Original Article

Violence Against Women: Prevalence and Psychiatric Consequences

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Background: Violence is a universal scourge that tears into the fabric of communities and affects the lives, happiness and wellbeing of millions of women worldwide, in all socio-economic and educational classes.
Objective: the aim of this study was to study the prevalence of violence against women, to detect types of abuse and the related socio-demographic risk factors, and finally to study the psychiatric consequences of violence against women.
Subject and Method: : A sample of females aged between 18 and 45 years was selected from Al Zahraa University Hospital; from obstetrics and gynecology and internal medicine clinics (Group I), while (Group II) was selected from psychiatric clinics. The total sample size was 1158; group I (620), group II (538), ages ranged between 18-45 years, all of the samples were subjected to the structured clinical interview for DSM Axis of Disorders (SCID-1) for diagnosis of Axis I psychiatric disorders, the structured clinical interview for DSM-IV Axis II personality disorders (SCID – II) and the World SAFE Questionnaire (Study of Abuse within Family and Environment).
Results: the prevalence of physical abuse was 43.2% (Group I) and 86.6% (Group II) with a high significant statistical difference between the two groups regarding various types of physical abuse. 16.6% of abused women were also abused during pregnancy, 44% of women in group-I were psychologically abused versus 87.7% of women in group II; 41% of group I patients were abused both physically and psychologically versus 86% of group II. 7.4% of group I were sexually abused versus 4.8% in group II. The prevalence of lifetime psychological abuse is 42.1% in group I, versus 53.2% in group-II. Violent victimization against women was more likely in those with psychiatric disorders than those without (81.1% versus 4.5%). Major depression was the most prevalent disorder amongst abused women. Generalised anxiety disorder was the second most prevalent disorder (17.9%) followed by dysthymic disorder (11.4%).
Conclusion: Violence against women is a prevalent phenomenon that results in significant negative emotional, mental and physical health outcomes for women.

Keywords: Prevalence, Women, Violence, Domestic, Physical, Sexual, Emotional Abuse, Psychiatric Consequences.

Abbreviations:
GAD: Generalized Anxiety Disorder
IPV: Inter-Personal Violence
SAFE: Study of Abuse within the Family Environment
SCID-CV: Structured Clinical interview for DSM - Clinician version
SCID-I: Structured Clinical interview for DSM-IV Axis II Disorders
SCID-II: Structured Clinical interview for DSM-IV Axis II Personality Disorders.

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INTRODUCTION

Violence affects the lives of millions of women worldwide, in all socio-economic and educational classes. It cuts across cultural and religious barriers, impeding the right of women to participate fully in society (Dennerstein, 1993). Interpersonal violence (IPV) was the tenth leading cause of death for women aged 15-44 in 1998 (Krug, et al. 2002). The world conference on Human Rights (Dennerstein, 1993) defined violence against women as any act that results in or is likely to cause physical, sexual or psychological harm or suffering to women, whether it occurs in public or private life.

Violence against women is primarily an intimate misdeed. Battering at home constitutes by far the most universal form of violence against women (Bunch, 1997). Moreover, around 64% of women who reported being physically or sexually assaulted were victimised by their intimate partners, and up to 70% of female homicide victims were reportedly killed by of their male partners (Tjaden and Thoennes, 2000).

Violence against women is a costly phenomenon, above and beyond its direct financial implication and the visible signs of assault, lays a huge intangible cost. Victims sustain injury to their mental wellbeing, performance at work, ability to sustain relationships, and ability to realise their full potentials and needs (Riger, et al. 2002). The loss is not solely to the victims' health; but also their dignity, sense of security, and freedom of self-determination. Hence, it is not surprising that the World Bank estimated that domestic violence accounts for 5% of the total disease burden in women aged 15-44 years in developing counties (World Bank, 1993).

Research on violence against women has increased dramatically over the past 20 years. While greatly enhancing public awareness and understanding of this serious social problem, such research however, created considerable controversy and confusion, especially with regards to the prevalence of intimate partner victimisation as finding varied widely from one study to another. There was an evident lack of consistency and systematic differences in the way violence was operationally defined, measured, and presented. Studies also differed in other respects as; methodological designs, selection of samples, forms of violence considered, range and style of questioning and data collection, and most importantly reports on measures taken to ensure privacy and confidentiality. Such variances can substantially affect prevalence estimates and influence the subject's willingness to disclose abuse (Heise, et al. 1994).

