Organization, 2002).



The social-ecological model for understanding the nature of violence

According to Johnson's (1995) typology of IPV, there is more than one type of IPV: e.g., 'patriarchal terrorism' or 'situational couple violence' (Johnson, 1995). However, this doctoral thesis focuses specifically on 'systemic' IPV against women, which refers to the fact that a lot of the time IPV is a long-term systemic and continuous abuse, which manifests as various strategic demonstrations of power and control by the perpetrator over the victim-survivor through manipulations: threats, intimidation, undermining, destroying of self-confidence, and making them increasingly dependent on their partner (WHO, 2019).

One of the main reasons for this phenomenon has been evidenced to be the existing imbalance of power and control between men and women, influenced by the context of deeply rooted gender inequality and historically patriarchal worldview in most societies of the world (Chandan et al., 2020; Hawkes et al., 2020; Wenigmann et al., 2024; WHO, 2018). Attitudinal variables play a significant role in men's perpetration and perception of IPV against women and its severity: men tend to perceive IPV as less severe than women. A recent systematic review and meta-analysis has found that there is a negative relationship between the perceived severity of IPV against women and such attitudes as "sexist views, victim blaming, excusing the perpetrator, rape myth acceptance, and traditional gender roles adherence" (Badenes-Sastre et al., 2024).

Types of 'systemic' IPV include psychological, economic, physical and/or sexual abuse, coercive and controlling behaviours by a current or former intimate partner, such as marital, co-habiting or dating partners (WHO, 2019). Physical IPV is criminalised in many countries and has been extensively studied across the world. It may include such acts as beating, slapping, kicking, pushing, pulling hair, and throwing things at a person (Masci & Sanderson, 2017). Sexual abuse includes any type of sexual behaviour against the free will of the concerned person and without their consent (WHO, 2013, 2019).

Psychological IPV is generally a less easily recognised form, which may manifest itself through name calling, humiliating, isolating, threatening or frightening behaviour, hurting pets, destroying personal possessions, and turning their children against victim-survivors (Martín-Fernández et al., 2019; Salis et al., 2014). Psychological IPV also includes economic violence (for example, controlling finances, not allowing the person to study or work, not allowing access to personal or family bank accounts, and demanding detailed reports for all spending), and coercive control (Stark & Hester, 2019).

Psychological IPV, including economic abuse and coercive control, are less clearly understood and often lack a common definition among different stakeholders (Brennan et al., 2019; Robinson et al., 2018; Stark & Hester, 2019).

Intimate Partner Violence and Mental Health Conditions

There is evidence that survivors of any type of IPV are at a higher risk of poor health outcomes compared to those who have not experienced IPV (Bacchus et al., 2018; Black et al., 2011; Reingle Gonzalez et al., 2018). Women with a history of IPV are at least three times more likely than women without it to develop mental health conditions (Bacchus et al., 2018; Gibbs et al., 2018).

IPV is a complex issue and according to Chandan and collaborators (2020): “IPV negatively impacts women’s sense of self, with other multiple losses in relation to income, work, housing, and social participation further undermining recovery into the long term” (Chandan et al., 2020).

Across the world, there have been associations established between experiencing IPV and anxiety, depression, pre-natal depression, post-traumatic stress disorder, and suicide (Chandan et al., 2020; Chmielowska & Fuhr, 2017; Devries et al., 2013; Dokkedahl et al., 2022; Estefan et al., 2016; Shamblaw et al., 2019; White et al., 2023; WHO, 2016b).

The Role of Mental Health Services

The evidence on the adverse mental health outcomes associated with exposure to IPV has significant implications for the development and delivery of mental health services (White et al., 2023). In recent years, an increasing number of authors have started recognising that mental health systems, services and professionals have a significant role to play in providing effective mental health services and support to IPV survivors (Karakurt et al., 2022; Sutton et al., 2020; WHO, 2016b).

According to the Lancet Psychiatry Commission on IPV and Mental Health (Oram et al., 2022), the support should start within the context of a mental health assessment, by asking all mental health service users, especially women and gender and sexual minorities, about their potential experiences of IPV (Oram et al., 2022). Mental health services are vital for IPV survivors to achieve healing and therapeutic, medical, and

personal recovery (McKibbin & Gill-Hopple, 2018; Oram et al., 2022). As Carman and co-authors (2023) have highlighted: “Overall, recovery from IPV is multidimensional and individualistic in nature. It is an arduous journey that evolves over a long period of time and requires a great deal of support.” (Carman et al., 2023)

For women, who are survivors of IPV and seek help, mental health support systems, services and mental health professionals can play a significant role in effectively addressing and assisting such a critical situation:

> *“By applying and emphasising an understanding of the connection between individual and structural explorations of gender, race, class, and other socially constructed identities, mental health professionals can utilise the skills necessary to challenge inequalities, which in turn can encourage survivors to create strategies that make sense to themselves and their communities”* (Sutton et al., 2020).

It is especially crucial in cases of psychological violence, coercive control, and economic violence, which are the types of IPV that often lack effective coverage by criminal justice laws and legal systems, making it an especially heavy burden on survivors of such violence, who have very limited opportunities to seek effective help and achieve justice.

The existing mental health systems, accessibility, affordability, and quality of mental health support services play a major role here. Thus, a better understanding of the effects of differences in the structuring, organisation and staff allocation of mental health systems in different countries is needed to better assess its effects and influences on the variety, capacity, and quality of responses by mental health support services to mental health problems, individual and population needs, and mental health conditions of survivors of IPV across the world.

In terms of existing interventions and mental healthcare options relevant to this population, cognitive-behavioural therapy-based interventions tailored to IPV survivors have been evidenced to be among the most effective approaches (Arroyo et al., 2017; Hameed et al., 2020). Additionally, a systematic review recently highlighted the importance for professionals who work with IPV survivors to be trained in specific trauma interventions, such as trauma-focused cognitive-behavioural therapy (Trabold et al., 2020). In general, integrating specific trauma- and violence-informed care approaches and practices in mental healthcare responses has so far been observed to be one of the

promising developments in the related transformation of mental health services for this population (Wathen & Mantler, 2022).

Nevertheless, there are knowledge gaps in this field concerning the specificities, accessibility, effectiveness of different interventions and quality of responses by mental healthcare services to the needs of IPV survivors, as well as about their personal experiences when accessing mental healthcare.

Main Objectives and Research Questions

The main objectives of this study are to assess the prevalence of IPV and mental health conditions among IPV survivors in Portugal and Lithuania; and to analyse and compare responses to the mental health needs of IPV survivors within the existing mental healthcare systems in both countries.

The research questions are as follows:

RQ.1) What do we currently know about the prevalence and context of IPV in Portugal and Lithuania?

RQ.2) What are the contemporary responses to the mental health care needs of IPV survivors in Portugal and Lithuania?

RQ.3) What are the experiences of IPV survivors who use mental health services in both countries?

RQ.4) How do Portugal and Lithuania compare in their mental health services' responses to the mental health care needs of IPV survivors?

Methods

Study Design

This observational cross-sectional mixed-methods study was conducted in two European Union member-states: Portugal and Lithuania. According to the World Bank, both are high-income countries. Lithuania may be described as a Northern country and Portugal as a Southern country. Also, the two countries are located on two opposite sides of the European Union: Lithuania in the East and Portugal in the West. The two countries have some similarities, for example, the relatively small size of land and population, predominant Catholic religion, a similar number of decades under an authoritarian regime during the 20th century, and a similarly low gender equality index, according to the European Institute for Gender Equality (EIGE, 2023).

In addition, the two countries have some distinct differences, especially concerning their history, current cultural, societal and political structures and influences, dynamics in personal relationships, families and communities, suicide rates, and achieved stages of development of their mental healthcare systems. Since IPV concerns relationships and is a type of gender-based violence, which is also very much related to socially constructed 'norms' in society, the comparison between the two countries aims to look at how the same public mental health problem may express itself in different geographical and cultural contexts: both the IPV itself and related mental health difficulties and the use of mental health services among survivors.

Sources of Data

In Portugal, data from the WHO World Mental Health Survey Initiative Portugal was used. This Survey was conducted in Portugal in 2008-2010, as a part of the broader worldwide WHO World Mental Health Surveys Initiative (Kessler, Aguilar-Gaxiola, Alonso, Chatterji, Lee, & Üstün, 2009; Kessler, Aguilar-Gaxiola, Alonso, Chatterji, Lee, Ormel, et al., 2009; Xavier et al., 2013). The Survey in Portugal was a cross-sectional study, representative of the Portuguese population. It was implemented by employing a stratified multi-stage clustered area probability household sample.

Participants of this Survey were those who had given their informed consent to participate in the Survey before each interview, who were 18 years or older, living in mainland Portugal, and Portuguese speaking (Xavier et al., 2013). More details about the study design, response rates, weighting of the data, fieldwork, and other procedures may be referred to in other publications (Cardoso et al., 2020; Xavier et al., 2013).

In Lithuania, an original survey was designed and implemented by an international team of academics and experts, in 2021 (the #ItsNotOk Initiative). A nationally representative sample of data concerning IPV and social 'norms' in Lithuania was collected. Several questions were included in this survey about the experiences of survivors of different types of IPV when approaching mental health services in the country.

Additionally, an original online survey was developed (Andrews et al., 2007) by the research team at the Lisbon Institute of Global Mental Health, in 2022. Identical online surveys were conducted in both countries to complement the abovementioned datasets.

The online survey aimed to collect both quantitative and qualitative data (Braun et al., 2021). It was disseminated publicly via internet channels in Portugal and Lithuania. The random and publicly open recruitment was conducted via social media, emails, and websites. Various Portuguese and Lithuanian non-governmental organisations and governmental institutions, as well as individual researchers, experts, and influencers, shared the online survey with their respective networks and audiences, and so did the national networks of victim support services for survivors of domestic violence in both countries.

Qualitative Study

Semi-Structured Interviews

Building on the design of the online survey, a protocol was developed for semi-structured interviews (Jacob & Furgerson, 2015). An option for the online survey participants to either provide their email addresses or to contact the lead researcher directly to participate in the semi-structured interviews (either in-person or online) was included in the online survey.

Both the online survey and semi-structured interviews explored the following data categories and questions:

1) Socio-demographic characteristics (gender of the participant; gender of the abuser; current age of the participant; their age when they experienced IPV for the first time; their age when they used mental health services for the first time; place of residence; place where they used mental health services).

2) Experience of IPV (*yes* or *no* answer).

'Intimate partner violence' was described as "*systemic violence that includes physical, psychological, economic and/or sexual abuse, coercive and controlling behaviours by an intimate partner, such as marital, co-habiting or dating partners*".

Types of IPV were described as follows:

- *Psychological* (includes calling names, humiliating, isolating, hurting your pets, destroying things dear to you, threatening, frightening, turning your children against you, etc.);
- *Economic* (includes controlling your finances, not allowing you to study or work, not allowing access to your/family bank accounts, demanding detailed reports for all your spending, etc.);
- *Physical* (includes pushing, hitting, slapping, kicking, throwing things at you, hair pulling, etc.);
- *Sexual* (includes any type of sexual behaviour against your free will and without consent).

3) Experience of seeking "*help or support in Portugal/Lithuania for mental health needs or emotional state due to or as a result of having experienced IPV*" (*yes* or *no* answer).

The concept of 'mental health' used in this study was described in the following way:

"*While answering the questions please understand 'mental health' as your emotional, psychological and social well-being. At any given time of their lives, everyone can have mental health difficulties. Such difficulties are not limited to specific mental health disorders or psychiatric diagnoses. It can also be feelings of anxiety, heavy emotions or dark thoughts, sleeping problems, changes in behaviour or habits, and similar*".

Participants were asked to describe in their own words their encounters with mental health professionals; what support they needed the most at the time; how were those needs met; what the professionals had to offer in response; how helpful was it; what were the most positive and negative aspects of this experience; what barriers (if any) did they face when seeking this support; what would they have liked the mental health professional(s) to have done differently.

In cases where the answer to the question about using mental health services was negative, the survey participants were asked to describe the reasons for not seeking help despite having experienced IPV.

4) Categories of encountered professionals (psychologist/psychotherapist; psychiatrist; family doctor/GP; social worker; other).

5) Categories of encountered services/settings (primary healthcare centre; general hospital – including A&E; specialised mental health centre; psychiatric hospital; NGO; emotional helpline; an individual mental health professional – directly; other).

6) The sector of services (public sector – state-funded; private sector – self-funded; a part of it public, and a part private).

Thirteen (13) in-depth semi-structured interviews were conducted between June 2022 and November 2023 with survivors of IPV who used mental health services in Lithuania.

Between July and December 2023, an additional round of fifteen (15) semi-structured interviews were conducted in Lithuania specifically with women with disabilities who experienced domestic violence, including IPV. These specific interviews were organised with support from and in collaboration with the Lithuanian Disability Forum.

Based on the research participants' preferences, 25 of the 28 interviews were conducted online using Microsoft Teams or Zoom Platforms, and three (3) were conducted in person. The in-person interviews took place in locations chosen by the participants, where they felt most comfortable. All participants signed informed consent forms before each interview. The confidentiality and anonymity of participants were ensured.

Focus Groups

Focus groups were conducted with professionals providing mental health support in both countries. A focus group guide was elaborated to explore the following areas with professionals in both countries:

1) Professionals' level of awareness and knowledge about IPV, as well as their specific practices of working with IPV survivors;

2) Professionals' perception of their role, as well as of opportunities and challenges faced, when providing mental health support to IPV survivors;

3) Professionals' perception of how their practices are affected and shaped by the existing mental health and social care systems in a respective country;

4) Observed or perceived practical challenges and barriers related to accessing the needed mental health care and support by survivors of IPV in a respective country.

In Lithuania, two online and two in-person focus groups were organised in October–November 2022, and in July 2023, respectively. They were organised with support from and in collaboration with a local non-governmental organisation Mental Health Perspectives.

In Portugal, one in-person and one online focus group were organised in November 2022, and November 2023, respectively. The in-person focus group was organised in collaboration with a unique specialised mental healthcare unit in the Portuguese region of Coimbra, which specifically serves persons who have experienced domestic violence, including IPV.

The online format was chosen for conducting some of the focus groups in both countries to enable the participation of professionals from different geographical locations, as well as to minimise the amount of time away from their work duties to be able to participate.

Summary of the methods applied in this study:

Method		Lithuania	Portugal	Total
Quantitative	Representative National Survey	1	1	2
Quantitative + Qualitative	Online Survey	1	1	2
Qualitative	Semi-Structured Interviews	28	0	28
Qualitative	Focus Groups	4	2	6

Data Analysis

For the descriptive statistical analysis, observed absolute frequencies (*n*) and relative frequencies (%) were used for all the categorical variables of interest. For the continuous variables, mean values and standard deviations (SD) were presented. First and third quartiles were included, and the median was chosen (instead of the mean) as a robust measurement of location when the data was found to have a skewed distribution.

For the bivariate statistical analysis, Chi-Square or Fisher's exact tests were employed to assess the association between categorical variables, as applicable. Univariate logistic regression models were obtained and the estimates of the odds ratios (OR) were presented, as well as the corresponding 95% confidence intervals (95%CI). The confidence level $\alpha = 5\%$ was used throughout the statistical analysis.

The data was analysed using the R software (R Core Team, 2020). The R *survey* package was used to obtain the relative frequencies, as well as all the statistical analyses that took into account the weighted data for the Portuguese population (Lumley, 2010). The R packages *psych* (Revelle, 2022), *car* (Fox & Weisberg, 2019), and *MASS* (Venables & Ripley, 2002) were also used when conducting analyses of the Lithuanian data.

For the qualitative analyses, all audio recordings of interviews and focus groups were transcribed verbatim and analysed thematically according to the recommendations of Braun and Clarke (Braun & Clarke, 2006, 2022). Transcripts as well as written responses to questions in the online surveys were read and re-read, and parts of the text were coded, synthesised, and divided into categories. An inductive approach was used to code the data and coding continued until no new concepts emerged from the collected data.

Thematic analysis (Braun et al., 2022; Braun & Clarke, 2006) was conducted using MAXQDA software (Software, 2022). The reporting of the findings of the qualitative part of the study followed the SRQR (O'Brien et al., 2014) and COREQ (Tong et al., 2007) standards, with additional consideration for MMARS reporting standards for mixed-methods studies (APA, 2020).

Research Team and Reflexivity

All members of the research team share an interest and many years of working in the fields of mental health, disability, human rights, public mental health, and gender-based violence. Their backgrounds cover not only positions in the academic sector and direct delivery of mental health services but also working within the non-governmental sector and engaging in civic activism.

Each one of them brings to this study a specific professional, as well as personal angle on the subject in question, which is in line with the values of qualitative research: i.e., valuing the subjectivity of each researcher as a resource, which may shape the research process in various ways (Braun et al., 2022; Braun & Clarke, 2019; Gough & Madill, 2012).

All research team members fully acknowledge the subjective influence of their own assumptions and the unique effects of this on the knowledge creation in this study.

This is seen as a strength due to the wide range of extensive knowledge and passion about the subject, as well as the invaluable professional and personal experiences of each research team member.

Ethical Considerations

In this study, general considerations for research ethics covered the obtaining of informed consent, including the clear possibility of withdrawal from it, privacy and data protection, anonymity, and confidentiality. Before giving their consent to participate in the study in written form, study participants received all the information concerning the study's objectives, voluntary nature of participation, confidentiality, and anonymity of the collected data.

In addition to the above, during all the stages of research design, implementation and analysis, the main principles of ethics in research with mental health service users (Draper, 2008; Jain et al., 2017; Keogh & Daly, 2009), as well as within the field of domestic violence and violence against women (Downes et al., 2014; Ellsberg & Heise, 2002; Fontes, 2004) were considered. This involves being aware of potential emotional distress and its impact on both research participants (WHO, 2016a), and researchers (Fontes, 2004); the sensitive nature of both the topic of violence and that of mental health difficulties; the importance of ensuring safety (WHO, 2016a); and support for all those involved throughout the lifespan of the study.

The measures outlined above were fostered by talking with the research participants about how they felt and offering information (during and after the interviews and within the online survey) about where they could find help and support if needed.

Moreover, accessible and ongoing support and supervision were available to the members of the research team at the Lisbon Institute of Global Mental Health.

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

Results

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Mental health conditions and utilisation of mental health services by survivors of physical intimate partner violence in Portugal: Results from the WHO world mental health survey

Ugnė Grigaitė [a,b,*], Sofia Azeredo-Lopes [c,d], Graça Cardoso [a], Bárbara Pedrosa [a,b], Deborah Oyine Aluh [a,b,e], Margarida Santos-Dias [a], Manuela Silva [a], Miguel Xavier [c], José Miguel Caldas-de-Almeida [a]

[a] Lisbon Institute of Global Mental Health, Comprehensive Health Research Centre/NOVA Medical School, Universidade NOVA de Lisboa, Lisbon, Portugal
[b] National School of Public Health, Universidade NOVA de Lisboa, Lisbon, Portugal
[c] Comprehensive Health Research Centre/NOVA Medical School, Universidade NOVA de Lisboa, Lisbon, Portugal
[d] Department of Statistics and Operational Research, NOVA Medical School, Universidade NOVA de Lisboa, Lisbon, Portugal
[e] Department of Clinical Pharmacy and Pharmacy Management, University of Nigeria Nsukka, Nigeria

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ABSTRACT

The aim of this article is to study mental health conditions among survivors of severe physical intimate partner violence (IPV) and their utilisation of mental health services. This study is an integrated part of the World Mental Health Survey Initiative-Portugal, for which data was collected from a nationally representative adult sample using well-validated scales. Logistic regression models were used in the analysis. The most common statistically significant mental health conditions among IPV survivors were suicide ideation, PTSD, major depressive episode, and generalised anxiety disorder. More than one in three survivors developed PTSD. Suicide ideation was likely to occur after first experiencing IPV. Almost a half of survivors received specialised mental health treatment; in most cases, delivered by a psychiatrist. Over 60 % addressed their mental health issues consulting general physicians or other healthcare professionals. Those who experienced family violence in childhood had greater odds of also experiencing IPV; survivors of IPV with this experience were more likely to receive mental health treatment. The need to promote greater awareness and competencies of not only mental health professionals but also of general physicians and other healthcare professionals to provide support more effectively to survivors of any type of IPV deserves to be emphasised.

* Corresponding author at: Rua do Instituto Bacteriológico 5, Edifício Amarelo, Lisboa 1150-190, Portugal.
E-mail address: grigaiteu@gmail.com (U. Grigaitė).

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1. Introduction

Systemic intimate partner violence (IPV) is globally acknowledged as a type of gender-based violence, a major public health concern, and a human rights issue, with at least one in three women experiencing it at some point in their life (Chandan et al., 2020; European Union Agency for Fundamental Rights, 2014; Garcia-Moreno et al., 2006; WHO, 2021). Women are much more likely than men to experience IPV (WHO, 2021). One of the main reasons for this phenomenon has been the existing imbalance of power and control between men and women, influenced by the context of deeply rooted gender inequality and patriarchal worldview in most societies of the world (Chandan et al., 2020; Grigaitė et al., 2019; WHO, 2021).

Evidence from 2014 shows that in Portugal more than 90% of those affected by IPV are women, mostly between 20–40 years old (Martins et al., 2014). At least 62 women 15 years of age or above were murdered by their male-intimate partners, and IPV was the reason for homicide in 60.8% of all autopsied women, as shown in a study published in 2013 (Pereira et al., 2013). The physical IPV is clearly criminalised in most countries, including Portugal, and has been extensively studied across the world.

In general, the evidence shows that survivors of IPV are at a higher risk of poor health outcomes (Bacchus et al., 2018; Black et al., 2011; Reingle Gonzalez et al., 2018). In addition, a strong relationship between experiencing IPV and poor mental health has been established. Women with a history of IPV are around three times more likely than women without to have a mental health condition (Bacchus et al., 2018). Systematic reviews of observational studies have revealed associations between surviving IPV and having symptoms of depression, pre-natal depression, post-traumatic stress disorder (PTSD), and suicide (Chmielowska and Fuhr, 2017; Devries et al., 2013; Shamblaw et al., 2019), to name a few. As highlighted by Chandan and collaborators: “IPV negatively impacts women’s sense of self, with other multiple losses in relation to income, work, housing, and social participation further undermining recovery into the long term”(Chandan et al., 2020).

For women who are survivors of IPV and also seek help, mental health support systems, services and mental health professionals can play a significant role in effectively addressing and assisting such a critical situation: “By applying and emphasising an understanding of the connection between individual and structural explorations of gender, race, class, and other socially constructed identities, mental health professionals

can utilise the skills necessary to challenge inequalities, which in turn can encourage survivors to create strategies that make sense to themselves and their communities"(Sutton et al., 2020).

The main objective of this article is to study the characteristics of survivors of severe physical IPV in Portugal, the prevalence of mental health conditions among these persons, and their utilisation of mental health services, as well as the associations with other possible determinants of seeking mental health care.

The research questions are as follows:

1) What are the prevalence and associated factors of persons exposed to severe physical IPV in Portugal, compared with those who have not had the experience of IPV?
2) What is the prevalence of specific mental health conditions among the survivors of severe physical IPV in Portugal and what are the respective associated factors?
3) What is the prevalence of service use among the survivors of severe physical IPV in Portugal and what are the factors associated with mental health treatment?

2. Methods

2.1. Study design and instruments

This is a cross-sectional study which is a part of the WHO World Mental Health Survey Initiative Portugal (WMHSIP). This unique and comprehensive Survey was conducted in Portugal in 2008-2010, as a part of the broader worldwide WHO World Mental Health Surveys Initiative (Kessler et al., 2009; Xavier et al., 2013). This article is also 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'.

The WMHSIP was representative of the Portuguese adult population. It was implemented by employing a stratified multi-stage clustered area probability household sample. Participants of the study were those who had given their informed consent to participate in the Survey before each interview, who were 18 years or older, living in mainland Portugal, and Portuguese speaking (Xavier et al., 2013).

The fully-structured face-to-face diagnostic interview WHO Composite International Diagnostic Interview (CIDI) tool was used in the Survey, based on the criteria of the International Classification of Diseases (ICD-10). The interviews were conducted by trained lay interviewers using Computer-Assisted Personal Interview (CAPI). The total number of participants in this study was 3849. More details about the study design, response rates, weighting of the data, fieldwork, and other procedures may be referred to in previous publications (Cardoso et al., 2020; Xavier et al., 2013). Informed consent was obtained from the participants and all procedures were approved by the Ethics Committee of the Nova Medical School, Nova University of Lisbon. All the data was anonymised and confidential.

2.2. Study sample and assessment of variables

Exposure to IPV was assessed by asking: '*Were you ever badly beaten up by a spouse or romantic partner?*' (*yes* or *no* answer). Only experiences of severe physical IPV (and not other types of IPV) were analysed in this study because only this data had been included in the Survey.

The socio-demographic characteristics taken into account were as follows: gender; age (categories of age groups: 18–34; 35–49; 50–64; 65 and older); level of education and level of parents' education (no education; some primary; primary finished; some secondary; secondary finished; some college; college finished or higher); employment (working, student, homemaker, retired and other, including unemployed and disabled); and level of personal earnings in euros (continuous variable). The level of education of the survivors and of their parents was included to assess whether the survivors' upbringing, family history or generational factors play a role in the IPV suffering or in seeking treatment.

The lifetime prevalence of various mental health diagnoses based on the ICD-10 (WHO 1992) was explored in the studied sample, as well as associations with receiving mental health treatment. All these binary variables (*yes* or *no* answers) are outlined in more detail in *Table 2*.

Given the importance of childhood adversities potentially affecting the risk of IPV and PTSD, it was decided to include the following three variables: *Did you experience family violence/ physical abuse/ sexual abuse in childhood?* (*yes* or *no* answers). The survivors'

age of the first onset of experiencing the severe physical IPV (categories of age groups: 18–29, 30–44, 45–59 and 60 or older) was also considered.