One of the biggest studies in the field was the World Health Organization, (2005) multi-country study on Women's Health and Domestic Violence against Women. Data were collected from over 24000 women in 10 countries representing diverse cultural, geographical, urban, and rural settings (Krug, et al. 2002). The study revealed that the proportion of women who had suffered physical violence by an intimate partner ranged from 13% to 16%, with most sites falling between 23% and 49%. Furthermore, Diaz Olavarrieta, et al. (2002) found that the prevalence of physical abuse among women attending internal medicine outpatient clinics was 41%.

On the other hand, and despite the seriousness of the problem, there is a lack of empirical knowledge regarding the magnitude and various dimensions of this problem in the Arab world (Haj Yahia, 2000). Studies on Arab women are very scarce. One such however, is the Egyptian Demographic Health Survey, which undertook a representative national sample of 14779 married women. This survey revealed that around 42-46% of married women who are either illiterate or have completed primary education, and 14% of women with higher education have been beaten by their husbands (El-Zanaty, et al. 1996). Another study conducted in 1997 on 100 women from Manshiet Naser district in Cairo revealed that 30% of women admitted to being subjected to abuse on a daily basis, 34% on a weekly basis, and 15% on a monthly basis (Tadros, 1998). Furthermore, Hassan, et al. (2000) found (11.1%) lifetime prevalence and (10.5%) one previous year prevalence of physical abuse among 675 women in the Egyptian Governorate of Ismailia. The study reported that slapping and beating (10.5 % and 9.5% respectively) were the most common physical abuse forms. With the reported high prevalence of physical violence against women in Arab culture, still more research is needed to systematically investigate the prevalence of other forms of emotional and sexual abuse, associated risk factors, cultural determinants, as well as their psychiatric consequences. This will help to create a framework of understanding of this complex problem that can enable policy and decision makers to appreciate the magnitude, cultural dynamics, and effects of violence against women in order to move them to action that can bring about improvements in women's lives.

OBJECTIVES

The study aimed to:

1. Estimate the prevalence of various types of abuse directed towards women.
2. Study the possible correlations of violence against women.
3. Study the psychiatric consequences of violence against women.

SUBJECTS AND METHODS

The study sample was selected from Al Zahraa University Hospital out patient clinics. A total of 1158 females with an age range of 18-45 years were selected randomly from internal medicine and obstetric and gynaecology clinics (Group I=538) and from psychiatric clinics (Group II=620).

Ethical approval was granted from the Faculty of Medicine for Girls at Al-Azhar University as well as an authorization from the Head of Departments of Internal Medicine and Obstetrics and Gynaecology. Informed consent was obtained from all participants, and due to the nature of the study and the events referred to therein, subjects were assured regarding confidentiality and anonymousity of all collected data.

All participants in the study were subjected to the following:

1. **Standardised Psychiatric Assessment:** This was done by an experienced and trained research investigator and included:

- ***The structured Clinical Interview for DSM Axis of Disorders (SCID-I):*** The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-1) is a clinician-administered, semi-structured interview for use with psychiatric patients or with non-patient community subjects who are undergoing evaluation for psychopathology. The SCID-I provides broad coverage of Axis-I psychiatric diagnoses according to DSM-IV (First, et al. 1997).
- ***The structured Clinical interview for DSM-IV Axis II personality Disorders (SCID-II):*** The structured Clinical interview for DSM-IV Axis II personality Disorders (SCID-II) is a semi-structured clinical interview was developed to assess DSM-IV personality disorders. A 119-item yes/no screening questionnaire is available to reduce interview time by identifying personality disorders that are unlikely to be present. Paralleling the screen, the SCID-II interview contains 119 sets of questions

in yes/no and open-ended format in addition to several additional questions to assess antisocial personality disorder (First, et al. 1997).

2. **The WORLD SAFE questionnaire (Study of Abuse within the Family and Environment–Arabic Version):** This questionnaire was developed by the WHO to be used in the WHO study of Women's Health and Domestic Violence (Hassan, et al. 2000). It covers a wide range of possible physical, emotional, and sexual abuse by both partners and non-partners perpetrators.

Statistical analysis: All data were recorded, tabulated and transferred to a Statistical Package for Social Sciences (SPSS) version 11. Student's t Test (t) was used for comparison between means. Pearson Chi-Square Test ($\chi 2$) was used for comparison between qualitative variables. P-value was used to indicate the level of significance.

RESULTS

The mean age of the recruited sample was 29.7± 6.1 years. The majority were married (93.3%) and had children. They had varying levels of education; but only 11.1% completed more than 12 years of education. This might have partially contributed to the high level (66%). of unemployment seen (Table 1). Most of the husbands were manual workers (65.6%), and the majority (n=944, 84.5%) received less than 12 years of education (Table 2).

Our results shows that psychiatric patients (Group II) were twice more likely to be abused than group-I where the prevalence of lifetime physical abuse was 43.1% in group-I versus 86.8% in group-II (Table 3) . This was reflected also in severity of abuse where 13.5% of group-I patients were abused severely versus 18.2% of group-II. As a consequence of physical abuse, 17% of abused women were hospitalised due to injuries. Moreover, we found that 16.6% of abused women were also abused during pregnancy (Table 4) . With regard to psychological abuse, 44% of women in group-I were psychologically abused versus 87.7% of women in group-II. There was high statistical significance (P<0.000) in co-occurrence of psychological and physical abuse. This was more in group-II (86%) versus 41% in group-I. 11% of the total subjects were abused both physically and sexually; However, there was no statistical significance found regarding the co-occurrence of sexual and physical abuse in-between groups. We also found that sexual abuse was less in psychiatric patients (4.8%) versus 7.4% in group-I, although violent victimization in general appeared to be more in psychiatric patients (81.1% versus 4.5%).

Table 1: General characteristics of women of the whole studied group (N=1158):

Mean Age ± SD	**29.77+ 6.13**	
Marital status	**N**	**%**
Single	41	3.5
Married	1080	93.3
Divorced	19	1.6
Widow	18	1.6
Number of children	**N**	**%**
No Children	124	10.7
One	143	12.3
Two	351	30.3
Three	292	25.2
Four	148	12.8
Five or more	59	5.2
Female occupation	**N**	**%**
Not Working	764	66
Working	394	34
Female education	**N**	**%**
Illiterate	387	33.4
<6 years schooling	241	20.8
6-12 schooling	402	34.7
>12 years schooling	128	11.1

Table 2: Characteristics of husbands of ever-married women (N=1117):

Husband occupation	**N**	**%**
Not working	61	5.5
Manual worker	733	65.6
Professional worker	323	28.9
Husband education	**N**	**%**
Illiterate	200	17.9
<6 years schooling	392	35.1
6-12 schooling	352	31.5
>12 years schooling	173	15.5

Table 3: Prevalence of women abuse, physical, psychological and sexual:

Type of abuse	**Group-I**	**Group-II**
• Physical	43.1%	86.8%
• Psychological	44%	87.7%
• Both	41%	86%
• Sexual	7.4%	4.8%

Table 4: Comparison between groups regarding prevalence of abuse during pregnancy, severity of abuse, hospitalization, and prevalence of non-partner abuse:

	Group-I		Group-II		χ2	P
	N	%	N	%		
Abuse During Pregnancy						
Abused	68	11.2	54	10.6	0.12	0.72
Not abused	538	88.8	457	89.4		
Severity of physical abuse						
Severe	84	13.5	100	18.6	7.91	0.019
Not severe	536	86.5	438	81.4		
Hospitalization due to physical abuse						
Yes	55	8.9	71	13.2	5.56	0.018
No	565	91.1	467	86.8		
Non-partner physical abuse						
Yes	62	12	120	22.3	41.6	0.000
No	558	90	418	77.7		

Risk factors for abuse in women appear to be related to; unemployment since the majority (76.5%) of abused women did not work, Illiteracy (43.9% of abused women) or having received less than 6 years of education (21.3%), abuse during childhood, where (17%) of abused women had a history of child abuse, and finally witnessing family violence during childhood as this was found in 12.5% of abused women (Table 5) .