To assess the utilisation of mental health care the study participants were asked questions about both the specialised mental health services and general healthcare services. The questions about specialised mental health services covered the following:

"Did you ever in your lifetime go to see any of the professionals on this list for problems with your emotions, nerves, mental health or your use of alcohol or drugs?" The list reads: *psychiatrist, psychologist, social worker, counsellor, any other mental health professional, such as psychotherapist or mental health nurse.*

To assess the non-specialised medical treatment, the questions covered the following:

"Did you ever in your lifetime go to see any other type of medical doctor (other than a psychiatrist) about your emotions, nerves, mental health or use of alcohol or drugs?";

"Did you ever in your lifetime go to see any other healthcare professional, such as a nurse, occupational therapist or other health professional about your emotions, nerves, mental health or use of alcohol or drugs?" (*yes* or *no* answers).

2.3. Data analysis

For the descriptive statistical analysis, observed absolute frequencies (*n*) and relative frequencies (%), the latter employing the weights to account for the whole Portuguese population, were used for all the categorical variables of interest. For the continuous variables, mean values and standard deviations (SD) were presented. First and third quartiles were included, and the median was chosen (instead of the mean) as a robust measurement of location, when the data was found to have a skewed distribution.

For the bivariate statistical analysis, Chi-Squared tests were employed to assess the association between categorical variables. Logistic regression models were used with the dependent variable indicating whether mental health treatment was undergone or not, with various possible factors that might influence the outcome being considered as the explanatory variables. These included sociodemographic factors, various psychiatric diagnoses or symptoms, and childhood adversities.

Estimated odds-ratios (OR) and corresponding 95% confidence intervals (95% CI) were obtained. The confidence level α = 5% was used throughout the statistical analysis.

The data was analysed using the R software (R Core Team (2020) 2020). The R *survey* package was used to obtain the relative frequencies, as well as all the statistical analyses that took into account the weighted data for the Portuguese population (Lumley 2010).

3. Results

3.1. Characteristics of the study sample

Out of the 3849 respondents of the Survey, 1099 answered the question about experiencing severe physical IPV: 3 men and 96 women gave a positive answer to the question, and 478 men and 522 women gave a negative answer. The main sub-sample corresponding to all women who answered *yes* (*n*=96) was considered in most of the analysis in this study, representing the weighted estimate of 14.3%, adjusted for the female population in Portugal.

Table 1: *Sociodemographic characteristics of women with and without the experience of severe physical IPV*

	Women in Portugal who experienced severe physical IPV (*n*=96)		**Women in Portugal who did not experience severe physical IPV (*n*=522)**		**OR (95% CI), *p*-value** [a] **(*) *statistical significance***
	Median				
Age of first experience of IPV (*n*=94)	23 (**Q1** = 19.2; **Q3** = 29.5)				
Age categories	***n***	**Weighted %**	***n***	**Weighted %**	
≤ 34	16	18	134	24	Ref.
35 – 49	29	26	160	27	1.331 (0.540, 3.282), 0.534
50 – 64	28	24	138	24	1.399 (0.553, 3.539), 0.478
≥ 65	23	32	90	24	1.813 (0.651, 5.049), 0.254
Education level	***n***	**Weighted %**	***n***	**Weighted %**	
Non or primary education	44	56	175	38	Ref.
Basic education	33	29	129	22	0.873 (0.451, 1.690), 0.686
Secondary education	12	11	89	19	0.407 (0.169, 0.980), 0.045*
College or higher	7	4	129	21	0.130 (0.049, 0.345), <0.001*

Education of the parents	***n***	**Weighted %**	***n***	**Weighted %**	
No education	23	28	92	19	Ref.
Some primary education	56	61	323	61	0.678 (0.315, 1.461), 0.320
Finished primary education	5	2	23	5	0.301 (0.082, 1.102), 0.069
Some secondary education	2	2	9	1	0.703 (0.100, 4.940), 0.723
Finished secondary education	4	4	40	6	0.442 (0.122, 1.604), 0.214
Some college education	2	1	6	1	0.699 (0.120, 4.083), 0.691
Finished college or higher	3	2	28	6	0.243 (0.055, 1.082), 0.063
Not applicable	1	-	1	-	-
Employment status	***n***	**Weighted %**	***n***	**Weighted %**	
Working	43	43	287	50	Ref.
Student	4	2	15	4	0.670 (0.166, 2.706), 0.573
Homemaker	5	9	34	7	1.459 (0.424, 5.021), 0.549
Retired	28	31	112	26	1.410 (0.660, 3.013), 0.375
Other	16	15	74	13	1.300 (0.584, 2.895), 0.520
Family violence	40	28	109	16	2.027 (1.144, 3.591), 0.016*
Sexual abuse	8	5	12	1	4.711 (1.662, 13.348), 0.004*
Physical abuse	34	28	121	17	1.845 (1.009, 3.373), 0.046*

[a] *Weighted % adjusted for the population in Portugal (weighted data from the R survey package was considered).*

Table 1 shows that among the survivors of severe physical IPV, 82% were 35 years and older. Around 85% of survivors had none or only primary and basic education level, which differed significantly from women who did not experience IPV (p<0.001).

The IPV survivors had only slightly higher education levels, when compared to the highest education of their parents – around 91% of parents had none or only primary and basic education levels. Moreover, women who experienced family violence, sexual abuse or physical abuse in childhood were significantly more likely to have the experience of severe physical IPV later in life.

3.2. Mental health conditions and suicide

The most prevalent diagnoses that were statistically significant among the survivors of IPV were PTSD (36%), Major Depressive Episode (29%), and Generalised Anxiety Disorder (25%). Panic Attack was the most prevalent diagnosis (37%) in the study sample but did not reach statistical significance. Suicide planning (17%), attempt (19%)

and ideation (39%) were all statistically significant when compared with women who did not experience IPV (see *Table 2*).

Table 2: *Mental health conditions and suicide in the study sample*

		Women who experienced severe physical IPV (*n*=96) *n* (%) [a]	**Women who did not experience severe physical IPV** (*n*=522) *n* (%) [a]	**OR (95% CI), *p*-value [a] (*) *statistical significance***
Lifetime diagnosis (ICD-10)	Generalised Anxiety Disorder	29 (25)	87 (10)	2.884 (1.585, 5.247), <0.001*
	Panic Attack	46 (37)	183 (26)	1.694 (0.960, 2.987), 0.069
	Social Phobia	11 (10)	72 (10)	1.014 (0.460, 2.236), 0.972
	Specific Phobia	33 (28)	188 (32)	0.820 (0.444, 1.516), 0.527
	Post-Traumatic Stress Disorder	35 (36)	132 (20)	2.251 (1.169, 4.335), 0.015*
	Any Anxiety Disorder	75 (72)	332 (52)	2.334 (1.150, 4.740), 0.019*
	Minor Depressive Episode	7 (4)	26 (3)	1.168 (0.451, 3.026), 0.749
	Moderate Depressive Episode	22 (17)	82 (9)	1.934 (1.021, 3.662), 0.043*
	Major Depressive Episode	32 (29)	122 (14)	2.470 (1.374, 4.441), 0.003*
	Any Depressive Disorder	61 (50)	230 (27)	2.661 (1.458, 4.854), 0.001*
Lifetime suicide	Attempt	26 (19)	38 (5)	4.060 (1.983, 8.314), <0.001*
	Planning	24 (17)	55 (7)	2.613 (1.327, 5.148), 0.005*
	Ideation	48 (39)	111 (16)	3.294 (1.827, 5.939), <0.001*

[a] Weighted % adjusted for the population in Portugal (weighted data from the R survey package was considered).

3.2.1. Suicide ideation

Suicide ideation was reported by as much as a half of the IPV survivors (*n*=48) and the median age of onset of suicide ideation of these women was 26 years (Q1 = 19.8; Q3 = 35.5).

3.2.2. Childhood adversities, experience of IPV, and PTSD

PTSD was the most prevalent statistically significant diagnosis in the studied population, which is especially relevant due to the traumatic nature of experiencing IPV. Out of the 96 women, 35 met the criteria for the diagnosis of PTSD (36%).

To account for potential confounding factors, this study took into consideration other traumatic experiences that may have contributed to the study participants' PTSD. Family violence, sexual abuse and physical abuse in childhood were all statistically significant in association with the experience of IPV (see *Table 1*).

When associations were analysed concerning childhood adversities and PTSD among survivors of severe physical IPV, it produced the results outlined in *Table 3*.

Table 3: *PTSD and childhood adversities in women who experienced severe physical IPV (n=96)*

		PTSD diagnosis, *n* (weighted %)	**No PTSD diagnosis,** *n* (weighted %)	**OR**	**95% CI**	***p*-value** [a]
Childhood adversities	Family violence	16 (34.2)	24 (24)	1.645	(0.551, 4.913)	0.369
	No family violence	19 (65.8)	37 (76)	Ref.		
	Physical abuse	11 (27.4)	23 (27.8)	0.982	(0.302, 3.187)	0.975
	No physical abuse	24 (72.6)	38 (72.2)	Ref.		
	Sexual abuse	5 (10.1)	3 (2.5)	4.447	(0.774, 25.547)	0.093
	No sexual abuse	30 (89.9)	58 (97.5)	Ref.		

[a] *Weighted % adjusted for the population in Portugal (weighted data from the R survey package was considered).*

For survivors of severe physical IPV, childhood adversities did not present any statistically significant difference concerning their odds of getting a PTSD diagnosis.

However, when considering all women (regardless of the fact that they might have experienced IPV or not, *n*=618), those who experienced family violence, physical abuse or sexual abuse in childhood were respectively 3 times (OR=3.119, 95%CI (1.895, 5.132), *p*<0.001), 2.6 times (OR=2.683, 95%CI (1.616, 4.453), *p*<0.001), and 3.3 times (OR=3.301, 95%CI (1.219, 8.939), *p*=0.019) more likely to receive a PTSD diagnosis in their lifetime than women who did not experience these childhood adversities.

When considering only women who did not experience IPV, results were also statistically significant for family violence (OR=3.39, 95% CI (1.93, 5.94), $p<0.05$) and physical abuse in childhood (OR=3.159, 95% CI (1.802, 5.538), $p<0.05$), in association with PTSD diagnosis.

3.3. Utilisation of mental health care services

Results in *Table 4* show that over 46% of IPV survivors who had any mental health diagnosis received treatment in specialised mental health services, and over 42% of them were treated by a psychiatrist. As much as 61% received mental health care from general medical doctors, and over 71% consulted other healthcare professionals.

Table 4: *Types of mental health treatment of IPV survivors by diagnosis*

	Psychiatrist treatment *n* (weighted %)	**Any specialised mental health treatment** *n* (weighted %)	**General medical treatment** *n* (weighted %)	**Any health treatment** *n* (weighted %)
Generalised Anxiety Disorder (*n*=29)	19 (63.9)	21 (68.2)	25 (86.9)	26 (89)
Panic Attack (*n*=46)	28 (62.9)	32 (68.9)	33 (74.6)	43 (92)
Social Phobia (*n*=11)	9 (90.7)	10 (95.3)	9 (86.6)	11 (100)
Specific Phobia (*n*=33)	15 (46.9)	17 (50.4)	27 (72.6)	30 (78.8)
Post-Traumatic Stress Disorder (*n*=35)	21 (50.8)	25 (57.2)	22 (52.7)	30 (64.8)
Minor Depressive Episode (*n*=7)	2 (27.3)	4 (51.4)	5 (61.8)	5 (61.8)
Moderate Depressive Episode (*n*=22)	14 (60.8)	15 (63.4)	14 (71.2)	20 (92.8)
Major Depressive Episode (*n*=32)	19 (54.9)	21 (59.2)	24 (79.7)	29 (89.1)
Any mental health diagnosis (*n*=83)	43 (42.5)	49 (46.4)	56 (60.9)	71 (71.4)

When comparing mental health treatment among women who experienced severe physical IPV and those who did not, we can see that the first group were significantly more likely to receive treatment by a psychiatrist than those who did not experience IPV (see *Table 5*).

Table 5: *Types of mental health treatment in the study sample*

		Women who experienced severe physical IPV (*n*=96) *n* (%) [a]	Women who did not experience severe physical IPV (*n*=522) *n* (%) [a]	*p*-value [a] (*) *statistical significance*
Lifetime treatment	Psychiatrist treatment	46 (36)	153 (21)	0.012*
	Any specialised mental health treatment	52 (39)	199 (29)	0.138
	General medical treatment	60 (52)	257 (40)	0.084
	Any health treatment	76 (61)	345 (54)	0.365

[a] *Weighted % adjusted for the population in Portugal (weighted data from the R survey package was considered).*

Table 6 presents sociodemographic and diagnostic predictors of receiving any specialised mental health treatment among survivors of IPV.

Table 6: *Sociodemographic and diagnoses type predictors of any specialised mental health treatment (n=96)*

		Any specialised mental health treatment (lifetime) OR (95%CI)	*p*-value (*) *statistical significance*
Age	≤ 34	Reference level	
	35 – 49	1.825 (0.341, 9.766)	0.478
	50 – 64	1.290 (0.234, 7.103)	0.768
	≥ 65	0.116 (0.019, 0.705)	0.020*
	Overall Test of Effect	2logLR=15.239, d.f.=92	0.004*
Education	Non or primary education	Reference level	
	Basic education	10.417 (3.190, 34.020)	<0.001*
	Secondary +College or higher	9.786 (2.153, 44.470)	0.003*
	Overall Test of Effect	2logLR=20.607, d.f.=93	<0.001*
Employment status	Working	Reference level	
	Student	1.339 (0.130, 13.763)	0.804
	Homemaker	0.276 (0.033, 2.321)	0.233
	Retired	0.213 (0.059, 0.765)	0.018*
	Other	0.533 (0.126, 2.243)	0.386
	Overall Test of Effect	2logLR=8.380, d.f.=91	0.092
Any Anxiety Disorder	No	Reference level	
	Yes	5.877 (1.591, 21.716)	0.008*
	Overall Test of Effect	2logLR=9.294, d.f.=94	0.003*
Any Depressive Disorder	No	Reference level	
	Yes	7.117 (2.456, 20.623)	<0.001*
	Overall Test of Effect	2logLR=15.455, d.f.=94	<0.001*

PTSD	No	Reference level	
	Yes	3.401 (0.948, 12.198)	0.060
	Overall Test of Effect	2logLR=3.741, d.f.=94	0.058
Panick Attack	No	Reference level	
	Yes	8.503 (3.079, 23.477)	<0.001*
	Overall Test of Effect	2logLR=19.799, d.f.=94	<0.001*
Suicide Ideation	No	Reference level	
	Yes	4.087 (1.506, 11.093)	0.006*
	Overall Test of Effect	2logLR=8.225, d.f.=94	0.005*
Family violence in childhood	No	Reference level	
	Yes	6.967 (2.529, 19.194)	<0.001*
	Overall Test of Effect	2logLR=16.184, d.f.=94	<0.001*
Physical abuse in childhood	No	Reference level	
	Yes	2.137 (0.751, 6.078)	0.153
	Overall Test of Effect	2logLR=2.085, d.f.=94	0.155

Survivors of IPV younger than 65 were more likely to receive mental health treatment throughout their lifetime when compared with the age group of 65 years and older. Also, the higher the IPV survivors' education level, the more likely they were to receive mental health treatment.

Although not statistically significant with the limitations implied by the small sample size, a clear tendency may be seen and requires further studying, regarding the employment status: the working women were more likely to receive mental health treatment (54%), as well as students (61%) when compared to homemakers (25%) and retired individuals (20%). Moreover, the median personal earnings for women who received mental health treatment was 1500 euros per month (weighted data: 25% percentile 750 euros; 75% percentile 5500 euros), while it was 500 euros per month (weighted data: 25% percentile 0 euros; 75% percentile 4500 euros) for women who did not receive mental health treatment.

Survivors of IPV, who had experienced family violence in childhood, had an estimated odds of having mental health treatment throughout their life around 7 times greater than the odds of this for women who had not experienced family violence. The results for experiences of physical abuse in childhood were not statistically significant. The sample size for experiences of sexual abuse in childhood was not large enough, thus, it was excluded from this analysis.

4. Discussion

4.1. Prevalence and associated factors of persons exposed to severe physical IPV in Portugal

The findings of this study demonstrate a major disproportion between female and male participants reporting to have experienced severe physical IPV, which goes in line with the general global tendency that females suffer IPV significantly and disproportionately more often than males (WHO, 2021). This is also in line with what was already known about the situation in Portugal, which indicates that an absolute majority of victims and survivors of IPV are female (Martins et al., 2014; WHO, 2012).

In 2014, the European Fundamental Rights Agency estimated that at least one in five women in Portugal had experienced physical and/or sexual violence by a current or previous intimate partner since the age of 15 years (European Union Agency for Fundamental Rights, 2014). The current study also shows that almost 15% of women in Portugal experience severe physical IPV.

It should be noted that the vast majority of IPV survivors had none or only primary and basic education levels, which differed significantly from women who did not experience IPV. This points to the importance of education, which is often tied to a context of having a broader general awareness and helps to develop better social and relational skills. Thus, having a lower education level may be associated with a higher risk of experiencing IPV (Kaukinen and Powers, 2015). It is also relevant that the survivors of IPV had only slightly higher education levels when compared to the highest education levels of their parents, which may point to potential generational risks and associations that require further investigation, especially when family violence is also present in childhood (Spearman et al., 2023).

The current study also confirms the global evidence that IPV is a very prevalent public (mental) health issue. When compared to other women in Portugal, those who have the specific experience of severe physical IPV show higher levels of various mental health conditions and of receiving mental health care.

4.2. Mental health conditions and suicide

When compared with those who did not experience IPV, the survivors had significantly higher prevalence of PTSD, Generalised Anxiety Disorder, and Major Depressive Episode. Similar results were demonstrated by another recent study in Portugal, which showed a greater prevalence of PTSD and depression among survivors of IPV (Machorrinho et al., 2023).

In the current study, contrary to the IPV survivors with a diagnosis of Moderate or Major Depressive Episode, those with Minor Depressive Episode did not differ significantly from women without the IPV experience. This possibly points to the severity of the trauma experienced and may be related to the fact that IPV survivors with less severe symptoms would possibly try not to consult healthcare professionals for as long as possible, to avoid disclosing their experiences of abuse, and thus, they might end up not getting the earlier and less severe diagnoses (Alves et al., 2019; Martins et al., 2014).

4.2.1. Suicide ideation

Although both suicide planning and attempt were significantly more frequent in IPV survivors when compared with women who had not experienced IPV, by far the most prevalent symptom among IPV survivors was suicide ideation. In general, research on associations between IPV and suicide ideation is limited (Devries et al., 2013). However, another recent study conducted in Portugal, confirmed that survivors of IPV presented a greater prevalence of suicide ideation (Machorrinho et al., 2023).

The current study also shows that, given the median age of women in Portugal when they first experienced severe physical IPV was 23 years and the onset of suicide ideation was 26 years, it suggests that the suicide ideation may be related to the previous experience of IPV.

Among other situations where suicide ideation may occur, there is evidence that pre-natal depressive symptoms and experiencing IPV are significantly associated with an increased risk of pre-natal suicide ideation (Alhusen et al., 2015; Devries et al., 2013). This is relevant to bear in mind due to the nature of intimate relationships and all the complex factors that may be at play simultaneously, potentially culminating in suicide ideation.

4.2.2. Childhood adversities, experience of IPV, and PTSD

More than one in every three women in Portugal who experience severe physical IPV also receive a diagnosis of PTSD. This finding is in line with the global evidence, which shows a significant association between experiencing IPV and presenting PTSD (Woods, 2005). More than one-third of the Portuguese women who experienced severe physical IPV and met the criteria for PTSD had also experienced family violence in childhood, while the remaining two-thirds had not. A similar tendency appears to apply to experiences of physical abuse in childhood: almost a third of those with PTSD had experienced it, and as much as over two-thirds had not. Even though for other women having the experience of childhood adversities significantly contributed to their greater odds of potentially getting a PTSD diagnosis, for survivors of IPV this was not the case. This could indicate that other traumatic life experiences may have contributed to these women's PTSD, possibly including the trauma of IPV, which requires further studying with larger sample sizes (Woods, 2005).

Traumatic events can invoke a sense of horror, helplessness, serious injury, or the threat of serious injury or death. Emotional or psychological trauma is the result of extraordinarily stressful events that adversely affect a person's sense of safety and security, making them feel helpless and extremely vulnerable. Such trauma can leave people struggling with upsetting emotions, memories, and anxiety that may be uncontrollable and not retreat for a significantly long time, contributing to chronic stress and increasing the risk of developing mental health conditions (Ozer et al., 2003). Clearly, IPV causes chronic stress and deep emotional trauma in survivors, and it is likely a contributing factor to the increased risk of developing PTSD (Bacchus et al., 2018).

Additionally, there may be a likely association observed between having experienced family violence, sexual or physical abuse in childhood and experiencing severe physical IPV later in life. It is important to note that, in this study, almost one-third of the women who experienced severe physical IPV had also experienced family violence or physical abuse in childhood. These numbers are clearly higher when compared with women who had not experienced IPV but did suffer family violence or physical abuse in childhood. Further studies may be of value to investigate the situation of women who had both the experience of family violence, physical or sexual abuse in childhood, as well as IPV later in life with regards to their odds of being diagnosed with PTSD. This is especially relevant

considering the potential effect of cumulative traumas, as evidenced by previous studies (Karam et al., 2014; Sacchi et al., 2020; WHO, 2012).

4.3. Utilisation of mental health care services

Compared with other women, those who have experienced severe physical IPV were significantly more likely to receive treatment by a psychiatrist. Almost half of IPV survivors who had any type of mental health diagnosis received specialised mental health treatment, and most of them at least spoke about their mental health issues with general physicians or other healthcare professionals. This is an important finding considering the evidenced general lack of knowledge and understanding of the specificities of IPV among non-specialised healthcare professionals, especially in the form of under-detection and under-reporting of suspected IPV cases (Clemente-Teixeira et al., 2022). This knowledge and related skills may be crucial to effectively meet the therapeutic needs of survivors of IPV, as well as to help ensure their better general safety (Martins et al., 2014). The healthcare sector may play a vital role not only in the early detection of IPV and providing healthcare to survivors, but also in building a trusting relationship with them, ensuring emotional support, acknowledging, and validating their experiences, as well as possibly referring them to other relevant authorities (Clemente-Teixeira et al., 2022; McKibbin and Gill-Hopple, 2018).

Survivors of IPV belonging to the youngest and the oldest age groups showed less frequency of utilising mental health treatment. With regards to the oldest generation, this appears rather counterintuitive because it could naturally be presumed that the older the person is the more likely they might have had some mental health treatment throughout their life. However, this is not the case, and the situation could be interpreted in several different ways.

Concerning the younger IPV survivors, it is possible that they did not report having received any mental health treatment yet, because the onset of mental health problems for women who have experienced severe physical IPV may occur some years later, when in their 30's (Loxton et al., 2017). This is also in line with results shown by previous studies in Portugal, which indicate that: 1) in more than half of the cases, the victims of IPV conceal the fact of the abuse; 2) frequently, they do not approach healthcare services; 3) the ones who do, only do so on average 6.5 years after the beginning of the IPV; and 4) even then, in around 19% of such cases, they hide the fact of the abuse from the healthcare professionals (Martins et al., 2014).

As for the older generation, among other options, it could be assumed that they potentially have more socially constructed ‘norms’ that they live by and more deeply rooted negative stereotypes and stigma attached to having mental health conditions and seeking mental health treatment, care, and support (Conner et al. 2010). It is also important to note that the age at which the first experience of IPV happened, does not seem to have any apparent influence on receiving mental health treatment among the studied population. However, this requires further investigation with larger sample sizes considering that the age effects may reflect recall bias for the older group, period or cohort effects, or be influenced by the relatively small sample size.

Another finding of this study, which corresponds to some previous findings, is that the higher the IPV survivor’s own education level, the more likely they are to receive mental health treatment. Hence, with every growing education level, people are more likely to seek mental health treatment and support (Steele et al., 2007). Similarities may be observed here between this association and a similar one related to the higher risk of experiencing IPV in association with lower education levels. It could be interpreted that the association of less mental health treatment concerning lower education levels could be potentially attributed to less mental health literacy, less subsequent income or less knowledge about the existing pathways for seeking help and support, among other possibilities.

More working women in this study sample received mental health treatment when compared to homemakers and retired individuals. In addition to the fact that employed women are likely to also have a higher education level and be more empowered to seek help and support when it is needed, the interpretation here may be at least two-fold. On the one hand, it may potentially be influenced by the lack of accessibility of mental health services in the public sector (Perelman et al., 2018); hence, private mental health care and treatment services may be favoured, and thus, only those who may afford it end up receiving the needed support and treatment (Rodrigues and Schulmann, 2013). On the other hand, those who are more likely to be at home most of the time, like homemakers and retired women, may be more isolated and controlled by the perpetrators of IPV and may find it more difficult to seek help and support with their mental health needs (Caetano et al., 2008).

4.4. Implications for mental health care practices

The 12-month prevalence of any psychiatric diagnosis in Portugal is 22.9%. However, only about one in three of those with moderate mental health problems receive treatment (Caldas-de-Almeida et al., 2013; Rodrigues and Schulmann, 2013). Results of a recent meta-analysis on the mental health factors and IPV perpetration and victimisation show a strong correlation between IPV and mental health problems, and suggest that clinicians who work with individuals in the context of IPV should proactively assess, refer for, and ensure treatment for mental health problems (Spencer et al., 2019). This includes not only mental health professionals but also other healthcare professionals and general physicians: in Portugal, around 66% of physicians often do not have any suspicion of IPV when it is concealed by the survivors; as much as 90% do not tend to even mention their legal obligation to denounce IPV when it is disclosed; and 52% do not address the victim's risk issues (Martins et al., 2014).

Moreover, it is vital that general practitioners are consciously aware of not only the high prevalence of IPV but also of the even significantly higher risk among women with disabilities and its association with poorer health status and access to healthcare, including mental health treatment (Barrett et al., 2009). It has also been highlighted in previous studies completed in Portugal, that there is a need to design effective interventions, which promote social and personal self-esteem fostering resources in survivors of IPV with or without disabilities, to moderate the relation between experiences of IPV and mental health conditions (Costa and Gomes, 2018).

5. Conclusion

Regardless of its limitations, this study demonstrates clearly that women in Portugal who experience severe physical IPV show high frequencies of mental health conditions and that there are several associations between their utilisation of mental health treatment and various other determinants, such as family violence experienced in childhood. More than one in every three women in Portugal, who experience severe physical IPV, also develop PTSD. The findings adjusted for other traumas, i.e., childhood adversities, indicate no statistically significant associations for survivors of severe physical IPV receiving a PTSD diagnosis, even though for other women these associations were significant.

The types of mental health treatment included specialised mental health services and access to general physicians and other healthcare professionals, who were all important points of access to the needed care and support. Women belonging to the youngest and oldest age groups of the research participants received mental health treatment less frequently than those between 35 and 64 years of age. On the other hand, women with higher education levels and those with higher personal income received it more frequently. Moreover, analysis of associations between certain childhood adversities and lifetime prevalence of mental health treatment has shown that those survivors of severe physical IPV, who had experienced family violence in childhood, have greater odds of having mental health treatment at some point in their life.

Areas for further quantitative and qualitative research concern potential associations between utilising mental health services and survivors' age of onset of IPV, employment status, experiences of physical and sexual abuse in childhood, generational risk factors like parents' education levels, and specificities related to IPV survivors' diagnosis of PTSD. There is a lot of room for research focusing on different types of IPV, also including psychological, economic, and sexual IPV. The need to promote greater awareness and competencies of not only mental health professionals but also of general physicians and other healthcare professionals to provide mental health care and support more effectively to survivors of any type of IPV deserves to be emphasised.

Limitations

The fact that the study is cross-sectional limits causal inferences, namely the direction of the associations. Another limitation of this study is the relatively small sample size, sometimes yielding wide confidence intervals and producing certain estimates with some lack of precision. It is relevant to note that the way the Survey and sensitive questions were administered by strange interviewers may have influenced the answers provided by participants. There might have been some recall bias, period or cohort effects, and underreporting, especially in the presence of a spouse, when asked about traumatic experiences, such as IPV. Additionally, due to the availability of only limited data on this subject having been included in the Survey, only experiences of severe physical IPV were looked at. Thus, the study leaves space for further exploration of relevant associations related to other types of IPV: psychological, economic, and sexual IPV.

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Scientific Paper No. 2

Responses to the Mental Health Care Needs of Survivors of Intimate Partner Violence in Portugal: A Qualitative Study

Grigaitė, U., Santos-Dias, M., Pedrosa, B., Aluh, D.O., Silva, M., Cardoso, G., Caldas-de-Almeida, J.M.

Abstract

Purpose: To explore the perspectives and perceptions of mental health professionals regarding their provision of mental healthcare to survivors of intimate partner violence (IPV), and to hear the lived experiences of IPV survivors about their use of mental health services in Portugal.

Methods: Two focus groups were conducted with 17 professionals from mental health services. Additionally, an online survey was developed to collect qualitative data on the experiences of IPV survivors who used mental health services in Portugal. Audio recordings of focus groups were transcribed verbatim and analysed thematically using MAXQDA software. A separate thematic analysis was conducted with the data from the online survey.

Results: The main themes emerging from the focus groups are as follows: 1) “Not everyone has the profile to work on this”; 2) Healthcare responses to a “social problem”; 3) A complex problem requiring complex responses; 4) “A station on a railway line that connects to other stations and stops”; 5) “We never demonise anyone”. Analysis of the IPV survivors’ experiences resulted in the following six themes: 1) “A wounded pride”; 2) “The doctor did not realise what was hidden”; 3) “Psychotherapy is a slow process”; 4) Impunity for the aggressor; 5) Medicalisation of the public sector; 6) What was really needed.

Conclusions: Mental health support is instrumental for IPV survivors’ recovery. Complex approaches that are needed include trauma- and violence-informed care, holistic, multi-disciplinary, and inter-sectoral efforts. Further research needs to explore the specificities of the utilisation of mental health services by IPV survivors, and what interventions are the most effective for this population in different geographical and cultural contexts. Implications for policy and practice include the need for mainstreaming of IPV-related knowledge and skills among mental health professionals; elimination of IPV stigma and victim-blaming attitudes in society; ensuring inter-sectoral working models between the mental healthcare sector, social care services, law enforcement, judiciary, and other relevant stakeholders.

Keywords: mental health services, public health, gender-based violence, intimate partner violence, Portugal.

Introduction

Intimate partner violence (IPV) is the most prevalent form of violence against women globally: at least one in three women experience IPV at some point in their life (Barbier et al., 2022; Chandan et al., 2020; European Union Agency for Fundamental Rights, 2014; Garcia-Moreno et al., 2006; Krug et al., 2002; Sanz-Barbero et al., 2018; WHO, 2021). Women are disproportionately more likely than men to experience systemic IPV: it is defined as a type of gender-based violence (WHO, 2021). This issue is multi-faceted and complex, resulting from factors related to gender inequality, gender stereotypes, a lack of legal procedures and laws (Pandea et al., 2019), and various socio-cultural contexts (Council of Europe, 2011).

In Portugal, there is limited statistical data concerning specifically IPV. The main official statistics cover the broader field of domestic violence: in 2023, the National Support Network for Victims of Domestic Violence received 3,016 adult survivors of domestic violence, of whom 2,943 (98%) were women (Commission for Citizenship and Gender Equality, 2024). As for IPV, according to the national survey conducted by the National Statistics Institute in 2022, 75.8% of the Portuguese population consider IPV against women to be 'very common'. Also, physical and psychological consequences as a result of being in a situation of any type of violence are most frequently reported by victims of specifically IPV (National Statistics Institute, 2023).

Global evidence shows that IPV has long-lasting effects on the physical and mental health of survivors making it a major public (mental) health concern (Oram et al., 2022; WHO & World Health Assembly, 1996; World Bank Group, 2023). Studies demonstrate that survivors of IPV (including coercive control, psychological, economic, physical and/or sexual IPV) are at a higher risk of negative physical and mental health outcomes (Bacchus et al., 2018; Black et al., 2011; Clemente-Teixeira et al., 2022; Dokkedahl et al., 2022; Gibbs et al., 2018; Johnson et al., 2022; Lohmann et al., 2023; Reingle Gonzalez et al., 2018; Spencer et al., 2022; White et al., 2023; WHO, 2021). Women who survive IPV are around three times more likely than women without this life experience to develop mental health conditions (Bacchus et al., 2018). For example, symptoms and diagnoses of depression, anxiety, post-traumatic stress disorder, and

suicide ideation are common (Chmielowska & Fuhr, 2017; Devries et al., 2013; Gibbs et al., 2018; Lohmann et al., 2023; Shamblaw et al., 2019).

Regardless of the high prevalence of mental health conditions among IPV survivors, only some of them seek help and support with their mental health needs. For example, our previous study, representative of the Portuguese population, shows that just over one-third (39%) of survivors of severe physical IPV in Portugal use specialised mental health services (Grigaitė et al., 2024). Mental health professionals, their knowledge, skills and competencies can play a vital role in supporting IPV survivors on their recovery journey (Sutton et al., 2020). Mental health professionals can make a significant difference by screening for IPV, ensuring safety, person-centred care, and providing trauma- and violence-informed support (Oram et al., 2022; Wathen & Mantler, 2022).

The main objective of this study is to explore the perspectives and perceptions of mental health professionals regarding their provision of mental health care to survivors of IPV and to hear the lived experiences of IPV survivors about their use of mental health services in Portugal.

Methods

Study Design

This is a qualitative explorative study conducted within an experiential framework (Hall, 1997). 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 nature of the topic and to allow for an in-depth discussion of the issue (Hennink et al., 2020). The study aims to capture and better understand the perspectives, experiences, and challenges that both mental health professionals and IPV survivors face concerning mental health services in Portugal.

Research Team and Reflexivity

All co-authors share a deep interest and many years of working in the fields of mental health, public health, human rights, and gender-based violence. They are not only academics but some are also clinicians, and human rights activists. Everyone brings a specific professional and personal angle to this study concerning the analysed subject,

which is in line with the values of qualitative research: valuing the subjectivity of each researcher as a resource, which may shape the research process in numerous ways (Braun et al., 2022; Braun & Clarke, 2019; Gough & Madill, 2012). All research team members fully acknowledge the subjective influence of their own assumptions and the unique effects of this on the knowledge creation in this qualitative study. Co-authors see this as a strength due to the wide range of extensive knowledge and passion about the topic, as well as the invaluable professional and personal experiences of each research team member.

Study Setting and Measures

One in-person and one online focus group were organised in November 2022 and November 2023, respectively. The in-person focus group was organised in collaboration with a unique specialised mental health unit, which specifically serves persons who have experienced or perpetrated domestic violence, including IPV. The online format was chosen for conducting the second focus group to enable the participation of professionals from various generic mental health services and different geographical locations. Both focus groups were conducted by the first and second authors of this article who have been working in the fields of public health, human rights, mental health, and gender-based violence for many years.

The focus group guide was elaborated to explore the following areas with professionals:

5) Professionals' level of awareness and knowledge about IPV, as well as their practices of working with IPV survivors;
6) Professionals' perception of their role, as well as of opportunities and challenges faced, when providing mental health support to IPV survivors;
7) Professionals' perception of how their practices are affected and shaped by the existing mental health system in Portugal;
8) Observed or perceived practical challenges and barriers related to accessing the needed mental health care and support by IPV survivors in the country.

Additionally, an online survey (Andrews et al., 2007) for capturing the experiences of IPV survivors was developed by the research team at the Lisbon Institute of Global Mental Health. The survey collected both quantitative and qualitative data (Braun et al., 2021). The online survey explored the following data categories and questions:

1) Socio-demographic characteristics (gender of the participant; gender of the abuser; current age of the participant; their age when they experienced IPV for the first time; their age when they used mental health services for the first time; place of residence; place where they used mental health services).

2) Experience with IPV (*yes* or *no* answer).

'Intimate partner violence' was described as "*systemic violence that includes physical, psychological, economic and/or sexual abuse, coercive and controlling behaviours by an intimate partner, such as marital, co-habiting or dating partners*".

Types of IPV were described as follows:

- *Psychological* (includes calling names, humiliating, isolating, hurting your pets, destroying things dear to you, threatening, frightening, turning your children against you, etc.);
- *Economic* (includes controlling your finances, not allowing you to study or work, not allowing access to your/family's bank accounts, demanding detailed reports for all your spending, etc.);
- *Physical* (includes pushing, hitting, slapping, kicking, throwing things at you, hair pulling, etc.);
- *Sexual* (includes any type of sexual behaviour against your free will and without consent).

3) Experience of seeking "*help or support in Portugal for mental health needs or emotional state due to or as a result of having experienced IPV*" (*yes* or *no* answer).

The concept of 'mental health' used in this study was described in the following way: "*While answering the questions please understand 'mental health' as your emotional, psychological, and social well-being. At any given time of their lives, everyone can have mental health difficulties. Such difficulties are not limited to specific mental health disorders or psychiatric diagnoses. It can also be feelings of anxiety, heavy emotions or dark thoughts, sleeping problems, changes in behaviour or habits, and similar*".

Participants were asked to describe in their own words their encounters with mental health professionals; what support they needed the most at the time; how were those needs met; what the professionals had to offer in response; how helpful was it; what the

most positive and negative aspects of this experience were; what barriers (if any) did they face when seeking this support; what would they have liked the mental health professional(s) to have done differently.

In cases where the answer to the question about using mental health services was negative, the survey participants were asked to describe the reasons for not seeking help despite having experienced IPV.

4) Categories of encountered professionals (psychologist/psychotherapist; psychiatrist; family doctor/GP; social worker; other).

5) Categories of encountered services/settings (primary healthcare centre; general hospital – including A&E; specialised mental health centre/community team; psychiatric hospital; non-governmental organisation (NGO); emotional helpline; an individual mental health professional – directly; other).

6) The sector of services (public sector – state-funded; private sector – self-funded; a part of it public, and a part private).

Study Participants

Professionals from different backgrounds who work in the public mental health sector in Portugal were invited to participate in focus groups. Invitations were disseminated via email and direct contact with several institutions, facilities, and individual professionals. They represented both in-patient and outpatient services, both the generic mental health services and the unit specialising in treating specifically survivors and perpetrators of domestic violence. Some services identified key persons for this topic and direct invitations were sent to them.

The online survey was disseminated publicly via internet channels in Portugal. The random and publicly open recruitment was conducted via social media, emails, newsletters, and websites. Various Portuguese NGOs and individual supporters shared the survey with their respective networks and audiences. So did the National Network of Victims' Support Services for Survivors of Domestic Violence (APAV). Portuguese-speaking persons aged 18 years or over, were invited to complete the online survey, aiming to explore the subjective experiences and perspectives of those who survived

IPV and who also experienced mental health difficulties. The online survey was open for responses between November 2022 and February 2024.

Data Analysis

Audio recordings of both focus groups were transcribed verbatim and analysed according to the recommendations for reflexive thematic analysis by Braun and Clarke (Braun et al., 2022; Braun & Clarke, 2006, 2022). First, audio recordings were listed once; then transcripts were read and re-read several times by the first and second authors. An inductive approach was used to code the data and coding continued until no new concepts emerged from the collected data. Parts of the text were coded, synthesised, and divided into thematic categories based on the similarity of meanings. Themes were created by the first author and then reviewed, discussed, and finalised by all co-authors, taking into account patterns both inside and between the thematic categories. This analytical process was also separately repeated with the qualitative data obtained through the online survey.

Reflexive thematic analysis was conducted using MAXQDA software (Software, 2022). The reporting of this study's findings was guided by the SRQR (O'Brien et al., 2014) and the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007) checklists.

Research Ethics

General considerations for research ethics included the obtaining of informed voluntary consent, the clear possibility for withdrawal from it, privacy and data protection, confidentiality, and anonymity. Before giving their consent to participate in the study in written form, research participants received all the information concerning the study's objectives, voluntary nature of participation, confidentiality, and anonymity of the collected data.

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

Results

Results from the Focus Groups

The focus groups lasted for 95 and 73 minutes. Ten professionals participated in the first focus group and seven in the second. Their professional backgrounds covered the fields of psychiatry, psychology, psychotherapy, and social work.

Participants represented in-patient and outpatient mental health services in the public sector, both generic mental health services, and a mental health unit specialising in supporting survivors and perpetrators of domestic violence. Their workplaces included both the specialised psychiatric and general hospital settings; both specialised mental health centres and general medical centres; crisis centres; and emergency services.

Participants came from two urban geographical locations in Portugal. The sociodemographic characteristics of the focus groups' participants are presented in *Table 1*.

Table 1: *Sociodemographic characteristics of the participants of the focus groups (n=17)*

Characteristic	**Frequency (n)**	**Percentage (%)**
Gender		
Female	13	76
Male	4	24
Profession		
Psychiatrist	5	29
Psychiatry Resident	5	29
(Clinical) Psychologist/Psychotherapist	4	24
Social Worker	3	18
Type of Sector		
Public	17	100
Place of practice		
City	17	100
	Median	**Min; Max values**
Years of professional experience	8	1;26

Themes from the Focus Groups

The focus groups' data analysis resulted in five main themes, as follows:

1) "Not everyone has the profile to work on this"; 2) Healthcare responses to a "social problem"; 3) A complex problem requiring complex responses; 4) "A station on a railway line that connects to other stations and stops"; 5) "We never demonise anyone".

"Not everyone has the profile to work on this"

Theme 1 highlights that not only a specialised but also a very different (from the 'usual') way of working is required from mental health professionals when supporting IPV survivors. Specific trauma- and violence-informed knowledge and skills are crucial. Also, professionals have to deeply reflect on their own life stories, experiences, and attitudes concerning relationships, domestic violence and IPV before they can successfully provide mental health support to others (see *Table 2*).

Healthcare responses to a "social problem"

Theme 2 illustrates that IPV might be perceived by some healthcare professionals as merely a "social problem". Nevertheless, some mental health professionals do recognise that, when providing healthcare to IPV survivors, the priority always lies with first of all stopping violence and ensuring safety. It is important to pay attention to social determinants of mental health: most study participants acknowledge a web of complexity in providing mental healthcare to IPV survivors because, in reality, it is practically impossible to separate the "health" from the "social" components in such cases (see *Table 2*).

A complex problem requiring complex responses

The data resulting in Theme 3 details the complexity of mental healthcare provision to IPV survivors. It points to the need for person-centred, needs-based, case-by-case, multi-disciplinary efforts, and a special regard for confidentiality and information sharing in such interventions. Support strategies may include individual and group sessions, and when appropriate the broader support network of the IPV survivor (see *Table 2*).

"A station on a railway line that connects to other stations and stops"

The importance of inter-sectoral collaboration is central to Theme 4. Mental health professionals recognise that in dealing with cases of IPV, a complex multi-disciplinary and inter-sectoral approach is needed. Mental health services are perceived as one of

the many parallel interventions by various stakeholders, which are all necessary as a whole to help survivors while on their recovery journey (see *Table 2*).

"We never demonise anyone"

Theme 5 highlights the determination of mental health professionals to work not only with survivors but also with perpetrators of domestic violence and IPV. Especially those working in the specialised mental health unit expressed their conviction: to address these situations most effectively and to potentially prevent further violence in the future, it is crucial to also work with the perpetrators (see *Table 2*).

***Table 2**. Selected quotes from focus groups: Themes 1 to 5 (n=17)*

Theme	Selected Quotes
1) "Not everyone has the profile to work on this"	"Everyone here has adapted their skills to reality. I believe that everyone here is truly excellent at what they do. And there is one fundamental thing: you cannot work in a place like this without having your personal issues resolved in the realm of relationships. At the beginning of all this [the development of the specialised mental health service], I often reflected on my life story. I found myself confronted with it here and there, suddenly facing it or in public spaces, you know? (…) It's not easy. We are confronted with, in a man's case, relationships with women. (…) I'll just draw your attention to that – not everyone is suited to work in this context." – Psychiatrist, specialised mental health unit "There is work here, a kind of dedication that is safeguarded by specific competencies. One must possess specific skills and knowledge in this area. (…) Networks play a crucial role—they protect people from burnout. In our "violence group", (…) we discuss each other's lives, our experiences." – Psychiatrist, specialised mental health unit "There is something important to emphasise here, which is the relationships we maintain with each other over the years – none of these [mental health] teams can function if people do not have very clear and healthy relationships. Because then others would come here with their dysfunctions; and if this here was already dysfunctional, things would be complicated." – Psychiatrist, specialised mental health unit
2) Healthcare responses to a "social problem"	**"**And from there, we realised it was important, the network realised it was important to have a response [to domestic violence] from Health. Because the country had no response from Health. It is really interesting because at the beginning of the century, violence was read as a "social problem". Where, let's say, health-related questions were not of much importance. And still today, I feel from some colleagues that there is still not a perception, a recognition, that this [domestic violence] has to do with mental health." – Psychiatrist, specialised mental health unit "Throughout the reception consultation, we would basically broaden our perspective with the family, with their networks, and also by activating strategies that, firstly, which is the main objective, to contribute to interrupting the cycle of violence." – Social worker, specialised mental health unit "In cases of violence in emergency contexts, when we have a full emergency ward, when this victim needs personalised care, our emergency services are not adequately prepared." – Social worker, generic mental health service
3) A complex problem requiring complex responses	"It is described as a continuous exposure to violence, the concept of microtrauma, which impacts people's mental health. And we, throughout our lives, are not always the same; we perceive things differently. Therefore, there needs to be that support network; when we stumble, that network catches us. I believe this has been very protective. And this implies, as I say, a significant willingness to be there for others." – Psychiatrist, specialised mental health unit "The symptomatology itself that comes from this situation, I mean, the situation itself generates discomfort and, specifically, symptoms of anxiety and depression. The same occurs during hospitalisation. Often, individuals admitted for various psychiatric symptoms, while conducting their assessments, their life stories reveal a history of abusive situations." – Psychiatrist, generic mental health service

	"A multidisciplinary team, where various knowledge areas come together. And here, there's genuine respect for the opinion of each specialisation." – Psychologist, specialised mental health unit "If it is an emergency crisis situation, urgency, we encounter this type of victim. It is obvious that there's a window, often an opportunity to work with the person to bring about some change in their life." – Social worker, generic mental health service "At this moment, in terms of difficulties, it can also be simultaneously a moment of contraction, certainly in terms of human resources; in terms of access to health services; and in terms of the difficulty people face in adhering to a programme because poverty is indeed a very real factor. However, if professionals are also alert, this moment can be significant." – Social worker, specialised mental health unit
4) "A station on a railway line that connects to other stations and stops"	"It is very important for [mental health] service users who are being monitored to understand that this is much bigger than just this service, isn't it? That's the impact... It is a station on a railway line that connects to other stations and stops" – Psychiatrist, specialised mental health unit "It is evident that this phenomenon of violence requires the involvement of all partners. It is our problem, all of us, isn't it? So, I think there is still much work to be done, especially because (…) Often, there is an outdated attitude of blaming the person and not valuing their complaints. We have encountered some patients who have come to us saying that the police did not accept their complaint. In such situations, we often make direct contact with the police station to try to resolve it." – Social worker, generic mental health service "[We collaborate] with professionals from various fields because only that way can we ensure that we properly support the patient in the team and can guide them appropriately." – Psychologist-Psychotherapist, generic mental health service "This intersects with all other disciplines for us. Even with the architectural structure of cities, right? Even this is an important consideration because violence is connected to something called fear. In any city where people might feel fear, it becomes a catalyst for violence." – Psychiatrist, specialised mental health unit "What are the challenges, opportunities, and difficulties… They are the ones that arise, I believe, in response to other, more or less differentiated answers in the field of mental health: the integration of care, which is, I mean, a well-known phrase that is used without having a concrete reflection in practice, between primary care, between continued care, between other areas of health, between other areas of psychosocial support. This coordination remains very deficient." – Psychiatrist, specialised mental health unit
5) "We never demonise anyone"	**"**We follow both the aggressors and the victims." – Psychiatrist, specialised mental health unit "The idea [of the specialised mental health service] was never to demonise anyone. Therefore, they are all users of the service. (...) The idea is that everyone suffered, some more, others less, also according to the proximity of the violence itself... And even in the case of the aggressors." – Social worker, specialised mental health unit

Results from the Online Survey

The online survey was completed by 92 persons, 29 (32%) of whom self-reported to have experienced IPV and 11 of them (38%) said that they also used mental health services. The vast majority of IPV survivors were women (90%) and abusers were men (93%). The sociodemographic characteristics of the survey participants are presented in *Table 3*.

Table 3. *Sociodemographic characteristics of the participants of the online survey (n=92)*

	Survey participants who experienced IPV (*n*=29)		Survey participants who did not experience IPV (*n*=63)	
Gender	***n***	**%**	***n***	**%**
Female	26	90	47	75
Male	3	10	16	25
Age category	***n***	**%**	***n***	**%**
18 – 24	1	3	1	2
25 – 34	7	24	11	17
35 – 49	9	31	29	46
50 – 64	11	38	15	24
65 – 82	1	3	7	11
Residence	***n***	**%**	***n***	**%**
City	16	55	26	41
Town/village	13	45	37	59
Age of first experience of IPV (n=27)	**Median (Min; Max values)**			
	24 (13;41)			
Gender of the abuser	***n***	**%**		
Female	2	7		
Male	27	93		
Type of IPV	***n***	**%**		
Psychological	29	100		
Economic	6	21		
Physical	17	59		
Sexual	14	48		
Age when used mental health services for the first time (n=11)	**Median (Min; Max values)**			
	30 (22;38)			
Place where used mental health services (n=11)	***n***	**%**		
City	4	36		
Town/village	7	64		

Themes from the Online Survey

Thematic analysis of the qualitative data from the online survey resulted in six main themes, as follows:

1) “A wounded pride”; 2) “The doctor did not realise what was hidden”; 3) “Psychotherapy is a slow process”; 4) Impunity for the aggressor; 5) Medicalisation of the public sector; 6) What was really needed.

"A wounded pride"

Theme 1 encompasses some of the possible reasons why IPV survivors might not seek help from mental health services and often conceal the fact of violence altogether. Some describe deep feelings of shame and fear, others feel that it might lead to devaluation by others, and others yet rely solely on themselves due to not having enough information on where and how the needed help could be accessed (see *Table 4*).

"The doctor did not realise what was hidden"

In Theme 2, those who did use mental health services highlight various limitations they faced, including victim-blaming attitudes, stigma, and mostly unmet expectations for support. According to study participants, mental health professionals do not tend to ask direct questions about their experiences of violence or abuse and do not recognise the signs, unless IPV survivors share their experiences openly. However, even in such cases when survivors open up about IPV, they might be, for example, mistakenly and inappropriately referred to couples' therapy (see *Table 4*).

"Psychotherapy is a slow process"

According to Theme 3, psychological support and psychotherapy are vital to IPV survivors. Be it a long or slow process, it is seen as essential by many survivors: it is crucial for their recovery from both the trauma of IPV and for their mental health and well-being. Also, it aids their understanding of what had happened to them, helps them not to give up, and guides them in rebuilding their sense of self and confidence (see *Table 4*).

Impunity for the aggressor

Theme 4 illustrates how sometimes the deeply rooted victim-blaming attitudes and a lack of specialised knowledge or appropriate working methods may result in IPV survivors feeling like they are not being heard or understood by professionals. Also, they might be subjected to being made "responsible" for their experiences of IPV. For example, they might be advised to change their personal outlook, change their diet, or leave their own homes and change their residence, while the "responsibility" of perpetrators might remain unrecognised, and support may not be provided to address the criminal behaviour of their abusers (see *Table 4*).

Medicalisation of the public sector

Theme 5 raises the question of differences between the public and private mental health sectors. Especially noting the often excessive reliance on psychotropic medications in the public sector, with a lack of alternative or complementary treatment options and

interventions. On the one hand, IPV survivors have named economic difficulties related to accessing private services. On the other hand, they were often unsatisfied with the fact that medication was the primary and most used response in public mental health services, which they felt was not enough (see *Table 4*).

What was really needed

Theme 6 summarises the main thoughts and recommendations of IPV survivors who participated in this study about what they needed the most from mental health services and professionals at the time. The most commonly expressed needs were down-to-earth and simply humane: for professionals to listen actively more and without judgement; to pay more attention to subtle cues and to proactively encourage discussions of IPV experiences; see the overall picture of the IPV survivor's environment, relationships, and refer for other types of needed support, for example, concerning childcare (see *Table 4*).