Table 5: Characteristics of abused females:

Variable	Physical abuse				χ2	P
	No		Yes			
Age mean ±SD	29.81±6.39		29.73±5.94		0.22	0.8201
Marital status	**No.**	**%**	**No.**	**%**		
Single	11	2.6	30	4.1	6.21	0.010
Married	405	95.5	675	92		
Divorced	3	0.7	16	2.1		
Widow	5	1.2	13	1.8		
No. of children	**No.**	**%**	**No.**	**%**		
No Children	53	12.8	71	10.1	25.69	0.0023
One	63	15.3	80	11.4		
Two	127	30.8	224	31.8		
Three	119	28.8	173	24.6		
Four	36	8.7	112	15.9		
Five or more	15	3.6	44	6.2		
Female occupation	**No.**	**%**	**No.**	**%**		
Not working	202	47.6	562	76.6	94.78	0.000
Working	222	52.4	172	23.4		
Female education	**No.**	**%**	**No.**	**%**		
Illiterate	65	15.3	322	44	119.6	0.000
<6 years	85	19.9	156	21.3		
6-12 years	217	51.3	185	25.2		
>12 years	57	13.4	71	9.5		

While Risk factors for men who perpetrate violence were found to be; receiving less than 6 years of education (42% of perpetrators) and illiteracy (24.4%), physical abuse as a child (24.7% of the abusers were victims of child abuse), witness to father abusing mother during childhood (31%), and abuse of one or more illicit drugs, where (21.5%) of those who abuse their wives were substance abusers (Table 6) .

Table 6: Characteristics of abusing husbands:

Variable	Physical abuse				χ2	P
	No		Yes			
Husband occupation	**No.**	**%**	**No.**	**%**	241.1	0.000
Not working	48	6.8	48	6.8		
Manual worker	566	80.4	566	80.4		
Professional worker	90	12.8	90	12.8		
Husband education	**No.**	**%**	**No.**	**%**	149.0	0.000
Illiterate	171	24.3	29	7		
<6 years	295	41.9	97	23.5		
6-12 years	176	25	176	42.6		
>12 years	62	8.8	111	26.9		
Educational Gap	**No.**	**%**	**No.**	**%**	40.73	0.000
Wife more educated	108	15.3	17	4.1		
Same level of education	360	51.1	273	66.1		
Husband more educated	236	33.6	123	29.8		

The majority of abused women noted that refusing sex was the major (69.9%) cause behind the abuse. This was followed by financial reasons (60.8%), mainly due to withholding money from the victim. While disobedience is commonly portrayed as the most common cause of spouse violence is Arabic culture, only 14% cited this as the prime cause behind abuse (Table 7).

Table 7: Causes of physical abuse as cited by abused women:

Causes of abuse	N	%
Refusing sex	513	69.9
Financial	447	60.8
House duties	250	34.1
Disobedience	110	14.9
Jealousy	75	10.2

We found statistically high significant differences in between groups with regards types of physical violence (Table 8). The abused individuals in the mentally ill group-II had higher prevalence and frequency of slapping, hitting, beating, and kicking than those in group-I. This was evident also with regards to

psychological abuse and its frequency, while for those who were sexually abused there were no statistically significant differences detected.

Our results showed that the most common form of psychological abuse was belittling (66.9%), followed by insulting (65%), abandoning (40%), threatening (29.9%), and frightening (27.9%). While the comments forms of sexual abuse were street harassment (33.3%), touching (25.2%), rubbing (18.9%), attempt of rape (12.6%), actual rape (6.3%), and finally exhibitionism (3.7%).

We found that Major Depression was the most prevalent disorder among abused women, followed by Generalised Anxiety Disorder (17.9%) and Dysthymic Disorder (11.4%). Major Depression and Dysthymia were more pronounced in those who were sexually abused before the age of 16 years (Table 9) .