Table 4. *Selected quotes from the qualitative online survey: Themes 1 to 6 (n=29)*

Themes	Selected Quotes
	Did not seek help
1) "A wounded pride"	"I thought I could handle the situation alone. A wounded pride. I couldn't understand how I was going through that. I didn't want anyone to see me any other way." "I was too depressed to ask for help." "I thought, I could be self-sufficient." "Shame and not knowing what to do at the time. I didn't have enough information. I didn't know where to look for it."
	Sought help
2) "The doctor did not realise what was hidden"	**"**I went to an appointment at the health centre. I shared with my family doctor that my marriage was not going well. I didn't go into details. Domestic violence was not shared. The doctor then referred me to couple's therapy. I had a couple's therapy session. We were given an exercise to do as a couple. We went for a second appointment. Neither my husband nor I, at the time, did the exercise. We didn't do any more sessions. The doctor did not devalue the request for help. But she didn't realise what was hidden." "There was a misunderstanding of the somatic manifestations ("It's all in your head"); a misunderstanding about the level of suffering caused in everyday life; misunderstandings about the effort required to "simply function", survive, and be a productive society member." "An air of surprise, a strangeness [from the medical professional] that I interpreted to mean: "How could a person like you not have detected a perverse personality in time?", which immediately embarrassed me."
3) "Psychotherapy is a slow process"	**"**It was essential to seek psychological support, as I felt I was unable to overcome the situation alone. I felt very lost and scared." "Psychotherapy is a slow process." "The services that I used were essential for my mental health as they guided me and helped me understand what was happening to me." "Emotional support: the impact was very positive because it gave me the courage to get out of the situation that seemed like there was no way out. Little by little, I regained confidence and my life."

4) Impunity for the aggressor	**“**Being told to change my place of residence was an "emotional barrier". It felt like impunity for the aggressor because I was advised to change my residence and location.” “I was told that I should change my attitude, diet, and go to the gym.”
5) Medicalisation of the public sector	**“**I went to the health centre. At the health centre, I was offered to take an antidepressant and I thought, “I don't want to... My mother took antidepressants all her life, and I don't think so...”. No, I didn't want to go there. I wasn't depressed, I was just having that problem [domestic violence], so what I wanted was to solve the problem, and not take medication to pretend that nothing exists and that everything is fine. (...) And another time they prescribed some more tranquillisers, so once again I had to turn to the private sector because the public sector doesn't work... No support, nothing, there is nothing. It's very, very, very weak.” **“**Only medication was offered at first. Psychotherapy plus medication – in more recent years.” **“**With medication, I was able to control my panic attacks and become "detached" from the insults.” **“**I highlight psychotherapy combined with medication as the most positive aspect, allowing me to balance the components of my emotional life with the necessary professional functionality.”
6) What was really needed	“[For mental health professionals] to listen more, show less judgment, and focus less on my individual responsibility for behavioural change.” “So that they wouldn't have just prescribed medication, and they would have listened more.” “So that they had had more of a "radar" and attention (a kind of "protocol"), so that during consultations, they could become aware of the quality of relationships, including violence between family members. At school, I report serious cases (including abuse) of children and young people accompanied in health centres, always in the company of their parents, whose doctors are far from imagining the traumatic family experiences...” “So that they had exercised their active LISTENING skills.” “To have taken the time to really understand what was latent. To have insisted on returning and listening more carefully. To have provided psychotherapy.” “I think that then I felt very alone, and I needed someone to make my children see what was going on, who wasn't me because I was as if “the bad one” who didn't like their father, and their father was the “poor guy” who didn't like his mother. And the mother was being mean to the father. And I really wish there had been someone from the outside who would have spoken to my children and explained to them what was going on here. That was greatly missed.”

Discussion

This was the first study in Portugal that qualitatively explored the existing responses by local mental health services to the mental health care needs of IPV survivors. The study provides insights from both the perspective of professionals and that of IPV survivors. It describes the specificities of the intersection between the field of IPV and the provision of mental healthcare.

It is important to note that, despite the research teams’ best efforts during the nearly two years of work, it has proven to be extremely difficult to recruit research participants for this study: both mental health professionals and IPV survivors were reluctant to share their stories and insights into the topic. This might potentially be explained by cultural and socially constructed barriers and public and self-stigma preventing the opening up about such intimate and personal topics as IPV (Taccini & Mannarini, 2023) and mental health difficulties (Thornicroft et al., 2022). It could also potentially be attributed to deeply rooted victim-blaming attitudes, shame, fear, self-reliance, and the general tendencies to conceal IPV experiences in Portugal (Martins et al., 2014).

Nevertheless, the study highlights that both IPV survivors and mental health professionals often do recognise the importance of mental health support for the recovery of those who have experienced IPV. The study also shows that when professionals do not have enough specialised knowledge about the complexity of IPV, the mental healthcare needs of survivors may be left unmet. This contributes to the global evidence which highlights that a transformation of mental health services is needed to establish a roadmap for strengthening responses across mental healthcare settings to the needs of IPV survivors (Oram et al., 2022). For example, integrating trauma- and violence-informed care approaches and practices in mental healthcare responses has so far been observed to be one of the promising developments in the related transformation of mental health services for this population (Wathen & Mantler, 2022).

The study also revealed some distinct disparities between the way IPV survivors and professionals reflect on the situation of IPV perpetrators. For example, while it is important to provide mental health support to both IPV survivors and perpetrators, it is crucial to do so in a mindful and balanced way, and not to take the responsibility away from the perpetrators while instead consciously or subconsciously assigning it to the survivors (Eigenberg & Policastro, 2016). Victim-blaming attitudes are deeply rooted across the world (including among mental health professionals) which may leave IPV survivors feeling “responsible” for what happened to them (Edmond et al., 2013). This in turn may potentially end up compromising their therapeutic efforts and recovery (Park & Kim, 2023).

In Portugal, even though psychotropic medication is a common treatment option in public mental health services, community mental health services, multi-disciplinary teams, and psychosocial interventions are also common (Caldas-de-Almeida et al., 2017). Thus, the Portuguese mental health system could provide an opportunity for more effectively fulfilling the need for complex, multi-disciplinary and inter-sectoral responses concerning the needs of IPV survivors. It could be a promising practice example, as long as mental health professionals would have enough specialised knowledge and skills to employ the existing resources, approaches, and interventions to support IPV survivors. If these community-based teams were to be developed further, it would be in line with the global evidence which says that to be successful, IPV interventions need to be complex, multi-disciplinary, and include components of psychosocial support and empowerment (Karakurt et al., 2022; Micklitz et al., 2023).

Moreover, what is positively unique in Portugal is the mental health unit that specialises in serving specifically survivors and perpetrators of domestic violence, including IPV. This is different from other European countries. For example, our recent study in Lithuania shows that many professionals working in mental health services in the country do not have any specialised training in domestic violence or IPV at all (*…Ref…*). This is also confirmed by a systematic review which reveals that IPV training for those providing mental health services is inconsistent across the world: mental health professionals often feel unequipped to support IPV survivors effectively (Sutton et al., 2020). In Portugal, even though it is currently quite limited in its scope and geographically is mostly limited to the region of Coimbra, nevertheless, there is a specialised mental health unit, which ensures that all professionals who work in such a specialised service have the needed knowledge and skills to best support IPV survivors. This illustrates a promising practice example in Europe.

Conclusion

The study findings contribute to the sparse literature available on the provision of mental healthcare services to survivors of IPV. The key findings highlight and confirm the general importance of mental health support for IPV survivors' recovery. The needed complex approaches include trauma- and violence-informed care, holistic, multi-disciplinary, and inter-sectoral efforts. Further qualitative and quantitative research is needed to explore the specificities of the utilisation of mental health services by IPV survivors, as well as what interventions might be the most effective for this population in different geographical and cultural contexts. Implications for policy and practice include the need for mainstreaming of IPV-related knowledge and skills among professionals in mental healthcare services; elimination of IPV stigma and victim-blaming attitudes in society; ensuring inter-sectoral working models between the mental healthcare sector, social care services, law enforcement, judiciary, and other relevant stakeholders.

Limitations

It is not possible to generalise the findings of this study. The format of an online survey comes with some limitations such as its voluntary online nature of participation, potentially limited access to the internet or the needed IT equipment in certain populations, the potential response and sampling bias, as well as not being representative of the general population. Also, the relatively small number of participants

in the online survey restricted any potential further statistical analysis beyond the descriptive statistics.

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Declaration of Interest Statement

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

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Prevalence and acceptability of psychological and/or economic intimate partner violence, and utilization of mental health services by its survivors in Lithuania

Ugnė Grigaitė[1], Sofia Azeredo-Lopes[2,3], Eglė Želmė[4], Paulius Yamin Slotkus[5,6], Maxi Heitmayer[7,8], Deborah Oyine Aluh[9,10], Bárbara Pedrosa[9], Manuela Silva[11], Margarida Santos-Dias[9], Graça Cardoso[11], José Miguel Caldas-de-Almeida[11]

[1]Lisbon Institute of Global Mental Health, Comprehensive Health Research Centre/NOVA Medical School, National School of Public Health, Universidade NOVA de Lisboa, Rua do Instituto Bacteriológico 5, Edifício Amarelo, 1150–190 Lisboa, Portugal
[2]Comprehensive Health Research Centre (CHRC), NOVA Medical School , Faculdade de Ciências Médicas, NMS| FCM, Universidade Nova de Lisboa, 1150-190 Lisboa, Portugal
[3]Department of Statistics and Operational Research, Faculdade de Ciências, Universidade de Lisboa, 1749-016 Lisboa, Portugal
[4]Behavioural Lab LT, LT-14247 Vilnius, Lithuania
[5]Paris Institute for Advanced Study, 75004 Paris, France
[6]Department of Psychological and Behavioural Science, London School of Economics and Political Science, London WC2A 2AE, UK
[7]Department of Psychological and Behavioural Science, London School of Economics and Political Science, London WC2A 2AE, UK
[8]London College of Fashion, University of the Arts London, London W1G 0BJ, UK
[9]Lisbon Institute of Global Mental Health, Comprehensive Health Research Centre/NOVA Medical School, National School of Public Health, Universidade NOVA de Lisboa, 1150-190 Lisboa, Portugal
[10]Department of Clinical Pharmacy and Pharmacy Management, University of Nigeria Nsukka, 410105, Enugu, Nigeria
[11]Lisbon Institute of Global Mental Health, Comprehensive Health Research Centre (CHRC), Nova Medical School, Nova University of Lisbon, 1150-190 Lisboa, Portugal
Address correspondence to Ugnė Grigaitė, E-mail: ugne.grigaite@nms.unl.pt and grigaitea@gmail.com

ABSTRACT

Background Lithuania has one of the highest averages in the European Union when it comes to psychological and/or economic intimate partner violence (PE-IPV). IPV survivors are several times more likely to have mental health conditions than those without IPV experiences. The aim of this article is to study the prevalence, characteristics and attitudes of PE-IPV survivors in Lithuania, and the predictors of them accessing mental health services.

Methods A cross-sectional study based on a national survey representative of the adult population. The survey was implemented by a third-party independent market research company employing an online survey panel. Logistic regression models were used in the analysis.

Results Almost 50% of women in Lithuania experience PE-IPV. Females are significantly more likely to experience it than males. The vast majority of women find PE-IPV unacceptable; however, only one-third of survivors seek any type of help. Only one-tenth approach mental health services, with divorcees being at higher odds of doing so.

Conclusions Further research is needed to explore predictors and contextual factors of why IPV survivors seek mental healthcare, or not. Policy implications include the need to eliminate IPV and mental health stigma; develop accessible mental health services and effective treatment approaches.

Keywords coercive control, Lithuania, mental health services, psychological and/or economic intimate partner violence

Ugnė Grigaitė, Doctoral Fellow, MSc
Sofia Azeredo-Lopes, Professor
Eglė Želmė, MSc
Paulius Yamin Slotkus, PhD
Maxi Heitmayer, PhD
Deborah Oyine Aluh, Doctoral Fellow, MPharm
Bárbara Pedrosa, Doctoral Fellow, MD, MPhil
Manuela Silva, Professor
Margarida Santos-Dias, BA
Graça Cardoso, Professor
Caldas-de-Almeida, Professor

Introduction

Intimate partner violence (IPV) is a global pandemic and major public health issue (1–4). It is also recognised globally as a type of gender-based violence, which means that women suffer disproportionately from IPV compared to men (5–7). The WHO estimates that at least one in three women worldwide experience physical or sexual violence by their intimate partner at some point in their life (3). Moreover, by far the most prevalent form of IPV is psychological violence (8–10). Psychological IPV, including coercive control and economic IPV, often precedes physical or sexual manifestations of abuse (11–13). Its prevalence is estimated to be from around 20% to as much as 90%, depending on the study's methods and setting (9,10,14–17).

In the European Union (EU), the average prevalence of psychological IPV is around 43%. In Lithuania, at least one in two women (51%) go through this experience at some point in their life (18,19). According to a local victims' support service, this number may be even higher at potentially over 60%, with at least 10% of victims experiencing economic IPV specifically (20). Therefore, the country is among those with the highest average levels of psychological IPV against women in the EU (17,18). However, official statistics may not reflect the magnitude of the issue, since psychological and/or economic IPV (PE-IPV) remains to be one of the most latent forms of crime. This is due to the practical difficulties of convicting perpetrators in court, as well as the fact that at least 30% of women conceal the experience and do not seek help at all (21,50).

Any type of IPV but PE-IPV in particular, has serious consequences for survivors' physical and mental health (3,8,13,22–25). Women with a history of IPV are around three times more likely to have mental health conditions (such as depression, anxiety or post-traumatic stress disorder), than those without this life experience (8,24,25). Some survivors do approach mental health services for support, though for many different reasons, (including negative societal attitudes and stigma), many do not seek help at all. (8,26–30). This type of gender-based violence is a complex, global public (mental) health issue and all healthcare services, including mental healthcare providers, have an important role to play in screening for and documenting it, as well as providing information and appropriate complex support (31–34).

In Lithuania, negative societal attitudes and socially constructed 'norms' greatly affect the way society deals with IPV, as well as how mental health services operate and respond to the needs of IPV survivors (35). These same attitudes also affect the way

survivors see themselves and recognise (or not) the violence and mental health conditions that they are experiencing (21). For example, economic violence can go unrecognised, being perceived as acceptable behaviour, or as part of the 'natural' order of socially constructed gender roles between a husband and wife (where the husband might have and maintain full control of the family's finances) (36). On the other hand, when IPV *is* publicly recognised, the general public tends to express a deeply rooted 'victim-blaming' attitude, with up to 50% of Lithuanians believing it is the woman's own fault that she experienced IPV (35). Moreover, mental health stigma is also prevalent and negative attitudes persist towards potentially seeking help and support from mental health services (37–39). Thus far, no studies in Lithuania explored the acceptability of PE-IPV among its survivors, in the context of mental health outcomes or socially constructed societal 'norms' as described above, nor the utilisation of mental health services by IPV survivors.

The main objectives of this article are to study the prevalence, characteristics and attitudes of survivors of PE-IPV in Lithuania, their utilisation of mental health services, as well as predictors of their likelihood to seek mental health care.

The research questions are as follows:

1) What is the current prevalence of persons exposed to PE-IPV in Lithuania and what are the associated factors, compared with those who have not experienced this type of IPV?
2) What are the levels of acceptability towards PE-IPV among persons who have experienced such violence, compared to those who have not?
3) How regularly do survivors of PE-IPV seek help and use available healthcare services, and what are the predictors of them accessing mental health services?

Methods

Study design and instruments

This is a cross-sectional study, which is based on a nationally representative survey conducted in Lithuania in 2021 (n=1001). This article is also a part of the 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'.

The 2021 survey was conducted in the framework of the #ItsNotOk Initiative and its design was based on references from both the field of IPV, and behavioural science (40,41). It was designed and coordinated by a group of scientists from Behavioural Lab LT, Human Rights Monitoring Institute, Lisbon Institute of Global Mental Health, Center for Social Norms and Behavioral Dynamics at the University of Pennsylvania, Department of Psychological and Behavioural Science at the London School of Economics and Political Science, and the University of Oxford.

The survey was implemented by a third-party independent market research company employing an online survey panel. The panel stores detailed and regularly updated profiles of its panellists, allowing for a targeted selection of study participants, to achieve the national demographic representation. To ensure that the survey sample was representative of the Lithuanian adult population by gender, age and region of living, the newest publicly available demographic statistics provided by the Lithuanian government were used to set the respective quotas. Participants were recruited accordingly by these quotas to reflect the national demographic composition. Within the targeted groups participants were selected at random. Participants of the study were those who had given their informed consent to participate, were 18 years or older, living in Lithuania, and Lithuanian speaking. The panel used a multisource recruitment strategy (via the web, telephone and face-to-face) to eliminate sample bias and conducted a quality check by removing responses filled-in too quickly and straight-lined responses.

The study was approved as an integral part of the broader mixed-methods study by the Research Ethics Committee of NOVA Medical School, NOVA University of Lisbon (Ref. No. 171/2021/CEFCM).

Study sample and assessment of variables

Exposure to psychological IPV was assessed by first describing this type of violence as "*behaviour by your intimate partner that includes calling names, humiliating, isolating, hurting your pets, destroying things dear to you, threatening, frightening, turning your children against you, etc*." and then asking the question "*Have you ever experienced psychological IPV?"* (*yes* or *no* answer).

Exposure to economic IPV was assessed by first describing this type of violence as "*behaviour by your intimate partner that includes controlling your finances, not allowing*

you to study or work, not allowing access to your/family bank accounts, demanding detailed reports for all your spendings, etc." and then asking the question "*Have you ever experienced economic IPV?"* (*yes* or *no* answer).

Only data on experiences of PE-IPV (and not other types of IPV) was analysed in this study because only this data had been included in the survey. Excluding experiences of physical IPV from this study was motivated by the fact that globally it has been studied extensively but PE-IPV has had much less scientific attention.

The sociodemographic characteristics assessed in this study included: gender, age (18–24; 25–34; 35–44; 45–54; 55–64; 65–75); education (never attended school; unfinished school; primary school; secondary school; vocational school; college; university); monthly household income after tax in euros (less than 450; 451–750; 751–1100; 1101–1700; more than 1700; cannot/do not want to say); residence (large city; large town; other town; small town/village (up to 2000 inhabitants)); relationship status (married, have a partner–unmarried; single; divorced; widow); number of people living together in the household (1; 2; 3; 4; more than 4; no one else).

The research participants' own levels of acceptability towards PE-IPV were assessed, by presenting them with the following statements and questions, first about psychological IPV, then about economic IPV: "*Some people in Lithuania use this type of behaviour against their intimate partners. Society may either think that it is acceptable or unacceptable. In your personal opinion, to use such behaviour against intimate partners is…*" (answer options: *acceptable; more acceptable than not; more unacceptable than acceptable; unacceptable*).

To assess the utilisation of mental health services, study participants were asked about whether they sought any kind of help and support at all, and also whether they sought help at specialised mental health services. The questions were as follows: *"Have you ever sought help for your experiences of psychological IPV?"; "Have you ever sought help for your experiences of economic IPV?"; "Did you receive the services of a psychologist/psychotherapist in the public sector?"; "Did you receive the services of a psychologist/psychotherapist in the private sector?"; "Did you receive the services of a psychiatrist in the public sector?"; "Did you receive the services of a psychiatrist in the private sector?"; "Did you receive services within a psychiatric hospital?"* (*yes* or *no* answers).

Data analysis

For the descriptive statistical analysis, observed absolute frequencies (*n*) and relative frequencies (%) were used for all the categorical variables. For the bivariate statistical analysis, Chi-Square or Fisher exact tests were employed to assess the association between categorical variables, as applicable. Univariate logistic regression models were performed with the dependent variables indicating whether various mental health services were sought by female survivors of IPV. The various potential factors that might influence the outcome were considered as explanatory variables. These factors included sociodemographic characteristics and the different types of violence that were experienced.

Estimated odds-ratios (OR) and corresponding 95% confidence intervals (95% CI) were obtained for each explanatory variable of the logistic regression models; their statistical significance was assessed by likelihood ratio tests. The significance level α=5% was considered throughout the statistical analysis.

The data was analysed using the R software (42). The R *car* package was used to obtain the likelihood ratio tests (43).

Results

In total, 1001 people participated in the survey: 534 females (53%), 459 males (46%), and eight people who identified as being of other gender or did not want to reveal their gender at all (1%). A statistically significant association between gender and experience of PE-IPV was found (p=0.020) with women being significantly more likely to have experienced PE-IPV than men. For this reason, the main sample included in this study was of the participants who identified as women (n=534), of whom almost half experienced PE-IPV (n=233). The sociodemographic characteristics of the study participants, together with the associated acceptability rates of both types of IPV are presented in *Table 1*.

The vast majority of women, regardless of whether they had experienced PE-IPV or not, found both types of IPV either unacceptable or more unacceptable than acceptable. Among survivors of PE-IPV there were 3% of women who found PE-IPV either acceptable or more acceptable than not. Among women who did not experience IPV this number was 2%.

Table 1: *The sociodemographic characteristics of women with and without the experience of psychological and/or economic IPV, and their associated levels of IPV acceptability (n=534)*

	Women in Lithuania who experienced psychological and/or economic IPV (*n*=233)		**Women in Lithuania who did not experience psychological and/or economic IPV (*n*=301)**		***p*-value *(Chi-Square Test)*** *(*) statistical significance*
Age category	***n***	**%**	***n***	**%**	0.008*
18-24	27	11.6	60	19.9	
25-34	26	11.2	48	15.9	
35-44	39	16.7	49	16.3	
45-54	55	23.6	42	14.0	
55-64	44	18.9	58	19.3	
65-75	42	18.0	44	14.6	
Education level	***n***	**%**	***n***	**%**	0.001*
Primary School	6	2.6	1	0.3	
Secondary School	37	15.9	37	12.3	
Vocational School	28	12.0	31	10.3	
College	72	30.9	67	22.3	
University	90	38.6	165	54.8	
Household income (per month)	***n***	**%**	***n***	**%**	<0.001*
Less than 450 EUR	33	14.2	28	9.3	
451–750 EUR	61	26.2	47	15.6	
751–1100 EUR	48	20.6	50	16.6	
1101–1700 EUR	35	15.0	58	19.3	
More than 1700 EUR	19	8.2	49	16.3	
I cannot/do not want to say	37	15.9	69	22.9	
Residence	***n***	**%**	***n***	**%**	0.004*
Large city	75	32.2	135	44.9	
Large town	63	27.0	52	17.3	
Other Town	59	25.3	60	19.9	
Small Town/Village (up to 2 000 inhabitants)	36	15.5	54	17.9	
Relationship status	***n***	**%**	***n***	**%**	<0.001*
Married	97	41.6	133	44.2	
Have a partner – unmarried	40	17.2	63	20.9	
Single	22	9.4	56	18.6	
Divorced	61	26.2	23	7.6	
Widow	13	5.6	26	8.6	
No. of persons the woman lives with (including children)	***n***	**%**	***n***	**%**	0.4
1	28	12.0	42	14.0	
2	78	33.5	88	29.2	
3	40	17.2	61	20.3	
4	24	10.3	43	14.3	
More than 4	14	6.0	11	3.7	
No one else (no children or they are older than 18 years)	49	21.0	56	18.6	

Acceptability level of psychological IPV	***n***	**%**	***n***	**%**	0.8
Acceptable	4	1.7	3	1.0	
More acceptable than not	0	0.0	1	0.3	
More unacceptable than acceptable	22	9.4	26	8.6	
Unacceptable	207	88.8	271	90.0	
Acceptability level of economic IPV	***n***	**%**	***n***	**%**	0.06
Acceptable	2	0.9	1	0.3	
More acceptable than not	5	2.1	1	0.3	
More unacceptable than acceptable	26	11.2	23	7.6	
Unacceptable	200	85.8	276	91.7	

As demonstrated in *Table 2*, less than one third (27.5%) of the PE-IPV survivors sought any type of help, and around 13% received mental health services. The most frequently used service was that of a psychologist/psychotherapist.

No significant difference could be observed in the utilisation of mental health services between women who experienced both types of IPV compared with those who experienced only one.

Table 2: *Help-seeking and types of mental health services accessed by survivors of PE-IPV (n=233)*

		Women who experienced both psychological and economic IPV (n=95) *n* (%)	**Women who experienced either only psychological IPV (n=112) or only economic IPV (n=26)** *n* (%)	***p*-value (Chi-Square Test)**
Public sector	Psychiatrist	1 (1.05)	2 (1.45)	0.792
	Psychologist/psychotherapist	6 (6.32)	7 (5.07)	0.684
	Psychiatric hospital	2 (2.11)	1 (0.725)	0.358
	Any mental health services	8 (8.42)	9 (6.52)	0.584
Private sector	Psychiatrist	4 (4.21)	1 (0.725)	0.071
	Psychologist/psychotherapist	4 (4.21)	7 (5.07)	0.760
	Any mental health services	8 (8.42)	8 (5.80)	0.436
Any type of mental health services at any sector		16 (16.8)	15 (10.9)	0.187
Any type of help		31 (32.6)	33 (23.9)	0.143

Out of all the sociodemographic predictors included in this study, as to whether or not survivors of PE-IPV seek help or access mental health services, only one, ('relationship status'), had a significant overall effect (see *Table 3*). Divorced women were most likely

to seek any type of help (p=0.002), as well as mental health services (p=0.006). The only other predictor that was significant for accessing mental health services, was living with more than 4 persons in the household (p=0.01).

Table 3: *Association between the sociodemographic factors and whether or not PE-IPV survivors sought help or accessed mental health services (n=233)*

		Seeking any type of help for experiencing PE-IPV OR (95%CI), *p*-value	**Seeking any mental health services for experiencing PE-IPV OR (95%CI), *p*-value** *(*) statistical significance*
Age category	18-24	Reference category	Reference category
	25-34	1.354 (0.5157, 3.604) 0.536	1.1857 (0.2715, 5.180) 0.814
	35-44	1.368 (0.5478, 3.531) 0.504	1.5183 (0.4184, 6.123) 0.529
	45-54	1.585 (0.6660, 3.971) 0.306	1.6139 (0.4699, 6.346) 0.458
	55-64	0.839 (0.3128, 2.248) 0.723	1.7660 (0.5358, 6.812) 0.367
	65-75	1.543 (0.6281, 3.945) 0.349	0.7500 (0.1440, 3.502) 0.712
	Overall Test of Effect	0.675	0.791
Education level	Primary School	0.167 (0.00784, 1.43) 0.1355	2.6667 (0.1366 17.061) 0.378
	Secondary School	0.500 (0.14317, 1.73) 0.2688	1.4118 (0.4880, 3.619) 0.492
	Vocational School	0.688 (0.22498, 2.13) 0.5097	1.4815 (0.4658, 4.011) 0.465
	College	1.312 (0.47150, 3.82) 0.6072	0.5970 (0.1908, 1.579) 0.328
	University	Reference category	Reference category
	Overall Test of Effect	0.427	0.496
Household income (per month)	Less than 450 EUR	Reference	
	451–750 EUR	0.659 (0.286, 1.540) 0.326	0.733 (0.2427, 2.329) 0.583
	751–1100 EUR	0.625 (0.263, 1.491) 0.283	0.493 (0.1363, 1.709) 0.261
	1101–1700 EUR	0.605 (0.250, 1.463) 0.260	0.521 (0.1439, 1.808) 0.300
	More than 1700 EUR	0.255 (0.068, 0.783) 0.246	0.278 (0.0396, 1.261) 0.126
	I cannot/do not want to say	0.521 (0.216, 1.256) 0.143	0.550 (0.1647, 1.836) 0.320
	Overall Test of Effect	0.290	0.652
Residence	Large city	Reference	Reference
	Large town	1.228 (0.6259, 2.355) 0.542	0.7706 (0.2665, 1.981) 0.604
	Other Town	1.021 (0.5070, 1.992) 0.953	1.0090 (0.3923, 2.432) 0.984
	Small Town/Village (up to 2 000 inhabitants)	0.885 (0.3904, 1.869) 0.757	0.6512 (0.1806, 1.876) 0.461
	Overall Test of Effect	0.882	0.845
Relationship status	Married	Reference	Reference
	Have a partner – unmarried	1.081 (0.5047, 2.206) 0.834	1.2315 (0.4141 3.3339) 0.690
	Single	0.808 (0.3115, 1.859) 0.636	0.5239 (0.0799 2.0078) 0.407
	Divorced	2.733 (1.4255, 5.213) 0.002*	3.3182 (1.3967 7.9627) 0.0063*
	Widow	0.683 (0.1570, 2.081) 0.550	0.5239 (0.0283 2.8127) 0.542
	Overall Test of Effect	0.016*	0.0237*
No. of persons the woman lives with (including children)	1	Reference	Reference
	2	1.9810 (0.8248, 5.530) 0.152	2.4129 (0.62621 15.8646) 0.260
	3	1.1722 (0.4138, 3.596) 0.769	1.7708 (0.36974 12.6179) 0.502
	4	1.2444 (0.3919, 4.067) 0.708	1.0462 (0.12259, 8.9275) 0.965
	More than 4	3.3684 (0.9534, 11.987) 0.055	8.5000 (1.69416 62.5870) 0.014*
	No one else (no children or they are older than 18 years)	1.5072 (0.5639 ,4.481) 0.430	2.4286 (0.56654 16.6348) 0.278
	Overall Test of Effect	0.316	0.117

Discussion

Main finding of this study

This is the first ever representative study of the Lithuanian population on the prevalence and acceptability of PE-IPV. It is also the first of its kind on the utilisation of mental health services by women exposed to this type of IPV. The study confirms that almost one in every two women in Lithuania experience PE-IPV, with females being significantly more likely to experience this form of domestic violence than males. This is in line with global tendencies concerning the prevalence of psychological IPV (8–10,14–17). Almost all independent variables included in the current analysis were significantly associated with experiencing PE-IPV, i.e., age, place of residence, relationship status, education, and income level. The results also show that the vast majority of survivors of PE-IPV found this type of behaviour by intimate partners unacceptable; yet only a minority of them sought any type of help to deal with it or approached mental health services.

What is already known on this topic

Research has previously highlighted that generally survivors of IPV tend to conceal the fact that they were abused. This may be due to a number of possible reasons, among which are fear, shame, self-blaming, societal and internalised stigma, victim-blaming attitudes, the context of minority stress such as discrimination, financial and/or emotional dependency on the abuser, or the fact that they might not even consciously recognise the behaviour of their intimate partner as abuse at all (21,36,44–46).

Previous studies mainly investigated the link between survivors of IPV and their physical healthcare, especially in primary care settings (31–34,47,48). It is important to note that most of these studies have been primarily focused on physical IPV and were conducted in the USA, Canada, Sweden and Australia. The current study emphasises and draws attention to the specificities of Lithuanian women experiencing specifically PE-IPV and the crucial role that mental health care services may play for this population.

What this study adds

The current study highlights that only around one in ten women exposed to PE-IPV in Lithuania access mental health services. The study showed no significant difference in accessing mental health services between survivors of just one type of IPV or both

psychological and economic IPV. This might be due to the fact that economic IPV is in fact a dimension of psychological IPV and a type of coercive control; thus, the impact of the abuse among women with these experiences may be similar (13,24).

Nevertheless, this finding is unexpected and alarming because studies across the world show that women with experiences of IPV, especially psychological IPV and coercive control, including economic IPV, are more likely than those with no experience of IPV to have mental health conditions (8,24,25). Hence, the current study highlights that even though the prevalence of experiencing PE-IPV is high and so is the expected rate of mental health conditions among these women, only a small fraction of them seek help at all or receive mental health services in Lithuania. There may be several possible reasons for this phenomenon.

Firstly, psychological and/or economic abuse are still much less recognised as types of domestic violence, compared to physical and/or sexual IPV (49). Additionally, physical abuse is significantly more often investigated by the police (50).

When considering mental health services specifically, the reasons for a general lack of interaction with them may be rooted in predominant negative attitudes towards mental health conditions and services in Lithuanian society (37,38). As it was recently emphasised in the OECD Health Working Paper (2022): “Despite legislative reform in recent years, there remains legislation prohibiting those with a diagnosed mental health disorder from taking up specified professions, and performing certain activities. Formal and informal modes of stigmatisation continue to act as a barrier to help-seeking and treatment” (38).

In the current study, divorcees had higher odds of accessing mental health services compared with other relationship statuses, which might be related to the fact that it is very difficult to seek help while still in an abusive relationship. This is especially relevant in the case of economic IPV, where the woman may become financially dependent on the abuser, with a highly threatened personal independence and economic security (12,13,25). Also, psychological IPV and coercive control especially, may leave the victim-survivor not only entrapped in the power and control wheel of manipulative strategies systematically used by the abuser, but also isolated, with a diminished self-esteem, and in a state of terror, none of which can easily contribute to seeking help (11,24,51).

Finally, practical reasons for not using mental health services may also be related to inaccessibility, and potentially a lack of services based in the community and in rural areas of the country (38). The inaccessibility of public mental health services may result in vast economic and social exclusion-related problems, since only those who can financially afford to use services in the private sector end up receiving the services, whilst the poorest and most vulnerable may be left behind.

This situation is alarming because in light of global evidence, not only physical but also mental healthcare services are vital for the path to healing of IPV survivors (31,52). In most IPV cases, a complex support is needed, taking into account all aspects of the human rights-based and bio-psycho-social model, as well as a trauma-informed approach (23,53,54). Studies have shown that mental health interventions for female IPV survivors have the greatest impact when they employ a holistic approach and provide individualised and trauma-informed support (55,56).

To encourage IPV survivors to seek help, societal stigma related to both IPV and mental health conditions needs to be eliminated. Broader implications for public health and policy in Lithuania include: the urgent need to develop more accessible mental health services in the community, a fostering of effective evidence-based interventions to better address the needs of IPV survivors, and to develop new therapeutic approaches, including trauma-informed support. Further quantitative and qualitative research with larger sample sizes is needed in order to better understand the predictors and contextual factors of why IPV survivors utilise mental health care services, or not; especially among survivors of PE-IPV.

Limitations

The study is cross-sectional which limits causal inferences, namely the direction of the associations. Due to the relatively small sample size in some parts of the analysis, more uncertainty was obtained in the estimates, due to larger CIs. There is room for further research and deeper analysis with larger samples of this population, and with validated instruments. Additionally, only experiences of psychological and/or economic IPV were analysed and included in the survey, due to the limited data availability on this subject. Thus, the study leaves space for further exploration of relevant associations related to physical and/or sexual IPV.

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Authors' Contributions

The study was conceptualised by the first author Ugnė Grigaitė and most of the co-authors contributed to the study design. The survey for data collection was designed, coordinated and implemented by Paulius Yamin, Maxi Heitmayer, Ugnė Grigaitė, and Eglė Žeimė. The main statistical analysis of the collected data was conducted by Sofia Azeredo-Lopes and Ugnė Grigaitė, with support from Eglė Žeimė. The first draft of the manuscript was written by Ugnė Grigaitė and all co-authors reviewed, commented on it, and provided their contributions. All co-authors reviewed and approved the final version of the manuscript.

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Responding to the needs of survivors of intimate partner violence in Lithuania: perceptions of mental health and social care professionals

Ugnė Grigaitė, MSc[a], Greta Klidziūtė, BA[b], Deborah Oyine Aluh, MPharm, PhD[a,c], Bárbara Pedrosa, MD, MPhil[a], Margarida Santos-Dias, BA[a], Manuela Silva, MD, PhD[d], Graça Cardoso, MD, PhD[d], and José Miguel Caldas-de-Almeida, MD, PhD[d]

[a]Lisbon Institute of Global Mental Health, Comprehensive Health Research Centre/NOVA Medical School, National School of Public Health, Universidade NOVA de Lisboa, Lisboa, Portugal; [b]Faculty of Public Health, Lithuanian University of Health Sciences, Kaunas, Lithuania; [c]Department of Clinical Pharmacy and Pharmacy Management, University of Nigeria Nsukka, Nsukka, Nigeria; [d]Lisbon Institute of Global Mental Health, Comprehensive Health Research Centre (CHRC), Nova Medical School, Nova University of Lisbon, Lisbon, Portugal

ABSTRACT

Around eight-out-of-ten survivors of domestic violence in Lithuania are women, and of those, eight-out-of-ten suffer violence specifically from their intimate partners (IPV). Women who experience IPV are at higher risk of having mental health conditions. This study aims to explore the perspectives of mental health and social care professionals regarding the provision of mental health support to IPV survivors in Lithuania. Four focus groups were conducted among 29 service providers from across the country. Audio-recordings were transcribed verbatim and analyzed thematically using MAXQDA software. The five main themes derived from the analysis reveal: 1) low levels of IPV awareness among IPV survivors who seek support with their mental health; 2) a lack of specialized training among professionals as a barrier to effective support; 3) a low prioritization on the national level; 4) little inter-sectoral collaboration which undermines the complexity of needed responses; 5) broader systemic problems. The provision of mental health support to IPV survivors lacks the recognition that IPV is gender-based violence and a major public (mental) health problem. The complexity of needed services is absent. Further research needs to explore the utilization of mental health services by IPV survivors and their perceptions concerning it.

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Introduction

Intimate partner violence (IPV) is a highly prevalent type of gender-based violence and a major global public health problem, with at least one in three women experiencing it at some point in their life [1], [2], [3], [4], [5], [6], [7]. Women are significantly more likely than men to experience IPV, worldwide [3]. Reasons why women experience IPV disproportionately more often than men are various and complex: social and cultural context [8], gender inequality, gender stereotypes, and a lack of legal procedures and laws [9]. The complexity of such reasons and the potentially long-lasting effects of IPV on the physical and mental health of survivors makes IPV a major public health concern [10], [11], [12].

In 2022, the Lithuanian police received almost 60,000 phone calls reporting domestic violence, of which only around 10% were registered as criminal acts: mostly those that specifically involved physical IPV (94%), and mostly those where women were the victims (79%). According to official national statistics provided by the State Data Agency, in the same year, eight out of ten (4,300) survivors of domestic violence in Lithuania were females and of those, eight out of ten (3,465) suffered violence specifically from their intimate partners [13]. However, it is important to note that these numbers do not reveal the true magnitude and prevalence of IPV, since it remains a latent crime. Even though only a small fraction of crimes concerning domestic violence and IPV are recorded in official statistics, there has been an increase of 1,2% in the number of recorded cases of domestic violence when compared to 2021 [13].

Evidence across the world shows that survivors of coercive control, psychological, economic, physical and/or sexual IPV are at a higher risk of poor physical and mental health outcomes [3], [14], [15], [16], [17], [18], [19], [20], [21], [22], [23]. Women with a history of IPV are around three times more likely than women without such an experience to develop a mental health condition [15]. There have been associations established between experiences of IPV and symptoms and diagnoses of various mental health conditions, such as depression, anxiety, post-traumatic stress disorder, and suicide ideation [20], [21], [24], [25], [26]. For example, psychological violence and especially coercive control are particularly associated with post-traumatic stress disorder for female survivors, and verbal abuse, dominance and isolation have a strong association with depression [23].

Not all women who are survivors of IPV seek support with their mental health needs; however, for those who do, mental health professionals can play a significant role in effectively addressing and assisting them in such a critical situation. Their role may be key in addressing the experienced trauma and pursuing not only medical but also personal recovery for every survivor of IPV [27]. Mental health professionals can make a vital difference in the path to healing and recovery of IPV survivors by screening for and recognising IPV, ensuring safety, autonomy, person-centred care, and trauma- and violence-informed support [12], [28]. Nevertheless, global evidence points to a major training gap concerning mental health professionals' training in how to identify and respond to IPV [29]. The Lithuanian domestic violence law was recently revised and several new related services and algorithms are currently being developed [30]. The mental health and social care sectors are closely intertwined and interlinked in Lithuania, various professionals sometimes work in both sectors simultaneously, referrals are often made from one service to another, and the same person may often be served by both systems at the same time. However, so far, the mental healthcare sector has not been an active participant in the ongoing developments. It is not clear what training, knowledge and general perceptions of matters concerning domestic violence, including IPV, mental health professionals have or how they deliver mental health services to survivors of IPV.

The main objective of this study is to explore the perspectives of mental health and social care professionals regarding the provision of mental health support to survivors of IPV in Lithuania; to hear their views about this specialised area of work and how their practices are influenced by the existing regulations and guidelines.

Methods

Study Design

This is a qualitative explorative study conducted within an experiential framework [31]. 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 within this study were chosen due to the sensitive and personal nature of the topic and to allow for an in-depth discussion of the issue [32]. The study aims to capture and better understand the experiences, perspectives and challenges

that professionals deal with while providing mental health support to survivors of IPV in Lithuania.

Research Team and Reflexivity

All co-authors share an interest and a number of years working in the fields of mental health, disability, human rights, public (mental) health, and gender-based violence. Their backgrounds cover not only positions in the academic sector and direct delivery of mental health services but also working within the non-governmental sector and engaging in civic activism. Each one of them brings to this study a specific professional, as well as personal angle on the subject in question, which is in line with the values of qualitative research: i.e., valuing the subjectivity of each researcher as a resource, which may shape the research process in various ways [33], [34], [35].

All research team members fully acknowledge the subjective influence of their own assumptions and the unique effects of this on the knowledge creation in this qualitative study. This is seen as a strength due to the wide range of extensive knowledge and passion about the subject, as well as the invaluable professional and personal experiences of each research team member.

Study Setting

Two online and two in-person focus groups were organised in October–November 2022, and in July 2023, respectively. They were organised in collaboration with a local non-governmental organisation ‘Mental Health Perspectives’. The online format was chosen for conducting two out of the four focus groups; to enable the participation of professionals from different geographical locations, as well as to minimise the amount of time away from their work duties to be able to participate. All four focus groups were conducted by the first and second authors who both have been working in the fields of public health, human rights, mental health, and gender-based violence for several years.

The focus group guide was developed and elaborated by the research team based on the objectives of this study. It aimed to explore the following areas with professionals:

1) Professionals’ level of awareness and knowledge about IPV, as well as their practices of working with IPV survivors;

2) Professionals' perception of their role, as well as of opportunities and challenges faced, when providing mental health support to IPV survivors;
3) Professionals' perception of how their practices are affected and shaped by the existing mental health and social care systems in Lithuania;
4) Observed or perceived practical challenges and barriers related to accessing the needed mental health care and support by survivors of IPV in the country.

Study Participants

Professionals from across the country and from different backgrounds who work in either public or private mental health and social care sectors in Lithuania were invited to participate. Invitations were openly and randomly disseminated via email and social media channels to a large number of institutions, facilities and professionals representing both in-patient and out-patient mental health services, social care facilities, as well as victim support services for survivors of domestic violence.

Additionally, two conveniently selected psychiatric facilities in the two largest cities of the country were approached directly, and in-person focus groups were arranged for their staff in collaboration with their administration and management teams.

Data Analysis

Audio recordings of all focus groups were transcribed verbatim and analysed according to the recommendations for reflexive thematic analysis by Braun and Clarke [34], [36], [37]. First, audio recordings were listed to once; then transcripts were read and re-read several times by the first author. An inductive approach was used to code the data and coding continued until no new concepts emerged from the collected data. Parts of the text were coded, synthesised, and divided into thematic categories based on the similarity of meanings. Themes were created by the first author and then reviewed, discussed, and finalised by all co-authors, taking into account patterns both inside and between the thematic categories.

Reflexive thematic analysis was conducted with the aid of MAXQDA software [38]. The reporting of this study's findings was guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist [39].

Research Ethics

Considerations for research ethics covered the obtaining of informed voluntary consent, including the clear possibility for withdrawal from it, privacy and data protection, anonymity and confidentiality. Before giving their consent to participate in the study in a written form, research participants received all the information concerning the study's objectives, voluntary nature of participation, confidentiality, and anonymity of the collected data.

This study was approved by the Research Ethics Committee of NOVA Medical School, NOVA University of Lisbon (Ref. No. 171/2021/CEFCM) as an integral part of the broader study titled 'Responses to Mental Health Care Needs of Survivors of Intimate Partner Violence by Mental Health Services in Lithuania and Portugal'.

Results

Details of Focus Groups

Two focus groups took place online and lasted for 47 and 51 minutes. Six professionals participated in one focus group and eight in the other. Participants came from five out of ten different regions of the country. Despite the invitation having been open to all professionals, in the end, only females (100%) registered to participate. Their professional backgrounds covered the fields of psychiatry, psychology, psychotherapy, social work, case management, and law. In their practice, they have encountered and supported survivors of psychological, economic, physical, and sexual IPV.

Participants represented in-patient and out-patient mental health and relevant social care services, in both the public and private sectors. Their workplaces included both the specialised psychiatric and general hospital settings; both specialised mental health centres and general medical centres; segregated social care institutions; crisis centres; support services for survivors of domestic violence; and private mental health care practices.

Additionally, two in-person focus groups took place in two psychiatric facilities in the two largest cities of Lithuania and lasted for 62 and 59 minutes. In the first facility, five staff members participated: three nurses and two social workers. In the second facility, ten

professionals participated: two psychiatrists, one psychologist, four nurses, one occupational therapist, one art therapist, and one social worker.

As described in *Table 1*, participants' age varied between professionals in their twenties and fifties (mean age being 40.42 years). Their professional experience ranged between one and 42 years. Participants came from ten different geographical locations in Lithuania.

Table 1: *Sociodemographic characteristics of the participants of focus groups (n=29)*

Characteristic	**Frequency (n)**	**Percentage (%)**
Gender		
Female	29	100
Profession		
Psychiatrist	3	10
Psychologist	4	14
Nurse	7	24
Social Worker or Case Manager	12	41
Occupational Therapist	1	3
Art Therapist	1	3
Lawyer	1	3
Sector		
Mental health care	22	76
Social care	7	24
Type of Sector		
Public	26	90
Private / non-governmental	2	7
Working at both	1	3
Place of practice		
City	22	76
Town / village	7	24
	Mean	**SD**
Age (years)	40.42	9.98
	Median	**Min; Max values**
Years of professional experience	9	1;42

Themes

The data analysis resulted in five main themes, as follows:

1) An unrecognised violence; 2) Professionals need specialised knowledge; 3) A low priority on the national level; 4) Limited utilisation of inter-sectoral collaboration as a barrier; 5) Systemic problems that hinder better practices.

An Unrecognised Violence

Theme 1 highlights that, IPV survivors who receive mental health support often have a limited awareness of the IPV that they experience. Professionals have observed that it often takes a considerable amount of time and external support for survivors to become aware of and recognise the IPV they experience at home from their loved ones. This is an important point considering the potential role that these professionals may then play in aiding the IPV survivors, helping them to recognise violence and consequently seek support to address the situation. (See *Table 2.*)

Professionals Need Specialised Knowledge

The data resulting in Theme 2 points to the unmet training needs of mental health and social care professionals, who lack specialised knowledge and skills. Such training is lacking not only in recognising IPV and supporting survivors to report it, but also in providing needed care and support in the most appropriate, effective, and trauma- and violence-informed way. Professionals reflected that training on this topic is not always available, is currently not systemic, not mandatory, and is not a part of their general professional education. Specifically mental healthcare professionals generally do not recognise IPV as a part of their job; usually, it is referred to as a ‘social’ and not a ‘medical’ problem. On the other hand, professionals from a social background (regardless of whether they work in the social or mental health care sector) generally do not recognise the trauma-related effects of IPV and its potential toll on the mental health of survivors. (See *Table 2.*)

A Low Priority on the National Level

Theme 3 illustrates that there is a lack of unified national guidelines and regulations to guide professionals in their work. Social care facilities have somewhat more internal guidelines about prevention, intervention and postvention of violence when compared with the mental healthcare sector. Mental healthcare professionals feel especially limited in what support they can provide to IPV survivors. Professionals (especially those

working in in-patient facilities) expressed that they often feel like their hands are tied due to existing laws and official regulations as to how much they can actually do in cases of IPV. Mental healthcare workers reflected on sometimes feeling quite helpless and unable to provide enough of the needed support, especially, when patients are discharged from in-patient facilities. There is a serious lack of continuity of care and support for IPV survivors, following their discharge from a psychiatric hospital: not only is there no follow-up from the side of the hospital itself but also there is a lack of other appropriate community-based and outreach services to ensure that follow-up support is at all possible. (See *Table 2.*)

Limited Utilisation of Inter-Sectoral Collaboration as a Barrier

A lack of inter-sectoral collaboration is central to Theme 4. When supporting survivors of IPV, a complex collaboration is crucial between mental health, social care, and other relevant sectors and services, including the Specialised Complex Support Centres (the Lithuanian victims' support services for survivors of domestic violence). An especially alarming result is the fact that a large proportion of mental health and social care service providers are not familiar with the purpose or sometimes even the existence of Specialised Complex Support Centres. Professionals tend to be unaware of the network of support services for survivors of domestic violence, which has been operating all across the country for a considerable number of years. (See *Table 3.*)

Systemic Problems that Hinder Better Practices

Theme 5 highlights that there are broader bureaucratic and systemic problems hindering potentially better practices and a more effective mental health support provision to IPV survivors. Professionals reflected on the lack of a unified state system and a clear algorithm for the provision of inter-sectoral and complex support services. Professionals lacked not only clear unified guidelines for aiding their practices but also a national and inter-sectoral algorithm for cases of support provision to IPV survivors in both the stages of intervention, as well as postvention. (See *Table 3.*)

Selected quotes that contribute to each of the Themes are outlined in *Table 2* and *Table 3*.