Table 8: Comparison between groups for the lifetime prevalence of physical, psychological and sexual abuse:

	Group I		Group II		χ^2	P
	No.	%	No.	%		
Lifetime Prevalence of Physical abuse						
Slapping	301	48.5	378	70.3	92.38	0.00
>3times	258	41.6	295	54.9	148.13	0.00
Hitting	52	40.6	376	69.9	160.37	0.00
>3times	201	32.4	298	55.4	202.11	0.00
Beating	250	40.3	351	65.2	113.5	0.00
>3times	207	33.4	275	51.1	155.32	0.00
Kicking	156	25.2	306	56.9	144.55	0.00
>3times	138	22.2	252	46.9	166.38	0.00
Lifetime Prevalence of Psychological abuse						
<3 times	59	9.5	132	24.5	247.8	0.00
>3 times	261	42.1	286	53.2		
Lifetime Prevalence of Sexual abuse						
Before 16	46	7.4	26	4.8	3.31	0.06
After 16	48	7.7	39	7.2	0.1	0.75

Table 9: Distribution of psychiatric disorders among abused females:

	Sexual Abuse				Psychological Abuse		Physical Abuse	
	Before 16 y		After 16 y					
	N	%	N	%	N	%	N	%
Psychotic disorder	2	2.8	8	9.2	50	7.4	45	7.4
Major depressive disorder	39	54.1	29	33.4	175	25.8	190	31.5
Dysthymic disorder	11	15.3	3	3.4	81	11.9	69	11.4
Bipolar disorder	0	0	12	13.8	41	6	40	6.6
Generalized anxiety disorder	1	1.4	0	0	96	11.9	40	6.6
Panic disorder	3	4.2	0	0	19	2.8	21	3.5
OCD	0	0	0	0	8	1.2	14	2.3
Somatoform disorder	8	11.1	22	25.3	86	12.7	91	15
Personality disorder	2	2.8	6	6.9	15	2.2	15	2.5

DISCUSSION

Violence against women is a global pandemic; and in developing countries, violence and discrimination against women are even more of a serious problem. Women in developing countries not only face systematic civil, socio-economic and political discrimination and inequity (Bunch, 1997); but also are frequently subjected to assault, rape, humiliation, verbal and psychological abuse, mutilation, and even murder. Arabic countries are not an exempt. Despite the scarcity of research, available evidence indicates a high prevalence of violence against women in Arabic countries. Surveys in Egypt, Palestine, and Tunisia show that at least one out of three women is beaten by her husband (Douki, et al. 2003). In this study, we report a lifetime prevalence of 43.1%, 44%, and 7.4% of physical, psychological, and sexual abuse respectively in a sample of medical outpatient clinics attendees. Our results, in respect to physical abuse, were very proximate to the results of other previous local studies by El-Zanaty, et al. (1996) and Tadros, (1998); while substantially higher than a more recent study by Hassan, et al. (2000) reporting a lifetime prevalence of only (11.1%).

We believe that the high prevalence of women abuse in Arab countries can be attributed to a myriad of interrelated factors. Culture, religion, media, and other socio-demographic factors play are important dimensions of such a complex problem.

The Arabic culture -with its inherent mediocre attitudes toward females, sex role stereotypy, non-egalitarian gender expectations, and patriarchal beliefs frames women in a subordinate position and deprive them of an equal social, economic, and political role. This skewed gender position can create a perfect milieu for female victimization in Arabic societies. Moreover, as with any patriarchal society, this skewed gender position is overly evident within the family context where

men traditionally enjoy ultimate power and uncontested right of decision making. Whenever men perceive threats to these powers and privileges, retributions and punishment may result which can lead to an increased likelihood of violence. Additionally, the conservative family oriented Arabic societies tend to minimize events that can disturb the family structure or function in order to preserve the family, even at the expense of individual family members. Hence, acts of violence against women at home are routinely trivialized as domestic matters and usually kept in secret (Douki and Nacef, 2002). Also misogynist violence such as female genital mutilation and honour killings are dismissed as cultural norms preserving the honour of the family.

Another important factor may be the misinterpretation of Islamic rules. Despite that the core of Islam affirms the equality of all human beings, and rejects all discrimination on the basis of race, class and gender. In particular, it gave women the right to equal education and civil and economic rights. Yet, still some exceptional rules related to marriage, divorce, witnessing capacity, and heritage are generalised and misinterpreted in favour of men's superiority and sometimes erroneously used as a religious justification for the use of violence against any misbehaviour by women.

Contributing to the aggravation of the problem is the role of the media. The high illiteracy rate among Arabic women (Hammoud, 2006), gives the media an uncontested role in dictating their behaviour and responses. Desensitization is a well-documented effect of viewing violence (Cantor, 2000). When women see scenes of violence against women perpetrated in media, they respond with indifference, apathy, or implicit approval, making such an aggression appear justifiable and acceptable. On the other hand, in perpetrators, desensitization reduces arousal and emotional disturbance and decrease sympathy for the victims. This may not only be a prime for violence; but can also increase the severity and frequency of abuse. Meanwhile, women in the Arabic media are sometimes stereotypically represented as passive, dependent, and helpless. This unfortunate image reinforces dependent attitudes and low self esteem. Women with such attitudes will accept violence and therefore not take any action to end the abuse (Guenena and Nacef, 1999).

There is no single sociodemographic factor that solely account for violence against women, hence research increasingly focused on common and usually interrelated social and demographic determinants (Heise, et al. 1994). These include age, education, and employment.

Young age has been always viewed as a risk for violent victimisation of women. Rennison and Welchans, (2000) reported that women between the age of 16 and 24 experience the highest per capita rate of violence. In our study the mean age of abused women was slightly higher 29.73±5.94; but there was no difference between the mean age of abused versus non abused females (p=0.82). Education is an important determinant of violence. Research indicated that years of education are usually lower among victims (Rodriguez, et al. 2001) and perpetrators (Hassan, et al. 2000) of violence. In our study; the abused victims and their abusers had high statistically significant lower education than the non-abused group. The educational gap between partners appears to play an important role as research suggests that abuse may escalate when a woman has a better education than her partner (Raphael, 2000). In our study, physical abuse was minimal (4.1%) when wife had a better education, whilst abuse was higher when both partners had the same level (66.1%) or husband being better educated (29.9%). Therefore, better female education can exert a favourable mitigating effect on rates of domestic violence. Work appears to be also a protective factor; we found that physically abused females had higher rates of unemployment which was highly statistically significant in comparison with the non abused group.

"Violence begets violence, and abuse breeds abuse" (Widom, 1989). Childhood maltreatment and abuse not only increases the risk of later partner abuse (Straus, 2000); but also the risk of Women re-victimization in adulthood (Coid, et al. 2001). A quarter of husbands with a history of childhood physical abuse in this study abused their wives. This rate nearly averages between other reported findings of 18% (Ehrensaft, et al. 2003) and 27% (Hassan, et al. 2000). On the other hand, we found that 17.3% of abused women were maltreated as children, which was close to the previous report of 18.2% by Hassan, et al. (2000). In the same context, witnessing or observing domestic violent behaviour can have a similar negative impact (Widom, 1989). Dodge, et al. (1990) found that men who as children witnessed domestic violence were twice as likely to abuse their own wives. In our study we found that 30% of abusing husbands witnessed domestic violence. Nearly, the same rate (27%) was reported by Ehrensaft, et al. (2003). Conversely, research indicted that witnessing familial violence can increase the risk of future women victimization two times (Garcia Linares, et al. 2005). This was further reflected in our finding that 13% of physically abused versus only 7.5% of non-abused women witnessed domestic violence (p=0.051).

Psychiatric consequences of violence against women:

Even though there is a recent plethora of data on violence against women, there are only few studies that systematically investigated its mental health consequences, despite the consensus that the psychological impact of violence can be more debilitating than physical injuries (Roberts, et al. 1998).

Ellsberg, et al. (1999) found that physical abuse accounted for approximately 70% of mental health problems among women. In our study we find that 81.7% of physically abused women have psychiatric disorders in comparison to only 34.5% of the non abused women. Thus, being a victim of abuse appears to increases the vulnerability to mental disorder roughly around 2.5 times.

The cause-effect relationship between violence and mental health problems is a matter of scientific debate and a baffling dilemma that is confounded by several factors, including the possibility of reverse causality. Clinicians are sometimes puzzled by this chick and egg question, and some consequently believe that mental health problems in this population should be treated as sequel symptom of abuse and not as mental disorders perse (Gondolf, 1998). This approach may deny treatment possibilities, result in a negative outcome, and increase the suffering of this already disadvantaged group (Jenkins and Davidson, 2001).