***Table 2**. Quotes from focus groups: Themes 1 to 3.*

Theme	Selected Quotes
1) An unrecognised violence	- "And they themselves may not have acquired so much knowledge, the potential victims of violence. It's just that they are often very resigned to the situation." – FG3, Social worker - "About violence… I have had several cases when you need to help the patient to recognise whether it is abuse or not, what type of violence they are experiencing." – FG2, Social worker/Case manager - "There is a lack of education for these people, that there is help. It is especially lacking for people with [psychosocial or intellectual] disabilities, so that they know where to turn for help. (…) Social workers have a significant role in helping them to understand that problem, that it is abuse, that it is domestic violence. Often women do not recognise that it is in fact abuse. For example, if she was locked in her room for a day, she accepts that it is normal, as if it was her own fault. (…) You know, we conducted research and they said they did not know. They said had they known, they possibly would have revealed it and sought help sooner; because often there are stereotypes and people are ashamed." – FG1, Lawyer - "They just maybe treat it more like as if this is how life is supposed to be. As if this is my destiny and I have to live this way, it's normal. Possibly they don't even think about the fact that it is violence in their everyday life." – FG4, Occupational therapist
2) Professionals need specialised knowledge	- "I think that the general perception is that everyone still thinks that 'doctors do the medical treatment, nurses do the nursing' and that's it. And because of that, maybe it doesn't happen that violence is recognised or understood. I think that such trainings are necessary, because our duty is not to turn away from what we possibly have noticed, but to be able to evaluate it, recognise that it is violence, and then check for everything." – FG3, Nurse - "There is no such diagnosis about violence, maybe generally with the Z-codes somewhere? (…) So, we treat the disorder. If it is not yet a disorder, we refer them on to psychologists, social workers, lawyers. (…) But for us to have some kind of specialised training, (…) I don't know but it is definitely not included in our programme [for psychiatrists]. (…) We pay attention that it is like a certain factor that provokes the disease, but nothing more." – FG2, Psychiatrist - "In reality, we should have at least some basic knowledge of various areas of life (…), especially when working in the healthcare sector. Also, specifically about violence, about support for survivors, but this definitely is not there, nobody highlights or emphasises this anywhere." – FG2, Social worker - "We do a lot of digging ourselves, as much as we can, but we would really like that kind of knowledge, those types of conversations, information on how to say certain words or phrases properly, appropriately. Because you know, with two words I might direct the patient in the opposite direction, or incline her towards my side, you know. There are those certain types of phrases that it would be really good to remember and use to appropriately approach the patient. A training, a methodology, that would be very good." – FG4, Psychologist/Psychotherapist - "I will also add, that it is not a part of the programme, and when we qualify and start working [as clinical psychologists], (…) well, we just try to find things that we care about, that we find interesting, (…) and then you just put bits of information together. (…) You have what you learn yourself. (…) It is a very individual thing. I think it is very much needed, yes, specifically about violence." – FG2, Clinical psychologist
3) A low priority on the national level	- "At our [social care] facility we have our institution's own ethical code and behavioural rules, not only for staff but also for residents. So, we follow those." – FG1, Social worker - "We also have created rules for residents, how they should and should not behave and what responsibility they have for it. And similarly, there are rules for staff, it is all standard, probably it is like this everywhere. But our uniqueness is that we also have this procedure developed in a visual format." – FG1, Social worker - "At our medical centre we only have such procedures related to children. Concerning adults, we do not have any such documents." – FG2, Social worker - "We also do not have any specific algorithm concerning this specific issue [domestic violence against adults]. (…) I think that, even though I have not personally ever experienced that the person suffers domestic violence here and now, and that I needed to react urgently; however, I can tell you that in extra intense situations you may definitely feel lost. And it would be very good to have the defined algorithm that would be known to everyone, that would clearly define who is responsible for what, who refers the patient where. Well, I would like such a tool for my work." – FG2, Social worker/Case manager - "Well, I can tell you it straight forward as it is... Since our hospital is not a facility that specialises in this area, we definitely do not have anything. Our hospital specialises in nursing, medical treatment, so we do not talk about this [domestic violence], it is not there." – FG2, Clinical psychologist - "We also do not have any algorithms, only when taking an anamnesis, you may try to find out about it and then just think what to do. (…) Generally, you just treat the disease itself and do not touch that problem [of domestic violence] too much. But to have some kind of algorithm – we do not have that. Not at a single facility among those where I work." – FG2, Psychiatrist

Table 3. *Quotes from focus groups: Themes 4 and 5.*

Theme	Selected Quotes
4) Limited utilisation of inter-sectoral collaboration as a barrier	- "Not once have we ever received information from or had any collaboration between medical centres or hospitals and the Specialised Complex Support Centre [for victims of domestic violence]." – FG2, Social worker - "[Specialised Complex Support Centre] What is that?" – FG4, Psychologist/Psychotherapist - "I do not even know about such services [Specialised Complex Support Centres], so there you have it. There is no collaboration." – FG2, Psychiatrist - "Apart from the Crisis Intervention Centre, we do not really collaborate with anyone else." – FG2, Clinical psychologist - "In our town, we do have a women's crisis centre and some temporary accommodation services for women and children who have experienced violence. However, I have never heard of the Specialised Complex Support Centre. (…) We do not collaborate – neither we go to them, nor they come to us." – FG1, Social worker - "Specifically, about domestic violence there is no collaboration. We only sometimes work with municipal social workers concerning the need for social care services or benefits." – FG2, Social worker/Case manager - "You know, but it is very difficult with mental health centres because of the very sensitive personal data. (…) The mental health centre will never tell you anything." – FG1, Lawyer - "If there are children, then there are also Case Managers. We, all professionals as a team sit with that woman. But this is exceptionally only when children are involved." – FG1, Lawyer
5) Systemic problems that hinder better practices	- "In my opinion, it is important that society talked more about domestic violence because it is such a broad and complex problem. (…) Maybe if we talked about it more, we would also notice things more. It is similar like I can give you an example of suicide prevention training. After this training course I understood how many people really think about suicide. Also, after attending the training about violence, a lot more things became clearer to me, (…) and then I realised how complex this topic is. (…) Hence, it would be really important to have some systemic information, and [for professionals] to have those key words and concepts, which you could hear from a client and then to know where to refer them to. This is as important in our society, as suicide prevention." – FG2, Clinical psychologist - "There is a lack of a state system. A different approach to the patient. For example, when there has been violence, various professionals would arrive, they would start working immediately, instead of us writing and sending letter after letter, but we usually don't get any answers. We just let them out [of the hospital], we know that let's say a man is violent, we inform all the services, but he even comes to take her home. And according to the law, we have no right to not allow that, because we are a medical institution, we don't have a police warrant, in that sense, not to let him go home with her. (...) I say, I miss a different attitude from the state itself, because even though we work on the ground, there is a lot of things happening, we have something here and there, but there is no unity. Everyone does their own thing, puts papers in a drawer, ticks some boxes and that's it. (...) There is no common system, (...) such a system is missing." – FG3, Nurse - "I have an example, but I do not work in the healthcare field. We currently have such a system that if I provide consultations to clients of the crisis centre or if a person comes to me concerning domestic violence, I must complete written reports that state the person's name, surname and date of birth. And we have to provide these reports to the municipality. And if the staff member who works at the municipality and reads our reports is that same abuser then that victim cannot really approach me for help because they must provide their personal details. Let's all be clear about this; the abuser will definitely recognise his sister or wife or similar. We really want some kind of a new system where we would not have to reveal personal details of potential victims (…), essentially, we have to potentially report about them to their abusers (…). But of course, there is no funding for this. (…) The system is really broken here." – FG2, Psychologist - "Yes, there definitely is a lot of uncertainty, it would be good to have a clear algorithm." – FG2, Social worker/Case manager - "Personally, in such a situation I wish there was an algorithm like we currently have concerning child protection system. It is all clear, where to call, who reacts, how police gets involved, psychologists (…), it is developed and functioning. (…) So, such an algorithm is needed [in cases of domestic violence] too. (…) I understand that everything is very complicated. (…), these are systemic questions. In the utopic world, it would be very helpful if we had such an algorithm: you would hear about domestic violence, then you would know exactly what to do to ensure safety and protect that person." – FG2, Clinical psychologist

Discussion

This was the first study in Lithuania to qualitatively explore the perspectives and perceptions of mental health and social care professionals, regarding their own provision of mental health support to survivors of IPV. The study provides deep insights into the specificities of the link between the field of IPV and the provision of mental health support and services.

The study highlights the professionals' perception that IPV survivors who receive mental health support often have limited awareness of the IPV that they experience. This leaves potential for a considerable amount of professional complex support provision, to enable survivors to become aware of the IPV they experience. At the same time, the study reveals that mental health and social care professionals lack the needed specialised knowledge and skills to facilitate this. It is important to note that mental healthcare professionals often do not recognise IPV as a part of their healthcare or medical responsibility: IPV is often seen as merely a 'social' problem. On the other hand, professionals with a social care background, even those working in the healthcare sector, generally do not recognise the trauma-related effects of IPV and its potential negative effects on the mental health of survivors.

In addition to the above, the study captures a low national prioritisation of this public (mental) health issue, and shows that there are no unified national guidelines or regulations to guide mental health and social care professionals in their work with IPV survivors. There is an alarming lack of 'continuity of care' following the discharge of an IPV survivor from a psychiatric hospital, no follow-up consultation, a lack of appropriate community-based and outreach services, a lack of inter-sectoral collaboration, and a variety of broader bureaucratic and systemic problems that hinder better practices in the provision of mental health support to IPV survivors.

Quite early into the study, it became apparent that the issue of IPV is more often than not perceived as a 'social problem', one that mostly concerns the field of social care services and not so much the mental healthcare sector. This was also illustrated by the fact that, despite major efforts by the research team to invite and involve medical professionals, in the end, a large number of the research participants were social workers, and very few psychiatrists responded. On the other hand, even among social care professionals, IPV was generally seen from a narrow point of view, mostly as a

concern of the justice system, and there was an overall lack of acknowledgement that IPV can affect the state of a person's mental health.

One of the limitations of this study is that the participating professionals were only women and that a large proportion of the participants had a social care (but not medical) background, even if they worked in the mental healthcare sector. Nevertheless, a lack of understanding among both mental health and social care professionals, that IPV is not only a personal but also a public (mental) health concern, contradicts the existing global evidence: it is a complex phenomenon that could be prevented by applying measures that, for example, focus on gender equality [8], [9], [10], [11]. This result of the current study reveals a substantial gap in practice: it contradicts the recently increased emphasis on these topics by the Lancet Psychiatry Commission on IPV and Mental Health (2022). Although the Commission describe the topic as fundamental, the current study shows that, in practice, survivors of IPV are not at all involved in the development and delivery of mental health services: "Mental health systems and providers can make a crucial difference in IPV survivors' path to healing, but too often the opportunity to do so is unfulfilled, and some survivors experience mental health services as harmful and retraumatising" [12].

One important role that some professionals already undertake and that others could develop further, is to inform and support IPV survivors to recognise IPV when they experience it [40], [41]. However, the current study confirms the finding previously highlighted in other studies across the world, concerning the difficulty among professionals and survivors to recognise IPV at all [40], [42], [43], [44]. This may be associated with societal attitudes, stigma and socially constructed 'norms' that may prevent persons who experience IPV and those around them to actually recognise it as abusive behaviour [45], [46].

The issue outlined above is especially relevant to coercive control, psychological, economic and sexual IPV. For example, marital sex is not only perceived by parts of Lithuanian society to be 'the duty of a wife' [47] but also may be internalised as such by women themselves and even become a strategy for mitigating other forms of IPV [48]. A similar phenomenon may be observed when it comes to economic IPV: in Lithuanian society, gender roles and power dynamics between a husband and wife (or between romantic partners) are often expected to employ the model where the man might have and maintain full control of the couple's finances and financial decisions [47]. It is important to note that such societal 'norms' may be internalised not only by IPV survivors

but also by professionals who are naturally a part of the same society. Hence, the specialised training of professionals about IPV and other forms of domestic violence is vital to mitigate such attitudes, increase the quality of care, and foster better practices.

On the other hand, even if IPV survivors recognise the IPV they are experiencing as abuse, they might still choose to conceal this fact. Global evidence shows that this can happen for various reasons, including shame, fear, self-blaming or victim-blaming attitudes, societal and internalised stigma, and financial or emotional dependency on the abuser [45], [49], [50], [51]. For these reasons, receiving timely and appropriate external help, reassurance and encouragement may be vital for taking steps to report IPV and seek further support [41].

Among the broad systemic problems that have been identified by the current study, several stand out as significant to the provision and quality of mental health care and support services for IPV survivors: 1) a lack of specialised training about IPV for mental health and social care professionals; 2) a lack of unified guidelines and regulations to guide professionals in their work; and 3) the absence of inter-sectoral collaboration in this field. This points to a gap in practice and a contradiction in light of global evidence, which shows that mental health services and appropriate mental health support are vital to survivors of IPV [12], [52].

Hence, fostering professional development in this area, as well as providing professionals with the needed tools for effective inter-sectoral work should be a state-level priority. As highlighted by Oram and collaborators (2022), mental health service providers could foster pathways to healing and well-being, and ensure safety for IPV survivors:

> *"All mental health professionals should have a good understanding of the gendered nature and dynamics of IPV, the effects of IPV on mental health, and the intersections of both IPV and mental health with other forms of oppression including racism, transphobia, ableism, and poverty"* [12].

Even though it is not possible to generalise the findings of this study, the reality depicted in it does not comply with the standards promoted by the Lancet Psychiatry Commission on Intimate Partner Violence and Mental Health (2022) outlined above. The current study shows that the practical reality on the ground is far from the recommendations for, and vision of comprehensive, holistic, and truly healing mental health support services for IPV survivors. To achieve these standards may require societal changes through

awareness raising and specialised training, as well as changes in work strategies, inter-sectoral collaboration, and the political will to develop and promote unified guidelines and algorithms as working tools for mental health and social care professionals [12].

Generally, as illustrated by the current study, IPV survivors require a complex approach for the provision of their mental health support: the complexity of such services could be based on the bio-psycho-social and human rights-based models, and trauma- and violence-informed approaches [19], [28], [53]. Some fundamental points are always relevant when supporting IPV survivors, be it in mental health, social care or other support services: ensuring safety, actively listening, building trust, fostering autonomy, and coordinating services through inter-sectoral collaboration [52]. The current study points to a major gap in practice where these basic principles are not always implemented. This is alarming and calls for action, with clear implications for both mental health and social care policy and services.

Conclusion

The study findings contribute to the sparse literature available on the topic of the provision of mental health care and services to survivors of IPV. The key findings highlight an urgent need for significant improvements of and changes in the overall functioning of mental health and social care systems in Lithuania. This should include fostering inter-sectoral collaboration, as well as raising public awareness about IPV, and developing the specialised knowledge and skills of mental health and social care professionals. Further qualitative and quantitative research to explore the utilisation of mental health services by IPV survivors, as well as their own perceptions of the link between IPV and the provision of mental health support is warranted.

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Declaration of Interest Statement

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

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Scientific Paper No. 5

Use of Mental Health Services by Survivors of Intimate Partner Violence in Lithuania: A Mixed-Methods Study

Grigaitė, U., Azeredo-Lopes, S., Aluh, D.O., Pedrosa, B., Santos-Dias, M., Silva, M., Cardoso, G., Caldas-de-Almeida, J.M.

Abstract

Purpose: The main objective is to study the use of mental health services in Lithuania by survivors of intimate partner violence (IPV).

Methods: For this cross-sectional convergent mixed-methods study, data was collected using an online survey designed by the research team (n=134). Logistic regression models were used. Additionally, semi-structured interviews were conducted with IPV survivors who used mental health services (n=13). Audio-recordings were transcribed verbatim, combined with the survey's qualitative data, and analysed thematically using MAXQDA software.

Results: One-third of the IPV survivors in this study used mental health services (n=30): mostly psychologists/psychotherapists, and mostly in the private sector. Around two-thirds expressed that their needs were only partially met or not met at all. No statistically significant associations were revealed by considering sociodemographic and violence-type predictors for the use of mental health services. However, the qualitative part of the study provides insights into the rich and complex spectrum of lived experiences and the specific contextual factors (environmental and personal) that may influence their use of mental health services.

Conclusion: The study highlights the differences between public and private sectors; the importance of mental health professionals having specialised knowledge about IPV, and trauma- and violence-informed care. It refers to mental health and IPV stigma, victim-blaming attitudes, and systemic problems such as over-medicalisation and the mental health system being under-resourced. There is a significant gap in practice when providing mental healthcare to this population. Further research is needed to explore the quality and effectiveness of mental health interventions provided to IPV survivors.

Keywords: mental health services, public mental health, gender-based violence, intimate partner violence, Lithuania.

Introduction

Intimate partner violence (IPV) is the most prevalent expression of violence against women [1]. Across the world, females are disproportionately more likely to experience IPV than males, mostly due to the existing imbalance of power and control between men and women [1],[2]. Hence, IPV is a type of gender-based violence, which is a major factor in gender inequality, as well as a human rights and public health problem: at least one in three women experience IPV at least once in their life [1],[2],[3],[4]. According to the national statistics, 80% of IPV victim-survivors in Lithuania are female [5].

Types of IPV include psychological, economic, physical and/or sexual abuse, coercive and controlling behaviours by a current or former intimate partner, such as marital, co-habiting or dating partners [6]. Physical abuse may include such acts as beating, slapping, kicking, pushing, pulling hair, and throwing things at a person [7]. Sexual abuse includes any type of sexual behaviour against the free will of the concerned person and without their consent [6],[8].

Psychological IPV is generally a less easily recognised form, which may manifest itself through name calling, humiliating, isolating, threatening or frightening behaviour, hurting their pets, destroying their personal possessions, and turning their children against them [9],[10]. Psychological IPV also includes economic violence (for example, controlling finances, not allowing the person to study or work, not allowing access to personal or family bank accounts, and demanding detailed reports for all spending), and coercive control [11]. Physical IPV is criminalised in most countries, including Lithuania, and has been extensively studied across the world. However, psychological IPV, including economic abuse and coercive control, are less clearly understood and often lack a common definition among different stakeholders [11],[12],[13].

There is evidence that survivors of any type of IPV are at a higher risk of poor health outcomes compared to those who have not experienced IPV [14],[15],[16]. Women with a history of IPV are at least three times more likely than women without it to develop mental health conditions [15],[17]. There have been associations established between experiencing IPV and anxiety, depression, pre-natal depression, post-traumatic stress disorder (PTSD), and suicide [2],[18],[19],[20],[21],[22].

For this reason, mental health systems, services and professionals have a significant role to play in providing effective mental health services and in supporting IPV survivors

[23],[24]. According to the Lancet Psychiatry Commission on IPV and Mental Health (2022), the support should start by asking all mental health service users, especially women and gender and sexual minorities, about their potential experiences of IPV, within the context of a mental health assessment [25]. Mental health services are vital for IPV survivors to achieve healing and therapeutic, medical, and personal recovery [25],[26]. As Carman and collaborators (2023) have highlighted: “Overall, recovery from IPV is multidimensional and individualistic in nature. It is an arduous journey that evolves over a long period of time and requires a great deal of support.” [27]

In 2013, research on the use of mental health services by survivors of IPV in the USA showed that despite services being accessible, the majority of research participants with high rates of depression and PTSD did not use any mental health services [28]. Similarly, in 2021, a nationally representative survey was conducted in Lithuania (by the same research team as that of the current study), which revealed that even though as many as one-in-two women in the country experience psychological IPV, only around one-in-ten of them use mental health services; however, the predictors of such results remained largely unclear [29]. As a follow-up, the current mixed-methods study was designed to analyse the associated factors and potential reasons behind an IPV survivors decision to use mental health services, or not.

The main objective of this article is to study the use of mental health services in Lithuania by survivors of IPV.

The research questions are as follows:

1) What are the sociodemographic characteristics and associated factors of persons exposed to IPV in Lithuania, compared with those who have not experienced IPV?

2) What are the specificities, predictors, and subjective reasons for using (or not) mental health services among IPV survivors?

3) What are the lived experiences of IPV survivors who used mental health services and how do mental health professionals respond to their needs?

Methods

Study Design and Population

This cross-sectional study employs a mixed-methods convergent design [30]. It is a part of the 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'. In addition to the quantitative analysis, the qualitative methods and phenomenological research design were chosen specifically for this study due to the sensitive, personal and nuanced nature of the topic. It helps to complement quantitative analysis by also addressing sociocultural elements and other human factors [30],[31]. The study aims to capture and better understand the essence of experiences, perspectives, and challenges that occur during clinical encounters between IPV survivors and providers of mental health services.

Online Survey

An online survey was developed by the research team at the Lisbon Institute of Global Mental Health [32]. The team consisted of professionals with extensive expertise, knowledge and professional as well as personal interest in the fields of public mental health, mental health services research, and gender-based violence. All team members acknowledge the subjective influence of their assumptions and the unique effects of this on the knowledge creation in the qualitative part of this study: the subjectivity of each researcher is valued as a resource, which may shape the research process in various ways [33],[34],[35].

The survey aimed to collect both quantitative and qualitative data [36]. It was disseminated publicly via internet channels in Lithuania. The random and publicly open recruitment was conducted via social media, email, and websites. Various Lithuanian governmental institutions and non-governmental organisations (NGOs), as well as individual researchers, experts, and influencers, shared the survey with their respective networks and audiences, and so did the national network of victims' support services for survivors of domestic violence. Lithuanian-speaking persons aged 18 years or over were invited to complete this online survey, exploring the subjective experiences and perspectives of individuals who survived IPV and who also experienced mental health difficulties. The online survey was open for responses between June 2022 and May 2023.

Semi-Structured Interviews

Building on the design of the online survey, a protocol was developed for semi-structured interviews [37]. An option for the survey participants to either provide their email addresses or to contact the lead researcher directly to participate in the semi-structured interviews (either in-person or online) was included in the online survey. As a result, 13 in-depth semi-structured interviews were conducted between June 2022 and November 2023 with respondents of the online survey. Based on the participants' preferences, eleven out of thirteen interviews were conducted online using the Microsoft Teams Platform, and two were conducted in person. In-person interviews took place in locations chosen by the participants where they felt most comfortable. All participants signed informed consent forms before each interview. Interviews were conducted by the first author of this article. The confidentiality and anonymity of participants were ensured.

Study Sample and Measures

Both the online survey and semi-structured interviews explored the following data categories and questions:

1) Socio-demographic characteristics (gender of the participant; gender of the abuser; current age of the participant; their age when they experienced IPV for the first time; their age when they used mental health services for the first time; place of residence; place where they used mental health services).

2) Experience with IPV (*yes* or *no* answer).

'Intimate partner violence' was described as "*systemic violence that includes physical, psychological, economic and/or sexual abuse, coercive and controlling behaviours by an intimate partner, such as marital, co-habiting or dating partners*".

Types of IPV were described as follows:

- *Psychological* (includes calling names, humiliating, isolating, hurting your pets, destroying things dear to you, threatening, frightening, turning your children against you, etc.);

- *Economic* (includes controlling your finances, not allowing you to study or work, not allowing access to your/family bank accounts, demanding detailed reports for all your spending, etc.);
- *Physical* (includes pushing, hitting, slapping, kicking, throwing things at you, hair pulling, etc.);
- *Sexual* (includes any type of sexual behaviour against your free will and without consent).

3) Experience of seeking "*help or support in Lithuania for mental health needs or emotional state due to or as a result of having experienced IPV*" (*yes* or *no* answer).

The concept of 'mental health' used in this study was described in the following way: "*While answering the questions please understand 'mental health' as your emotional, psychological and social well-being. At any given time of their lives, everyone can have mental health difficulties. Such difficulties are not limited to specific mental health disorders or psychiatric diagnoses. It can also be feelings of anxiety, heavy emotions or dark thoughts, sleeping problems, changes in behaviour or habits, and similar*".

Participants were asked to describe in their own words their encounters with mental health professionals; what support they needed the most at the time; how were those needs met; what the professionals had to offer in response; how helpful was it; what were the most positive and negative aspects of this experience; what barriers (if any) did they face when seeking this support; what would they have liked the mental health professional(s) to have done differently.

In cases where the answer to the question about using mental health services was negative, the survey participants were asked to describe the reasons for not seeking help despite having experienced IPV.

4) Categories of encountered professionals (psychologist/psychotherapist; psychiatrist; family doctor/GP; social worker; other).

5) Categories of encountered services/settings (primary healthcare centre; general hospital – including A&E; specialised mental health centre; psychiatric hospital; NGO; emotional helpline; an individual mental health professional – directly; other).

6) The sector of services (public sector – state-funded; private sector – self-funded; a part of it public, and a part private).

Data Analysis

The descriptive statistics included absolute (n) and relative (%) frequencies for the categorical variables. Medians, 1st and 3rd quartiles were provided for skewed quantitative data. The Chi-Square or Fisher's exact tests were applied accordingly to assess the association between two categorical variables. Logistic regression models were obtained and the estimates of the odds ratios (OR) were presented, as well as the corresponding 95% confidence intervals (95%CI). Dependent variables indicated whether or not mental health services were used by IPV survivors, with sociodemographic characteristics and violence types considered as explanatory variables. Likelihood-ratio tests were conducted to provide an overall test of effect. The significance level α=0.05 was considered throughout the analysis.

The R statistical software [38] and the R packages *psych* [39], *car* [40], and *MASS* [41] were used. The STROBE guidelines for the reporting of cross-sectional studies were followed.

All audio recordings of interviews were transcribed verbatim and analysed thematically according to the recommendations of Braun and Clarke [42], [43]. Transcripts and written responses to questions in the online survey 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. The thematic analysis [34], [42] was conducted using MAXQDA software [44]. The reporting of the findings of the qualitative part of the study followed the SRQR [45] and COREQ [46] standards, with additional consideration for MMARS reporting standards for mixed-methods studies [47].

Research Ethics

General considerations for research ethics covered the obtaining of informed consent, including the clear possibility of withdrawal from it, privacy and data protection, anonymity, and confidentiality. Before giving their consent to participate in the study in written form, study participants received all the information concerning the study's

objectives, voluntary nature of participation, confidentiality, and anonymity of the collected data.

In addition to the above, during all the stages of research design, implementation and analysis, the main principles of ethics in research with mental health service users [48], [49], [50], as well as within the field of domestic violence and violence against women [51], [52], [53] were considered. This involves being aware of potential emotional distress and impact on both research participants [54], and researchers [52]; the sensitive nature of both the topic of violence and that of mental health difficulties; the importance of ensuring safety [54]; 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 and within the online survey) 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 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).

Results

Online Survey

The online survey was completed by 134 persons, 95 (70.9%) of whom self-reported to have experienced IPV and 30 of them (31.6%) said that they also used mental health services. The proportion of male abusers is significantly greater than the proportion of female abusers ($X2=145$, $df=1$, $p<0.001$). The sociodemographic characteristics of the study participants are presented in *Table 1*.

Table 1: *Sociodemographic characteristics of the study participants, experiences of IPV, and the use of mental health services (n=134)*

	Persons in Lithuania who experienced IPV (*n*=95)		**Persons in Lithuania who did not experience IPV (*n*=39)**		***p*-value *(*) statistical significance***
Gender	***n***	**%**	***n***	**%**	
Female	93	97.9	34	87.2	0.022*
Male	2	2.1	5	12.8	
Age category	***n***	**%**	***n***	**%**	
18 – 24	7	7.4	6	15.4	0.061
25 – 34	42	44.2	11	28.2	
35 – 49	35	36.8	12	30.8	
50 – 66	11	11.6	10	25.6	
Residence	***n***	**%**	***n***	**%**	
City	63	66.3	29	74.4	0.362
Town/village	32	33.7	10	25.6	

Age of first experience of IPV (n=95)	**Median**
	24 (**Q1** = 20; **Q3** = 28)

Gender of the abuser	***n***	**%**	***p*-value**
Female	5	5.3	
Male	88	92.6	<0.001*
Other	2	2.1	
Type of IPV	***n***	**%**	
Psychological	85	89.5	
Economic	26	27.4	
Physical	60	63.2	
Sexual	49	51.6	

Age when using mental health services for the first time (n=29)	**Median**
	28 (**Q1** = 22; **Q3** = 35)

Place where used mental health services (n=30)	***n***	**%**
City	26	86.7
Town/village	4	13.3

No statistically significant results were obtained when analysing and comparing the sociodemographic and violence-type predictors between IPV survivors who used mental health services and those who did not (see *Supplementary File 1*).