In several cases mental health problems can postdate the abuse (Cascardi, et al. 1995). In our study psychiatric disorders surfaced as common consequences of abuse. We found that the abuse predated the mental disorder in 80% of cases of somatoform disorder, 65% of cases of anxiety disorders, and 60% of cases of depression. Hence, it appears that the experience of abuse often erodes women's mental health leading to a variety of disorders.

Major Depression can affect one third of battered women (Roberts, et al. 1998). In this study, major depression was three times more in abused (25.9 %) versus non abused women (8.5%). Moreover, victims of abuse are more liable to suffer from Generalized Anxiety Disorder (Foa, et al. 2000). We found that GAD was the second most common psychiatric disorder in battered women (14.7%) in comparison to only 7.1% in non abused women.

Suicidal attempts and Deliberate Self Harm are common in abused women to escape or block the pain and suffering (Bergman and Brismar, 1991). We found that 10.4% of the physically abused women had attempted suicide at least once. In a culture with traditionally low suicide rates and negative attitude towards suicide (Okasha, 2001), such rates of suicide attempts in this population should be alarming. Hence, when clinicians are confronted with a female patient who has attempted suicide should always consider the possibility of ongoing physical abuse.

In general, Egyptians subjects tend to translate their feelings into a body language and mask their emotions behind multiple somatic complaints (Okasha, 2001). Hence, Somatoform Disorders are of particular importance as they can represent the disguised suffering of alexithymic and emotionally suppressed abused females. Lown and Vega, (2001) found that women who reported abuse were significantly more likely to complain of persistent health problems and one or more significant somatic symptoms. McCauley, et al. (1995) reported 19.7% prevalence rates for somatization among abused women which is near to our finding of 12.8%. Furthermore, for abused women Somatization (57.1%) was the commonest type of Somatoform Disorder followed by Hypochondriasis (17.5%), Conversion Disorders (14.4%) and finally Somatoform Pain Disorders (11%).

Psychological abuse: The impact of psychological abuse alone is understudied, despite the fact that it can be devastating on health sometimes even more than physical violence (Coker, et al. 2000). On of the major problems facing research in this arena is the lack of standardization regarding what acts mount to qualify psychological abuse, as there is a wide cultural and social variation in this respect. In our study we found a lifetime prevalence of 52.7% and 42.1% for psychological abuse in psychiatric and non-psychiatric subjects respectively. However, Hassan, et al. (2000) reported lesser lifetime prevalence (22.2%) for this type of abuse.

Sexual abuse: Sexual aggression as a separate form of aggression is frequently ignored, and usually combined with physical violence. This is particularly unfortunate since the majority of physically abused women are also sexually assaulted (Monnier, et al. 2002) thus making the consequences of each type of abuse difficult to disentangle (Coker, et al. 2003). In our study we found a rate prevalence of 7.5% and 6.2% for sexual abuse before and after 16 years of age respectively. This lower prevalence may be an underreporting that can be partly attributed to the sensitivity of this issue as Arabic women fear the stigma if they broke their silence. Women who are sexually assaulted are socially rejected and their reputation is ruined. In Arabic cultures people usually hold women responsible for being sexually abused. Amidst the double standards of Arabic society, a woman would thereby be the victim and the accused at the same time.

Sexual abuse is destructive and has profound consequences and impact on the mental health and development of victims. Depression is often the most frequent symptom in survivors of childhood sexual abuse. Victims of sexual abuse are three times more likely than non victims to experience major depressive disorder (Green, 1993). We found comparatively higher rates of major depression (54.1%) and dysthemia (15.3%) in those who were sexually abused before the age of 16, while personality disorders were evident in those who were sexually abused at a later age. On the other hand, sexual abuse, especially at early ages places the woman's sexual development and future

intimate relationships at jeopardy. Sexually abused women usually respond to this trauma by heightened anxiety about sexual contact and avoidance of relationships.

Prevalence of abuse among Psychiatric patients:
Although a significant body of research has focused on the victimization of severely mentally ill persons, relatively little attention has specifically addressed violence inflicted against mentally ill women (Friedman and Loue, 2007). This victimization may have a detrimental impact on the outcome and quality of life of these individuals and may be a further disadvantage in an already vulnerable population (McFarlane, et al. 2006). In our study, the prevalence of physical abuse in the psychiatric patient group was 86.8% which is higher to some extent than the WHO study and the demographic health survey. This may be attributed to the difference in the type of the sample. Mental illness is also a well recognised risk factor for physical abuse. Briere and Jordan, (2004) found that between 51% and 97% of women diagnosed with mental illness reported experiencing lifetime physical and psychological violence.