Supplementary File 1: *The use of mental health services by the survivors of IPV: the sociodemographic, and violence-type predictors (n=95)*

	IPV survivors who used mental health services (*n*=30)	**IPV survivors who did not use mental health services (*n*=65)**	***p*-value**
Gender	***n* (%)**	***n* (%)**	
Female	29 (96.7)	64 (98.5)	0.534
Male	1 (3.3)	1 (1.5)	
Age category	***n* (%)**	***n* (%)**	
18 – 24	2 (6.7)	5 (7.7)	0.748
25 – 34	11 (36.7)	31 (47.7)	
35 – 49	13 (43.3)	22 (33.8)	
50 – 66	4 (13.3)	7 (10.8)	
Residence	***n* (%)**	***n* (%)**	
City	22 (73.3)	41 (63.1)	0.326
Town/village	8 (26.7)	24 (36.9)	
Type of IPV	***n* (%)**	***n* (%)**	
Psychological	29 (96.7)	56 (86.2)	0.163
Economic	11 (36.7)	15 (23.1)	0.167
Physical	19 (63.3)	41 (63.1)	0.981
Sexual	15 (50.0)	34 (52.3)	0.834

The most commonly used mental health services among IPV survivors were those provided by a psychologist or psychotherapist (93.3%), and 66.7% of them approached the practitioner directly. One-third (36.7%) of IPV survivors used mental health services only in the public sector; others either fully or partially self-funded in the private sector. Study participants indicated that what they needed the most at the time of seeking help was emotional support (30%) and psychotherapy (53.3%). Almost 17% expressed that their needs were not met at all. For more details, see *Table 2*.

Table 2: *Details of mental health services used by the IPV survivors (n=30)*

Mental health services	**Survivors of IPV who sought mental health services (*n*=30)**	
	n	**%**
Type		
Psychiatrist	8	26.7
Psychologist/psychotherapist	28	93.3
Any specialised mental health service	29	96.7
GP – General practitioner	1	3.3
Social worker	2	6.7
Other	4	13.3
Setting		
Primary health care centre	9	30.0
General Hospital (including A&E)	5	16.7
Psychiatric hospital	2	6.7
MH centre	9	30.0
NGO	3	10.0
Helpline	5	16.7
Direct contact with a professional	20	66.7
Sector		
Public	11	36.7
Private	7	23.3
A part in public, and a part in private	12	40.0
Place of mental health services		
City	26	86.7
Town/village	4	13.3
Most needed at the time		
Emotional support	9	30.0
Psychotherapy	16	53.3
Medication	1	3.3
Other	4	13.3
Offered by mental health services		
Medication	12	40.0
Talking therapy	24	80.0
Referral to other professionals	4	13.3
Other	3	10.0
Perceived met (or not) needs by the services		
Fully met	11	36.7
Not met at all	5	16.7
Partially met	14	46.7

None of the studied sociodemographic or violence-type predictors bore significance concerning the use of mental health services by the IPV survivors (see *Table 3*).

Table 3: *Sociodemographic and violence-type predictors of using mental health services among IPV survivors (n=30)*

		Any mental health services OR (95%CI)	*p*-value
Gender	Male	2.207 (0.085, 57.117)	0.580
	Female	Ref.	
	Overall Test of Effect	0.585	
Age	18 – 24	Ref.	
	25 – 34	0.887 (0.163, 6.820)	0.895
	35 – 49	1.477 (0.273, 11.360)	0.667
	50 – 60	1.429 (0.191, 13.410)	0.733
	Overall Test of Effect	0.749	
Residence	City	1.610 (0.636, 4.363)	0.328
	Town/village	Ref.	
	Overall Test of Effect	0.320	
Psychological IPV	No	Ref.	
	Yes	4.661 (0.817, 88.060)	0.154
	Overall Test of Effect	0.089	
Economic IPV	No	Ref.	
	Yes	1.930 (0.745, 4.954)	0.171
	Overall Test of Effect	0.173	
Physical IPV	No	Ref.	
	Yes	1.011 (0.415, 2.530)	0.981
	Overall Test of Effect	0.981	
Sexual IPV	No	Ref.	
	Yes	0.912 (0.382, 2.176)	0.834
	Overall Test of Effect	0.834	

Semi-Structured Interviews

The data from semi-structured interviews (n=13) was combined with the additional qualitative data obtained via the online survey (n=95). As a result, the data on the experiences of those who used mental health services (n=30) and those who did not (n=65) was thematically analysed. The details of the participants of semi-structured interviews are presented in *Supplementary File 2.*

Supplementary File 2: *Details about semi-structured interviews and socio-demographic characteristics of participants (n=13).*

No.	Length (in minutes)	Setting	Participant's gender	Gender of abuser	Participant's age	Participant's age when 1st experienced IPV	Age when approached mental health services	The place where used mental health services
1.	24.3	Online	F	M	29	23	26	Vilnius
2.	22.4	Online	F	M	23	14	15	Kaunas
3.	23.6	Online	F	M	31	20	21	Vilnius
4.	33.5	Online	F	F	25	22	22	Kaunas
5.	35.7	In-person	F	M	35	20	32	Vilnius
6.	24.2	In-person	F	M	34	23	25	Vilnius
7.	53.1	Online	F	M	25	17	21	Vilnius
8.	26.4	Online	F	M	30	16	22	Vilnius
9.	24.6	Online	F	M	39	37	37	Vilnius
10.	28.8	Online	F	M	30	22	25	Vilnius
11.	57.2	Online	F	M	32	12	16	Alytus/Kaunas
12.	29.6	Online	F	M	25	15	16	Vilnius
13.	53.5	Online	F	M	50	19	30	Druskininkai

Not Using Mental Health Services

The analysis of the reasons for not seeking help from mental health services (n=65) resulted in six main themes outlined below. Each theme is illustrated by selected quotes in *Table 4*.

Theme (1) *Feelings of shame, fear, and self-blaming*. The study participants described various difficult feelings that have prevented them from seeking help and approaching mental health services. These feelings ranged from general shame, fear of their abusers, and fear of condemnation by society, to fears of receiving a psychiatric diagnosis and having a psychiatric medical record. Some women were also conscious of the potential victim-blaming attitudes in society should they reveal their IPV situation, while others blamed themselves and did not believe that help was possible at all. A few women mentioned their sociocultural background and upbringing as the main reasons why they concealed the fact of IPV and did not seek help.

Theme (2) *Not having the information*. A common reason among research participants for not having sought help was the lack of awareness and information about mental health services and options. Some women said that they did not even know that support might have been possible at all, some did not know about free-of-charge options for

mental healthcare, and others simply did not know where to go, call or turn for help, in their specific individual circumstances.

Theme (3) *Not recognising the IPV*. Another common theme and reason for remaining in abusive relationships without external support was the fact that women often struggled to identify and recognise that what was happening to them was abuse. This was especially common in cases of psychological violence and coercive control where physical aggression was absent. Culturally and socially constructed “norms” played a role in some cases, for example, where sexual intercourse in a marriage might be perceived as “the duty of a wife”.

Theme (4) *Victim-blaming attitudes and actions*. Many research participants referred to negative societal attitudes and victim-blaming, as well as IPV and mental health stigma. They also referred to the consequences of their upbringing based on “traditional family” values and other socially constructed “norms”, such as “traditional” gender roles in the family, and the privacy of the family that has to stay “behind closed doors”.

Theme (5) *Relying on oneself*. The topic of relying only on oneself resonated among many participants. Women said they did not think that anyone else would understand them and that they would just deal with all their problems by themselves. Some research participants believed that the abuse would not last long, that it was temporary, and that they would get through it without external help. Again, some of this “self-reliance” manifested as a result of the women’s upbringing and a common belief that personal matters should not be made public.

Theme (6) *Financial difficulties*. The potential financial burden of having to pay for quality mental health services, especially for psychotherapy, was one of the common reasons for not using mental health services. Women felt that such services were expensive and they could not afford them. They did not see the free-of-charge public sector as a good enough alternative worth testing.

Table 4: Selected quotes from the online survey (n=65).

Theme (Not Seeking Help)	Selected Quotes
1) Feelings of shame, fear, and self-blaming	"I was afraid of condemnation and accusation that I was to blame because that was the attitude of society." "I was afraid of my husband." "I was afraid. I didn't think I would get help. I was and still am ashamed. I was a minor, I was afraid of long, legal processes, of condemnation. I was afraid of any [psychiatric] records in my health files." "It was embarrassing, I thought it [IPV] was my own fault." "You start questioning yourself that maybe you are overreacting, reacting too sensitively." "It was embarrassing, I thought everyone was going to blame me." "The consequence of my upbringing is to "not take the garbage out of the house publicly". Also, shame in society."
2) Not having the information	"I didn't know I could, that there was such a possibility." "I didn't know where to turn." "I don't even know where to go for help, and here in Lithuania, such problems are often written off as unimportant. More often you'll hear "You're making things up" or "So what can't you even give him one? Then why are you with him?". Of course, it's also hard to describe where and when and what happened, because it's unpleasant."
3) Not recognising the IPV	"At the time (more than 10 years ago) I didn't understand that it was violence." "It seemed like it had to be that way because we were a couple and I had to have sex even if I didn't want to." "Because for a long time, I did not understand that I was experiencing such [psychological] violence. I was constantly accused that everything was my fault and I believed it. When my eyes opened, I started the divorce process. And then when it was all over, time healed everything. I went through all the institutions (police, children's rights, social services, etc.). Our institutions and laws are not able to help in cases of psychological violence."
4) Victim-blaming attitudes and actions	"Why [seek help]? To be humiliated by the people working in those institutions who will try to find the fault in me, as if I had brought it all onto myself? A friend went to the police after being raped, and instead of getting help, she was pressured not to initiate the search [for the perpetrator]. They will harass you and cause psychological pressure until you withdraw your statement or don't even submit it in the first place." "Because you would mostly get mocked as if you have deserved that." "I was brought up "not to do the family's laundry in public". I thought I would manage by myself, it seemed that we would be able to solve this problem between ourselves. We haven't managed to solve it."
5) Relying on oneself	"I tried to solve everything myself." "I thought I would deal with my problems on my own." "I can still take it."
6) Financial difficulties	"I don't have the financial resources for a private psychologist." "I don't know where to turn to. It seems like it would be expensive." "Sexual violence did not recur after talking to my husband. I wanted to see a psychologist, but I couldn't afford it financially, and I didn't manage to get a family doctor's referral. At the moment, I don't experience a lot of other forms of violence, I've come to terms with it."

Using Mental Health Services

The analysis of the data on the experiences of IPV survivors who did use mental health services (n=30) resulted in five main themes described below. Each theme is illustrated by selected quotes in *Table 5.*

Theme (1) *Services in the public and private sectors*. A minority of IPV survivors used mental health services only in the public sector. Most of them either fully or partially relied on private services. Reportedly, the reasons for this are rooted not only in the long waiting times and regular queues to get public services but also in the limited amount of time allocated by the professionals to each client (which is significantly longer in the private sector). Sometimes the professionalism and attitudes of doctors and therapists were found to be better at private services. On the other hand, this situation brings with it major financial implications and difficulties, and only those IPV survivors who could afford it received the professional support they needed.

Theme (2) *Skills and attitudes of mental health professionals*. Many study participants shared negative stories about the lack of skills and negative attitudes of mental health professionals whom they encountered. The need for specialised knowledge about domestic violence and IPV among mental health professionals was named as one of the key elements for effective support. Women talked about the gaps in the education of mental health professionals and their frequent lack of knowledge and skills when working with cases of IPV. Nevertheless, some of the research participants also highlighted what made or could have made their experiences more positive in this regard. What they needed the most at the time was emotional and psychological support, information, time, specialised knowledge about IPV, compassion, sensitivity, listening and understanding by their allocated professionals, complex and coordinated support, and inter-sectoral collaboration among different institutions (e.g., the mental health services, social care sector, police and justice system, children's support services, crisis centres, and victims' support services).

Theme (3) *Mental health services and trauma*. According to IPV survivors, many mental health professionals often do not recognise the need to assess or take into account the experience of IPV as an important factor that may influence the mental health state of their clients. The women said that they often encountered dismissive behaviour from professionals, sometimes even stigmatisation, and victim-blaming attitudes. Often, the psychological trauma of a violent experience was not recognised (not even in

psychotherapy) and not responded to, nor analysed or otherwise addressed. According to the research participants, looking back, they recognise and deeply believe that the professionals did not pay enough attention to the topic of IPV while supporting them, even though it was a fundamental trauma in their lives. Many of them mentioned that they felt misunderstood by professionals and were not listened to. In addition, mental health professionals often seemed to consider domestic violence and IPV as simply a "social problem" seemingly irrelevant to mental health care, treatment, and recovery.

Theme (4) *Barriers to effective support.* IPV survivors talked about the vital importance of psychological help and mental health services but also highlighted the general lack and inaccessibility of such services in the community, especially in more rural areas. In such cases, transport and finances become major barriers to seeking and receiving much-needed professional help. The general lack of information about how and where to seek help, especially free of charge, is another barrier. So are the victim-blaming attitudes among professionals. Financial difficulties were named as one of the key barriers because women felt they had no choice but to go for private services to get accessible quality care and effective support.

Theme (5) *Systemic problems*. The highly overloaded and under-resourced public sector, with its long waiting times and short appointment times, were regularly listed as the main systemic problems. As was the prevalence of IPV stigma in society, including among professionals. Generally, the medical model and the over-medicalisation of mental health services resonated throughout many of the research participants' stories. They felt their needs for psychological and emotional support were often not met due to doctors simply prescribing psychotropic medication as the main source of treatment. In several cases, women complained that in the end their problems only increased after becoming addicted to these medications.

Table 5: Selected quotes from the semi-structured interviews and online survey (n=30)

Theme (Seeking Help)	Selected Quotes	
	Positive Experiences	**Negative Experiences**
1) Services in the public and private sectors	"[In the public sector] the professionals worked in a complex way. I first consulted a psychiatrist, she then sent me to a psychotherapist, and a test was conducted. It was specific, clear actions, and that (based on that test) there would be a follow-up on whether I needed treatment or whether psychotherapy would suffice." "In the private sector, I met a psychotherapist who listened to my inner pain, helped me look at the situation in a different way, and supported me. Thanks to her help, I managed to piece together my inner self, and learned to hear, feel, and love myself."	"There were very long queues [in the public sector], and I needed help. Here and now, I found myself a private [doctor]." "The polyclinic told me to go privately because they couldn't help me." "All those times when I used mental health services for free, I felt this kind of, I don't know, maybe laziness, and [professionals] trying to finish the consultation as soon as possible, not to ask too many questions." "I can assure you that I did not receive help from either the public or the private sector. Both in private and in public, only the first conversation is somewhat effective, followed by "stuffing" with drugs which only make you more dependent."
2) Skills and attitudes of mental health professionals	"I received a lot of support and help. Mental health professionals helped me get out of the cycle of violence and understand that I am not the one to blame for what was happening." "They understood me, didn't blame me, and very sensitively and gently guided me towards healing." "The contact, trust in each other, safety, and competence were very important, especially in the situation of violence. Because I also have had an experience [with another professional] who seemed to have experience in counselling or psychotherapy but their values and attitudes towards violence or gender-based violence prevented them from effectively providing help and responding to the exact needs I had at the time. The full competence of a professional is very important, including not only knowledge but also experience and their personal qualities – attitudes, beliefs, and values."	"I felt lost because several professionals to whom I turned for help treated the situation in the complete opposite ways. One of them encouraged me to "save the relationship" and change my own behaviour and attitude in the hope that then my partner would communicate and behave differently. While the other one said that I had fallen into a toxic relationship and the healthiest thing for me would be to cut off all communication with my [at the time] beloved long-term partner." "The appointments were quite banal, the comments [by the professionals] sounded like condemnation, it was almost like: "It's her own fault"." "The psychotherapist said that one incident of violence could have been a mistake, but if it happened again, I should end the relationship. Today, after having completed my psychology studies, I do not agree with those words said [by the professional], especially to a 15-year-old girl." "A psychotherapist who tells me how I should think, how I should act. Who "beats" me up with his words to bring me down to his way of thinking. It reminded me of the person who abused me. There is a common lack of sensitivity due to not knowing what it [IPV] is."
3) Mental health services and trauma	"Psychotherapy helped me discover, recognise, name, and survive traumas, even though I still haven't recovered from them yet. Psychotherapy and medication helped me cope with severe depression at the time and not "fall out" of life, instead slowly returning to it." "I went for help due to symptoms, and later in psychotherapy, I remembered the violence, episodes of sexual violence that I had forgotten." "The most positive aspect was the suggested writing therapy techniques." "Only just now, basically only in psychotherapy, I'm finally working with and addressing the pain which I experienced back then."	"It was necessary to go deeper into my mental and emotional state. To help me regain my self-confidence. Five years of living with an aggressive narcissistic man turned me into a lost woman who was afraid of everything." "The main thing is that the male doctors would not sexually harass and stare because there was a lot of that. (…) I shared [my experience] in group therapy sessions, and there were also such provocations. There were really very, very unprofessional comments where they would say, "You were raped, now you want it to happen again". Well, just like that, where, I don't really understand that it can be called therapy. In group therapy they just spoke like that in a very insulting tone, it would just be better if there was at least a little sensitivity." "At the polyclinic, I heard that they can't really help me, because I'm a relatively healthy person, but I've suffered a lot of [psychological] traumas. (…) I couldn't tell anyone about all the horrors that happened to me in the past. I felt unheard and full of dark secrets." "It helped me to understand the specificities of toxic relationships, but there was no deeper analysis of the consequences. During the therapy, attention was not focused on my relationship with the abuser, but more on the analysis of me and my relationship with my parents, the environment, etc."

	Negative Experiences
4) *Barriers to effective support*	"Financial obstacles: the services are not cheap, and if they are cheap, there are long queues. In cases when the service was cheaper, it was not always possible to find a common language with the psychologist."
	"It would be good if there were more such professionals, free of charge or by paying a lower price. I had to give up certain material things in my life, just to be able to visit a psychologist."
	"Financial, transport, information barriers, fear of contact, fear of encountering a bad professional, mistrust of diagnosis and prescribed psychotropic drugs, serious side effects of medications, also the unethical behaviour of the psychologist in the polyclinic."
	"A lack of information about free help."
	"The barriers of attitudes [of the professionals], lack of money, lack of opportunities to work, and nowhere to leave a small child."
	“Financial barriers (for buying medicine and travel), attitudinal barriers (I felt misunderstood [by the professionals])."
	"Transportation is an obstacle because I live outside the city. Also, the obstacle of attitudes: there has been a lack of a deeper look at the problem."
	"It requires attention for the individual situation, not a bunch of prescriptions for medication and “out the door” as quickly as possible."
5) *Systemic problems*	"Mental health centres are heavily overburdened and meeting with state-funded professionals could only take place once a month. My need was greater, so I had to find professional help privately."
	“I was very satisfied with a private doctor, unlike in the public sector.”
	“[What is the most needed] it is time, first of all, to give you time. Attention to detail, and listening, because it was more like the doctor had already had her preconception: if I come crying – it’s depression. We only talked for maybe ten minutes. Simple attentiveness [is needed], time, listening and I would even say professionalism. Because it seems like, well, I understand that psychiatrists have to graduate to become psychiatrists, but it seems like most people don't even know certain things, where I know better, and I'm telling them my symptoms and I'm like, yeah, I'm here I have been learning about this condition for a long time, (...) for me it is this way and that way. And they keep asking me questions (...) as if they hadn't heard of it before. It just seems that some doctors, especially the older generation, have outdated knowledge.”
	"For a long time, it was difficult to find a person with whom I would feel heard. (…) Recommendations to suppress my internal emotions with psychotropic drugs did not satisfy me."
	"The “help” was harmful. Maybe somehow I would have solved my problems on my own, and now the [psychotropic] drug addiction has added to all the problems."
	"I remember that there [in a psychiatric hospital] it was like a [psychotropic] drug party: they tried to prescribe me some specific ones, then they tried other types."

Discussion

Main Findings

This is the first mixed-methods study which aimed to analyse the use of mental health services in Lithuania by IPV survivors. The study not only included a quantitative analysis but also used qualitative data to gauge the contextual factors and individual experiences of IPV survivors [30]. It reflects the broader context for when and how IPV survivors use mental health services (or not), how these services respond to their needs (or not), and provides some contextual reasons and subjective insights into the specificities of the issue.

The results confirm that only a fraction of IPV survivors use mental health services, even though they are at a higher risk of having mental health conditions compared to women who never experienced IPV [15],[17]. Those who used mental health services mostly approached psychologists or psychotherapists, and mostly either fully or partially self-funded these services in the private sector. Around two-thirds of them expressed that their needs were only partially met or not met at all.

The quantitative analysis did not find any statistically significant associations between several sociodemographic and violence-type predictors and the use of mental health services by IPV survivors. However, the qualitative part of the study captures the nuanced and complex picture of this very subjective, personal, yet majorly prevalent issue. It provides insights into the spectrum of IPV survivors' lived experiences and also various more specific contextual factors (environmental and personal), which may influence whether IPV survivors use mental health services, or not.

Among the main reasons for neither seeking help nor using mental health services, the results highlight: victim-blaming attitudes in society and self-blaming; public and internalised stigma (both of IPV and mental health difficulties); the resulting feelings of shame and fear; a lack of information about possible support avenues; and not being able to afford to pay for mental health services.

Those who used mental health services highlighted: the differences between public and private sectors; the importance of the skills of professionals and their specialised knowledge about IPV, trauma- and violence-informed care; and also referred to IPV stigma and victim-blaming attitudes. The study results also highlight informational, infrastructural, financial, and attitudinal barriers to the effective provision of mental health care to IPV survivors. Finally, it points to systemic problems, such as over-medicalisation and the mental health system being overstretched and under-resourced.

Mental Health and IPV Stigma

In Lithuania, around one-third of the population would not like to live in the same neighbourhood as someone who has a mental health diagnosis, and more than one-in-ten Lithuanians have negative preconceptions and prejudices against persons with mental health difficulties [55]. People with mental health conditions and psychosocial disabilities are among the most discriminated vulnerable groups in the country [56]. For this reason, issues related to mental health stigma have major implications and the

current study captures the impact that mental health stigma may have on IPV survivors. It was named as one of the reasons for not seeking help within the mental healthcare sector: IPV survivors were afraid of the potential psychiatric diagnosis and subsequent psychiatric medical record. This corresponds to the fact that, globally, mental health stigma is pervasive and has a major negative impact on the well-being of persons experiencing mental health difficulties. Not only may it contribute to the worsening of their mental health conditions but it also may delay or completely stop people from seeking help [57].

The impact of IPV stigma (both societal and self-stigma) was even more pronounced in this study, also contributing as a barrier to IPV survivors seeking help. This is in line with the global evidence that both public and self-stigma have negative implications for IPV survivors, including depression and PTSD, which they may experience specifically due to this stigma [58],[59],[60]. Moreover, such stigma may affect not only IPV survivors' help-seeking behaviour but also the quality of support they receive from mental health professionals and others [61]. An especially harmful and pervasive consequence of IPV stigma in society and among professionals is the attitude of victim-blaming (when IPV survivors are blamed for the violence they have been subjected to) [62]. In the current study, as well as in previous studies from other countries, it has been clearly illustrated that victim-blaming attitudes and subsequent conduct by professionals may cause secondary victimisation and additional trauma for IPV survivors [63].

Mental Health Support

Due to the trauma and mental health impacts of IPV (especially those of coercive control), mental health support is vital for IPV survivors [64],[65]. In general, because of its frequent co-occurrence with various health conditions, it is important to screen and assess for IPV in both primary care and mental health services to improve treatment planning, support provision, and referral [26],[66],[67],[68],[69],[70]. Contrary to the current study's finding of the common over-medicalisation in mental healthcare, studies across the world highlight psychological interventions, especially psychotherapy, as crucial resources for the management and promotion of the health of IPV survivors [71]. Studies show that the process of psychotherapy contributes to their better quality of life [71],[72]. More specifically, cognitive-behavioural therapy-based interventions tailored to IPV survivors have been evidenced to be among the most effective approaches [73],[74]. A systematic review recently highlighted the importance for professionals who work with

IPV survivors to be trained in specific trauma interventions, such as trauma-focused cognitive-behavioural therapy [75].

Mental health service providers who lack an understanding of IPV's complexity and lasting impacts risk providing ineffective services and even causing further harm [76]. For example, incorrect needs assessments may enhance the risk of IPV survivors feeling misunderstood and unheard; subsequently, ineffective service provision may lead to low compliance with the services provided or even care avoidance [77]. The lack of specialised knowledge about IPV among mental health professionals resonated throughout the current study as one of the main barriers to IPV survivors receiving quality mental health support. This links-in with the recent global study which highlights that only around one-in-two psychiatrists and psychologists are likely to have received IPV-related training: "Clinicians from countries with relatively better-implemented laws addressing IPV and those who encountered IPV more often in their regular practice were more likely to have received training"[66].

To address these issues and prevent the potential re-traumatisation of IPV survivors by professionals, the concept of trauma-informed practice has been established. It aims to understand the effects of trauma with its potential consequences for health and behaviour [78],[79],[80]. Moreover, this concept has recently been developed further into the model of trauma- and violence-informed care. It aims to not simply reinforce the idea that the effects of trauma are located in the individual but to also address IPV as a pervasive complex problem, embedded in structural inequities and linked to stigma and discrimination, social determinants of health, other public health problems, such as poverty, gender "norms", sexism, and misogyny [76]. The results of the current study highlight clear gaps in practice in this regard, and the lack of effective trauma- and violence-informed mental health care in Lithuania.

Recently, a systematic review and meta-analysis summarised thirty years of research on the efficacy of psychosocial interventions for IPV survivors. The results suggest that various psychological approaches and related interventions not only have favourable effects on managing the mental health symptoms of IPV survivors but also on preventing the recurrence of IPV [81]. All these results, including the contribution of the current study, indicate the urgent need for specific policy prioritisation and practice attention toward this majorly prevalent and complex public (mental) health issue. In Lithuania, this also includes dedicating more adequate financial and human resources to enhance and empower the public mental health sector in the country. Finally, it is also important to

acknowledge that mental health professionals may have their own experiences of domestic violence and IPV (that they might or might not be consciously aware of) and this is important to take into account when developing policies, interventions, and support mechanisms [82].

Limitations

The cross-sectional design of the study limits causal inferences and the direction of the associations. Another limitation of this study is the relatively small sample size, sometimes yielding wide confidence intervals and producing certain estimates with some lack of precision. The format of an online survey also comes with some limitations such as its voluntary online nature of participation, the potential response and sampling bias, as well as not being fully representative of the general population. Also, the survey did not reach as many participants from rural areas as from larger cities. Finally, for these reasons, it is not possible to fully generalise the findings of this study.