Some mental disorders may increase the risk of victimization. In this study, we found a high prevalence (86.5%) of abuse among patients with Schizophrenia. In these individuals, problems with reality testing, impaired judgment, negative symptoms, cognitive deficits, and difficulties with social relationships can increase vulnerability to abuse. Moreover, the disturbed behaviour in schizophrenia is sometimes culturally attributed to acts of possession by spirits, jinni, sorcery, or envy-eye. This in itself can predispose to a unique type of physical abuse since families with such beliefs usually take their patients to traditional healers who hit them, cut them, or even suffocate them in order to rid off the evil spirit or jinni.

In bipolar patients, the prevalence of abuse was 88.8%. In these individuals manic and the associated disinhibited behaviour constitutes a breach in the social norms especially in females and usually interpreted as a major conduct problem which is dishonouring to families. Such patients are usually isolated, restrained, subjected to various forms of violence, and may face honour-killing. Furthermore, sexually disinhibited behaviours are often misinterpreted as flirtation and seduction which can increase sexual victimization in these individuals.

Depressive disorders may be a major cause of violent victimization in mentally ill individuals. Our study revealed a high prevalence of abuse (84%) among patients with Depression. Abused individuals cited the refusing sex (69.9%) and negligence of household duties (34.1%) as common causes behind violence. In Major depression, neglect of appearance, loss of pleasure and decreased libido may be interpreted as sex refusal which may render them more prone to abuse by their sexually-demanding partners. Moreover, the loss of interest, apathy, low energy and motivation usually impacts on the patient's activities of daily living and ability to cope with household duties and parenting requirements, and hence my precipitate abuse.

Abuse during pregnancy:
Women appear to be at a higher risk of abuse during pregnancy. Abuse during pregnancy can be partly attributed to the younger age of partners, leading to ignorance of responsibilities and the higher prevalence of unplanned and/or unwanted pregnancies. Estimated rates of violence during pregnancy vary depending on the study design and sample selected. Gazmararian, et al. (1996) estimated that between 4% and 17% of all women are abused during pregnancy. This is reflective to our finding that 16.6% of physically abused women experienced abuse during pregnancy (Table 7).

RECOMMENDATIONS

The finding of high prevalence rates of several forms of abuse against women in this study screams for a unified approach where political, social, and religious leaders should endeavour to improve women's legal and socioeconomic status as an initial step to promote her position in such a patricentric culture. Challenging the commonly held misconceptions, the deeply rooted cultural attitudes, and the erroneously interpreted religious beliefs should be done through culturally sensitive and effective awareness programs that challenge women subordination. This should be coupled with a parallel development in the governmental policies and the legislative arena to consolidate the women's right to an equal social, economic, and political role and protect their physical and psychological wellbeing. Moreover, primary prevention programs for violence against women should address the needs for better education, vocational training, and increased employment opportunities for females; develop education campaigns to increase the awareness with the problem, and exert control on unsolicited violent media scenes. In addition, it is necessary to support women living with violence, and develop a comprehensive health sector and social care response to tackle the various physical, psychological, and social consequences of violence against women. Finally, to endeavour to collate systematic data that can be incorporated to produce national statistics and to stimulate interdisciplinary research in this critical area to allow better understanding of the problem and produce evidence-based knowledge that can usefully inform the policy makers.

CONCLUSION

Violence against women is a global public health and social problem that may be particularly evident in developing countries. The magnitude of the problem

is wide, its dimensions are complex, and its impact is horrific. Victims of violence against women suffer from adverse physical, mental, and social consequences. The mentally ill females are particularly vulnerable to several forms of abuse, which adds to their suffering and their already disadvantageous position. In Arabic societies, several measures should be implemented not only to tackle this undesirable social phenomenon; but also to improve the social, economic, and political status of females. Still more research and national data are therefore needed to draw an informed portrait of this complex problem.

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