Ethics Approval

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

Authors' Contributions

The study was conceptualised by the first author U.G. and most of the co-authors contributed to the study design. The survey for data collection was designed and developed by all co-authors and coordinated and implemented by U.G. The main statistical analysis of the collected data was conducted by S.A.L. and U.G. The thematic analysis of the qualitative data was conducted and the first draft of the manuscript was written by U.G. and all co-authors reviewed, commented on it, and provided their contributions. All co-authors reviewed and approved the final version of the manuscript.

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Scientific Paper No. 6

When Gender, Disability, Domestic Violence, and Mental Health Services Intertwine: Experiences of Women with Disabilities in Lithuania

Grigaitė, U., Aginskaitė, S., Pedrosa, B., Aluh, D.O., Santos-Dias, M., Silva, M., Cardoso, G., Caldas-de-Almeida, J.M.

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.

Aim: 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. Fifteen semi-structured interviews were conducted with 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 fields 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.

Keywords: domestic violence, intimate partner violence, disability, mental health services, Lithuania.

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 it 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 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].

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" [14].

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 conducive to DV but can also prevent survivors from seeking help [15].

Moreover, women who survive DV, including IPV, are around three times more likely than women without this life experience to develop mental health difficulties [16]. 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 [17]. 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 [18], [19].

In Lithuania, a victimology study 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 experienced violence from their intimate partners 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: 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, they lacked comprehensive assistance, complex support provision throughout the process, ensuring a safe environment, and services that would foster their independence [20].

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.

Methods

Study Design

This is a qualitative explorative study conducted within an experiential framework [21]. 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 (Hennink et al., 2020). 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.

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 (Braun et al., 2022; Braun & Clarke, 2019; Gough & Madill, 2012). 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.

Study Setting, Measures, and Participants

The research team developed a protocol for semi-structured interviews [22]. The semi-structured interview guide aimed to explore the following data categories and questions:

1) Socio-demographic characteristics (gender of the participant; gender of the abuser; 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).

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 their encounters with various professionals, including mental health services; what support they needed the most at the time; how those needs were met; what the professionals had to offer in response; how helpful was it; what were the most positive and negative aspects of this experience; what barriers (if any) did they face when seeking this support; what would they have liked the professional(s) to have done differently; how did they find 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 despite having experienced DV/IPV.

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 minutes. 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.

Data Analysis

All audio recordings of interviews were transcribed verbatim and analysed thematically according to the recommendations of Braun and Clarke [23], [24]. 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 [23], [25] was conducted using MAXQDA software [26]. The reporting of the findings of this study followed the SRQR [27] and COREQ [28] standards for reporting qualitative studies.

Research Ethics

During all the stages of research design, implementation and analysis, the main principles of ethics in research with mental health service users [29], [30], [31], as well as within the field of DV and VAW [32], [33], [34] were considered. For example, it was important to be aware of potential emotional distress and impact on both research participants [35], and researchers [33]; the sensitive nature of both the topic of violence and that of mental health difficulties and disabilities; the importance of ensuring safety [35]; 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).

Results

Details of Interviews

Fifteen women with hearing, vision, physical, psychosocial and intellectual disabilities from five different geographical areas of Lithuania participated in this study. 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)*

	Women with disabilities who experienced DV/IPV (*n*=15)	
Age category	***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

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.

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 experiences.

"It's just like everyday life"

A large part of the research participants revealed that for a long time, they did not recognize 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.

Often, women accepted the violence they experienced as a usual "everyday thing", the only familiar reality, often they were just resigned to it. 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 assistance and due to the risk of further physical harm from the abuser for trying to escape or seek help.

"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. Sometimes the same thing was repeated to them not only by the abusers themselves 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. 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.

The survivors' own "fault"

Research participants 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, stigma and blaming the victims for the violence they have experienced encouraged them to remain silent, not to share, not to tell anyone about their experiences, not to ask for help. 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 (especially if it was cases of specifically IPV).

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.

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; 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.

According to the research participants, when they remember how they approached mental health care professionals, now, looking back, they recognise and believe that the professionals did not pay enough attention to the topic of violence, this fundamental trauma in their lives. 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 general lack and unavailability of psychological help and other mental healthcare services in the community 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, including disability-related accessibility issues.

Selected quotes that contribute to each of the Themes are outlined in *Table 2* and *Table 3*.

***Table 2**. Quotes from semi-structured interviews: Themes 1 to 3.*

Theme	Selected Quotes
1) The intersection of gender, violence, and disability	"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 "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 "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 "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
2) "It's just like everyday life"	"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 "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 "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 “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 "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

3) "Who else is going to look after me?"	"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 "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 "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

Table 3. *Quotes from semi-structured interviews: Themes 4 and 5.*

Theme	Selected Quotes
4) The survivors' own "fault"	"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 "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 "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
5) Mental health services as a vital but deficient resource	"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 "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 "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 "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 "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

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 [18], [36], [37]. 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 [38]. 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 [39], [40].

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 [41], [42]. Also important is the fact that because of 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 and necessary day-to-day support. In such cases, women with disabilities may feel deeply dependent on the abuser both physically, emotionally, and financially. 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 [43].

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 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 conducive to DV/IPV but can also prevent survivors from seeking help in time (or at all) [15].

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 [44]. 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 [44]. Additionally, the research participants named negative experiences due to the existing stigma and stereotypes in society, not only because of DV/IPV [44], but also due to disability and mental health conditions [45], [46]. 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], [47], [48]. 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 [37]. 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 [49]. 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 [18], [19], [50], [51].

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 possible to reach those living in the more rural communities during this study.

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 fields 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.

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Declaration of Interest Statement

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

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Discussion

The findings of this doctoral thesis contribute to the scarce literature on the responses to the mental healthcare needs of IPV survivors, including those with disabilities. This study was implemented within the existing mental healthcare systems in two European countries: Portugal and Lithuania. The results contribute to a better understanding of the prevalence and complexity of IPV as a global public mental health issue and the specificities of the required responses by mental healthcare services to the needs of this specific population in both countries and beyond.

Prevalence and Context in Both Countries (RQ.1; RQ.4)

Globally, it is estimated that at least one in three women experience physical and/or sexual IPV at some point in their lives (WHO, 2021). In this study, we had an opportunity to analyse data representative of the Portuguese population specifically concerning cases of *severe physical IPV* against women. The study demonstrates that the prevalence of this specific form of IPV in Portugal is just over 14% (Grigaitė, Azeredo-Lopes, Cardoso, et al., 2024). This result is lower than the global average; however, the difference might be explained by the fact that only data on *severe* physical IPV was included in the study.

In Portugal, no official State data is available on the prevalence and specificities of IPV; it is only available on the broader data category of 'domestic violence'. This is problematic since the specific prevalence of different types of IPV in the country is unclear. As for 'domestic violence': in 2023, the National Support Network for Victims of Domestic Violence received 3,016 adult survivors of domestic violence, of whom 2,943 (98%) were women (Commission for Citizenship and Gender Equality, 2024).

These numbers do not reveal the real magnitude of the prevalence of IPV in Portugal and it remains a latent crime. For example, even though it was not gender- or IPV-type-specific, a study conducted in 2022 found the prevalence of IPV victimisation in Portugal to be as high as 64.4% (Capinha et al., 2022).

In contrast, the Lithuanian State Data Agency does have some statistical data available on IPV, even though it is also limited and does not fully represent the reality of the national prevalence due to being based only on the cases that are registered with the

police. The latest available data reports that, in 2022, 6,119 victims of crimes committed as a result of domestic violence were registered in Lithuania: the majority (4,300 or 78.8%) of adult victims were women, and 80.6% of them were victimised specifically by an intimate partner (State Data Agency, 2023).

The results of this doctoral study on the prevalence of IPV in Lithuania concerning *psychological IPV*, including coercive control and economic IPV, are above global average estimates but in line with the EU average for *psychological* IPV of around 44% (Grigaitė, Azeredo-Lopes, Žeimė, et al., 2024). This result is also in line with other studies, which estimate the prevalence of this type of IPV in Lithuania to be around 50% (European Union Agency for Fundamental Rights, 2014; Žukauskienė et al., 2021).

In this study, some distinct differences between the two countries were observed when recruiting study participants for the qualitative part of the study, as well as for the online surveys. The online survey in Lithuania was completed by more IPV survivors (93 women) than in Portugal (26 women): this result is inversely proportional to the population size of the two countries (there are around 3 million inhabitants in Lithuania and around 10 million in Portugal). Similarly, it was much easier in Lithuania than in Portugal to reach mental health professionals and IPV survivors who would be willing to participate in the focus groups and semi-structured interviews.

Possibly, the recruitment of research participants in Lithuania was more successful than in Portugal because the author of this thesis is Lithuanian. Also, the topic of 'domestic violence', including IPV, has been in the public discourse and on the agenda of decision-makers in Lithuania a lot in recent years. The Lithuanian Law on Protection from Domestic Violence was recently revised; as a result, several new related victim support services and algorithms for recognising and responding to cases of domestic violence, as well as for the provision of support, are currently being developed and piloted (Law on Protection from Domestic Violence, 2023). In parallel, Lithuanian non-governmental organisations and certain State institutions have been actively and consistently implementing various large-scale public awareness-raising campaigns for several years. It can only be presumed that all these measures have possibly resulted in the general public and IPV survivors in Lithuania being more open to talking about this problem and sharing their related personal experiences.

Responses by Professionals in Both Countries (RQ.2; RQ.4)

This study confirms that mental health support is very important to IPV survivors since they have increased odds of developing mental health conditions and using mental healthcare services compared with those who have not experienced IPV. This is in line with global literature, which highlights that health professionals must recognise the relevance of IPV (among other types of violence) in diverse situations of healthcare delivery, including mental healthcare services (Cho & Kwon, 2018; White et al., 2023).

This means developing and employing such strategies in the delivery of services as screening for IPV, educating healthcare professionals on assessing for IPV and adjusting the university healthcare curriculum to include the topics of domestic violence and IPV (Kennedy, 2017).

Even though the subject of this study is global, the situation is unavoidably influenced by local and cultural contexts in different countries and ways of organising mental healthcare services. This study has shown that responses by mental health professionals to the needs of IPV survivors may largely depend on the level of specialisation of mental healthcare services.

For example, the professionals in the unique specialised mental healthcare unit for survivors and perpetrators of domestic violence (including IPV) in the region of Coimbra in Portugal were more aware of the complexity of the needed mental healthcare responses and more open to utilising inter-sectoral collaboration than those who worked in generic mental health services, in both Portugal and Lithuania.

Nevertheless, in both countries, most of the study participants recognised a lack of and the need for specialised knowledge to be able to work more effectively with IPV survivors. A similar need for and value in specialised education concerning domestic violence and IPV among mental healthcare professionals has also been evidenced and highlighted by studies conducted in other countries (Burns et al., 2022; Djikanovic et al., 2011; Giesbrecht et al., 2023; Vranda et al., 2022). A lack of such knowledge and needed skills may act as a barrier to effective service provision, including the potential for quality screening for IPV among users of mental healthcare services.

More specialised training about IPV is necessary to address not only the knowledge gaps but also the perceptions and attitudes of healthcare providers which have been evidenced to hinder IPV screening and subsequent responses in healthcare settings (Bhandari & Goslings, 2012). For example, it is important to address and prevent stigma among professionals:

> *"Training should reduce professionals' patriarchal values, increase their knowledge about IPV against women, self-reflection on how personal experiences and social identity influence their practice, and self-reflection on their own practice in general."* (Murvartian et al., 2024)

Perceived Social Problem vs. Mental Healthcare Concern (RQ.2; RQ.4)

In this study, both in Portugal and Lithuania, mental health professionals (especially those working in generic and not specialised mental health services) have regularly perceived IPV as a "social problem" and not so much as a healthcare concern. Social care professionals who participated in this study also did not necessarily recognise that IPV can affect the state of a person's mental health.

This is concerning because the high prevalence of IPV and high rates of various mental health conditions among IPV survivors strongly point to the need to recognise the importance of mental healthcare as a crucial and integral part of support services for survivors of IPV and domestic violence. This means not only ensuring the relevant training for mental health professionals but also educating providers of social care and victim support services about addressing the mental health needs of survivors of domestic violence, including IPV (Edmond et al., 2013). Ensuring and fostering inter-sectoral collaboration amongst all these services is key.

Moreover, this study points to the need to promote greater awareness and competencies of not only mental health and social care professionals but also of general physicians and other physical healthcare professionals to be appropriately trained and prepared to provide mental health support effectively to IPV survivors (Grigaitė, Azeredo-Lopes, Cardoso, et al., 2024).

Experiences of Survivors and Trauma- and Violence-Informed Care (RQ.3; RQ.4)

Regardless of the high prevalence of IPV (and of mental health conditions among survivors of IPV) in both Portugal and Lithuania, this study has found that in some cases, only around one-third of IPV survivors may seek any type of help, and as little as one-tenth of them may end up using mental health services. This is especially so in cases of psychological IPV (Grigaitė, Azeredo-Lopes, Žeimė, et al., 2024), rather than severe physical IPV (Grigaitė, Azeredo-Lopes, Cardoso, et al., 2024).

The qualitative part of the study has revealed that the experiences of IPV survivors in both countries can be quite similar when it comes to the reasons for not seeking help. Research participants in both countries expressed deeply rooted feelings of shame, fear of perpetrators, fear of condemnation by society, self-blaming, and lacking information. The IPV-related stigma was observed to be present in both countries. This is still a highly prevalent issue across many countries and often ties in with victim-blaming attitudes in society that are often a result of sexist beliefs and the acceptability of IPV against women (Leon & Aizpurua, 2024; Taccini & Mannarini, 2023).

However, in Lithuania, the additional strong stigma and fear of mental health conditions were more pronounced than in Portugal. For example, in Lithuania, IPV survivors expressed that fear of receiving a psychiatric diagnosis and having a psychiatric medical record was one of the reasons for not seeking help and not approaching mental health services.

Possibly, this could be interpreted to be a result of the fact that there have been strong developments in the mental health law, policy, and services in Portugal and mental health services are somewhat more developed in Portugal when compared with Lithuania. Portugal's mental health reform has been ongoing for many years, compared to only several years in Lithuania. Additionally, Portugal even has a unique mental healthcare unit dedicated specifically to survivors and perpetrators of domestic violence, including IPV, which shows a more advanced development in this field. On the contrary, even though there have been a lot of recent and strong developments in Lithuania in the field of domestic violence law, policy, and practices; however, no specialised mental healthcare services or programmes have so far been developed for survivors.

Survivors of IPV who did use mental health services in either Portugal or Lithuania observed and highlighted various limitations they faced, including victim-blaming

attitudes and stigma by mental health professionals, and unmet expectations for support. According to the study participants, mental health professionals often do not tend to ask directly about their experiences of IPV and do not recognise the less obvious non-physical signs. A lack of needed knowledge and skills, as well as negative attitudes by mental health professionals towards IPV-related matters, were identified as major barriers to better mental healthcare provision to IPV survivors in both countries.

Another barrier that was identified in both countries was a lack of accessibility and over-medicalisation of public mental healthcare services. This is especially relevant when it comes to financial barriers to receiving psychotherapy, which is more available in the private sector in both countries. In general, emotional support and psychotherapy were identified in both countries as something that IPV survivors needed the most when approaching mental health services. This is a potential illustration of a culturally determined need: contrary to the findings of this study, another study that analysed a similar question in Sri Lanka found that the care most desired by survivors was primarily psychosocial and not psychological; in Sri Lanka, which is classed as a middle-income country, it was instead prioritising the matters concerning socioeconomic needs, parenting, and safe environment in non-clinical community settings (Palfreyman et al., 2024).

In general, this study highlights that complex responses are needed by IPV survivors when it comes to their mental health needs and recovery from the IPV trauma. A similar point was already highlighted by the WHO more than 20 years ago by recognising that responses to various types of violence by the healthcare sector are usually mostly just reactive and at best therapeutic; however, they are very fragmented instead of addressing the complex phenomenon of violence in a more comprehensive and holistic way (World Health Organization, 2002). According to Gear and collaborators (2018), “responding sustainably to IPV in healthcare is a persistent problem of particular complexity for public health policy internationally”. The very complexity of the problem in question continuously challenges a sustainable integration of appropriate and effective responses to IPV in healthcare systems (Gear et al., 2018).

For example, in light of some mental health professionals not realising the complexity of IPV, some of the IPV survivors in this study shared their experiences when they were inappropriately referred for couples therapy. It has been highlighted in research that it is highly important to assess for ‘systemic’ IPV and coercive control in a relationship before determining if a couple is in fact suitable for couples therapy (Stith & Spencer, 2024). In

cases where mental health professionals fail to establish this in time, the prescribed couples therapy may lead to more damage rather than positive outcomes. As Schecter emphasised back in the 80's:

> "*Couples therapy is an inappropriate intervention that further endangers the woman. It encourages the abuser to blame the victim by examining "her" role in his problem. By seeing the couple together, the therapist erroneously suggests that the partner, too, is responsible for his behaviour*." (Schecter, 1987)

In addition to better assessing for the above, mental health professionals also need to recognise the trauma of IPV and its effects on the mental health of IPV survivors: this specific need echoed throughout the experiences of the participants of this study, in both Portugal and Lithuania. This is in line with what has been established in other studies across the world which detail that clinicians tend to lack the understanding of trauma-specific experiences of IPV survivors such as flashbacks, dissociation, depersonalisation, and numbing; also, how survivors can be supported to rebuild their self-confidence and their identities, recognise their potential, regain joy in life, and start healing (Fischer et al., 2023).

Fischer and co-authors (2023) emphasise that mental health professionals should understand the impacts of violence beyond mental health diagnoses; this includes a focus on social, relational, well-being impacts, and intersectional aspects:

> *"Clinicians and researchers must create new psychosocial outcome measures that move beyond mental health symptoms and capture trauma-specific understandings (particularly when investigating the impact of violence); and new measures that capture survivors' strengths and recovery based on our own goals."* (Fischer et al., 2023)

IPV survivors may experience cumulative traumatic stress which may lead them to use not only domestic violence-specific support platforms but also social care and mental healthcare services. Hence, mental health professionals must increase their awareness of IPV trauma and its impact on survivors (Fischer et al., 2023), as well as the importance of their therapeutic responses, the approach they take, and the direct environment in which they provide services (Anyikwa, 2016). As pointed out by White and collaborators (2023): "Knowing the prevalence of IPV and trauma history in help-seeking women,

mental health services should take women's trauma histories, including current/active IPV, and have trauma-informed approaches in place" (White et al., 2023).

Hence, mental health professionals can make a significant difference not only by screening for IPV, ensuring safety and person-centred care, but also by providing trauma- and violence-informed care and support (Oram et al., 2022; Wathen & Mantler, 2022). Integrating trauma- and violence-informed care approaches and practices in mental healthcare responses has so far been proven to be one of the promising developments in the transformation of mental healthcare services to better meet the needs of IPV survivors (Wathen & Mantler, 2022).

Originally, the concept of *trauma-informed care* was developed to better address the needs of survivors of trauma and prevent the potential re-traumatisation by professionals. Trauma-informed care models aim to better understand the effects of trauma with its potential various consequences for health and behaviour (Butler et al., 2011; Lewis-O'connor & Sievers, 2023; Substance Abuse and Mental Health Services Administration, 2014).

More recently, this concept has been expanded further to become the model of *trauma- and violence-informed care*. According to Wathen and Mantler (2022), it aims to not simply reinforce the idea that the effects of trauma are located in the individual but to also address IPV as a pervasive complex problem, embedded in structural inequities and linked to stigma and discrimination, social determinants of health, and other public health problems, such as poverty, gender "norms", sexism, and misogyny (Wathen & Mantler, 2022).

As promising as the trauma- and violence-informed care practices may be, still, as emphasised by Ford-Gilboe and others (2024), few comprehensive and tailored IPV interventions that are complex and include responses to healthcare concerns have so far been tested; an ongoing evaluation in both the physical and mental healthcare settings and systems is needed (Ford-Gilboe et al., 2024).

> *"Future work should address how supportive clinical contexts that facilitate effective inquiry, disclosure, and referral to services can be created, acknowledging that what works in one context may not work in another."* (Melendez-Torres et al., 2023)

Situation of Women with Disabilities (RQ.3)

It is important to note that the already pandemic levels of prevalence of IPV against women globally are even higher for women with disabilities: they are two to five times more likely to experience domestic violence, including IPV, when compared with women without disabilities (European Parliament, 2018; Gupta et al., 2023; Hughes et al., 2012; UN Committee on the Rights of Persons with Disabilities, 2016). The most vulnerable to this risk are women with mental health conditions, psychosocial, and intellectual disabilities (Dammeyer & Chapman, 2018; Hughes et al., 2012).

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 due to perceiving the lives of people with disabilities 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 conducive to domestic violence and IPV but can also prevent survivors from seeking help (McGowan & Elliott, 2019).

In this study, fifteen Lithuanian women with disabilities survivors of domestic violence and IPV shared their experiences. Their stories illustrate an even more complex picture and specific situations which they are faced with.

For example, adding to the usual complexities of IPV against women, women with disabilities may additionally experience disability-based IPV. This may express itself by the perpetrator manipulating the (non)providing of the necessary daily support and personal care, deprivation or limitation of assistive devices, arbitrary regulation of medication doses, neglect and ignoring of individual needs.

Moreover, because of the need for individual support, women with disabilities may become deeply dependent on their abusers in their daily lives: the perpetrator can also be the primary source of vital day-to-day care and support. In such cases, women with disabilities may feel deeply dependent on the abuser both physically, emotionally, and financially. This dependence may lead to feelings of helplessness and disbelief that there is a way out of the present situation of IPV.

Systemic problems of the lack and inaccessibility of individual support and community-based services contribute to this problem. The research participants in Lithuania shared various doubts and fears about such situations as, for example, if the abuser were to be separated from the survivor after seeking help and evicted from their home, the woman would be left without vital daily support.

The lack of such community support services that could replace the daily care provided by the IPV perpetrators in Lithuania, especially in the context of mental healthcare, is evident and has been documented in international literature (Wijker et al., 2022).

Nevertheless, in cases when the research participants with disabilities who have experienced violence sought help, they found mental healthcare services to be significantly important.

Hence, in addition to everything outlined in the previous sections of this thesis concerning the needed knowledge and skills of mental healthcare professionals about domestic violence and IPV applies in cases of survivors with disabilities too, which is in line with global literature (Walter et al., 2024).

Moreover, it adds to the need for professionals to also have knowledge and skills about different specificities of the additional aspects of disability and what it might mean for the survivors and their situations.

Finally, it should be noted that it is deeply concerning that globally, there is still little evidence of effective mental healthcare interventions for survivors of violence who have disabilities (Pastor-Moreno et al., 2024).

Strengths and Limitations

Some of the strengths of this study are outlined below:

This thesis focuses on an understudied topic of the existing responses by mental healthcare services to the needs of IPV survivors in two European countries: Portugal and Lithuania. Hence, it was conducted in two countries with some similarities but also with some distinct differences and diverse cultural contexts. The study employs not only

quantitative but also qualitative, and mixed methods approaches. Adding to the quantitative data, special attention was paid to the personal experiences of IPV survivors. Also, an effort was made to connect the study to the additional topic of disability. All the above has enabled a comprehensive and in-depth analysis of the subject.

The study positions IPV as a global public mental health problem and analyses various related concerns, specificities and implications from both the perspective of mental health professionals and IPV survivors, including those with disabilities. The study results provide a comprehensive picture of the issue in question and include service providers' and service users' views and perspectives.

Limitations of this study include the following aspects:

The fact that the study is cross-sectional limits causal inferences, namely the direction of the associations. The quantitative parts of the study had relatively small sample sizes, sometimes yielding wide confidence intervals and producing certain estimates with some lack of precision.

While completing the study's national representative Surveys, there might have been some recall bias, period or cohort effects, and underreporting among the participants, especially in the presence of a spouse, when asked about traumatic experiences, such as IPV. Also, there was potential for response and sampling bias in online Surveys. Additionally, due to the availability of only limited data on this subject having been included in the national representative Surveys, only experiences of severe physical IPV in Portugal and that of only psychological IPV in Lithuania were statistically analysed. Thus, the study leaves space for further exploration of relevant national estimates and associations related to other types of IPV. Nevertheless, the qualitative parts of the study did indeed cover all types of IPV in both countries.

To have a broader evaluation of the subject from the social-ecological perspective, it is necessary to study the contextual factors more profoundly and in-depth. It would be important to have a more robust assessment of the contextual differences that may affect the studied phenomena in both countries. Unfortunately, this was not feasible and impossible to achieve in this particular study.

Conclusions and Implications for Theory, Policy, and Practice

The key findings of this doctoral study highlight and confirm the high prevalence of IPV and the importance of mental health support for IPV survivors' recovery. The needed complex approaches include trauma- and violence-informed care, holistic, multi-disciplinary, and inter-sectoral efforts.

However, the current profile, organisation, and provision of mental healthcare services in Portugal and Lithuania generally have significant gaps when it comes to addressing such a complex public mental health concern as IPV. Most of the studied mental healthcare services in these two countries are not equipped well enough to effectively and appropriately respond to the individual needs of IPV survivors. The only exception is the unique mental healthcare unit in the Portuguese region of Coimbra, which specialises in providing mental health support specifically to survivors and perpetrators of domestic violence, including IPV.

Apart from this one mental healthcare unit, which is unique not only in Portugal but also in Europe, many of the generic mental healthcare services and professionals in both countries often demonstrate a lack of recognition that IPV is a public mental health concern: it is regularly perceived as more of a "social problem", which is not necessarily recognised as being relevant to the provision of mental healthcare services. Generally, a lack of effective interventions has been observed. Trauma- and violence-informed care approaches are often missing, and both countries could benefit from a better inclusion of IPV survivors with lived experiences of mental health conditions into the related policy and practice planning and implementation.

Further qualitative and quantitative research is needed to explore the specificities of the utilisation of mental healthcare services by IPV survivors, as well as determine what interventions might be the most effective for this population in different geographical and cultural contexts. Implications for the public health policy and practice include the need for mainstreaming of IPV-related knowledge and skills among professionals in mental healthcare services; elimination of both the mental health and IPV stigma and victim-blaming attitudes in society; ensuring multi-disciplinary and inter-sectoral working models between the mental healthcare sector, social care services, law enforcement, judiciary, and other relevant stakeholders.

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