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Article

Relationship between intimate partner violence and depression symptoms in Turkish women: A cross-sectional study

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Abstract

Background: Understanding the relationship between intimate partner violence (IPV) and depression/depressive symptoms is important in developing strategies to reduce the burden of depression and prevent IPV and its effects.
Objectives: This study examined the relationship between IPV against women and depressive symptoms.
Methods: This cross-sectional study conducted on 485 women from January to June 2023 in Turkey. Data were collected using a questionnaire assessing sociodemographic characteristics, Beck Depression Inventory (BDI), and Intimate Partner Violence against Women Scale (IPVAWS). Data were analysed using Student's t-test, ANOVA, Pearson correlation and multiple linear regression analysis in SPSS 24 software.
Results: IPV and depression were found in 45.6% and 24.9% of the women, respectively. According to the multiple linear regression analysis, in which sociodemographic variables were controlled, one-unit increase in violence exposure scores increased the BDI scores by 0.49 times ($p<0.001$).
Conclusion: Regardless of sociodemographic characteristics, beliefs about violence, and perceived social support, depressive symptomatology increased with increasing IPV exposure in women. Healthcare professionals should keep in mind the possible underlying exposure to intimate partner violence in women with depressive symptoms.

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Implications of this paper in nursing and midwifery preventive care:
Education and prevention efforts to increase public awareness of depression and IPV can be important steps in protecting and improving women's health. Considering intimate partner violence exposure as a possible underlying cause of depressive symptoms may guide the design of depression diagnosis and treatment

Introduction

According to the World Health Organization (WHO), intimate partner violence (IPV) is defined as violence perpetrated by current and former partners in an intimate relationship. The frequency and severity of violence may vary over time and may include physical, sexual, psychological, and/or economic coercion. All forms of violence have psychological consequences because the main purpose of violence is to harm the integrity and dignity of another person [1].

IPV is recognized as a significant public health issue and a violation of human rights [1]. Its prevalence is alarmingly high at global, regional, and national levels [2]. As per WHO's report, one in three women worldwide has experienced physical or sexual violence from their intimate partners at some point in their lives. In 2018, the lifetime prevalence estimates of IPV were as follows: 20 percent in the Western Pacific, 22 percent in high-income countries and Europe, 25 percent in the WHO Regions of the Americas, 33 percent in WHO Africa, 31 percent in the WHO Eastern Mediterranean, and 33 percent in WHO Southeast Asia [2]. A synthesis of the literature reveals that the reported rates of IPV in Turkey vary significantly across different studies, ranging from 13% to an astounding 78% [3].

IPV can have a devastating impact on the physical, sexual, and mental health of victims [4,5]. IPV is associated with increased mortality, injury and disability, poor general health, chronic pain, substance abuse, reproductive disorders, and

poor pregnancy outcomes [4]. Depression is one of the most common consequences of IPV. Depression is a serious health problem that can cause various symptoms such as constant sadness, loss of interest in activities, changes in appetite, sleep disorders, difficulty concentrating, and thoughts of death or suicide [4,5]. According to WHO data, the rate of depression, which is one of the leading causes of disability worldwide, is 4.4% [6]. In Turkey, approximately 17% of 83 million people face mental health problems and 3.2 million people suffer from depression [7]. Studies conducted at the regional level involving women at different life stages have reported that the prevalence of depression varies from 7.3% to 42.2% [8].

A systematic review and meta-analysis showed that there were moderate or strong positive associations between IPV and depression, the risk of depression increased 1.5-2-fold in IPV victims, and the majority of depressive outcomes (9%-28%) were associated with lifetime exposure to IPV [9]. IPV may trigger a depressive episode or the stress of living in a violent relationship may lead to chronic depression. IPV can also make it difficult for victims to access the resources and support they need to cope with trauma and lead healthy lives [10,11]. It is stated that it is important to understand the relationship between IPV and depression/depressive symptoms in reducing the burden of depression and developing strategies to prevent IPV and its effects, and more research is needed in this regard [9]. Intercultural differences in the relationship between IPV and depression have also been reported. Differences in help-seeking, coping strategies, racism, and cultural values may mediate the effects of IPV on depression [12].

In Turkey, patriarchal traditions and gender inequality often create an environment in which violence against women is considered acceptable and justified. Turkey has a history of conflict and violence. This contributes to a culture of violence that leads to an increase in violence against women [3]. In addition, many other factors can play a role in increasing violence, such as economic insecurity, lack of access to justice, and mental health problems [13]. In Turkey, the relationship between IPV and mental health outcomes is mostly limited to research results on clinical samples [14,15] or specific target groups, such as postpartum or pregnant women [16]. One study addressed the relationship between different forms of IPV and depressive symptoms in women [17]. However, although cultural beliefs play a role in violence [13], and the protective effect of social support on mental health in IPV victims is known [18], no study has addressed the relationship between IPV and depressive symptoms in this context. All these factors make it difficult to explain the link between IPV and depression. Therefore, this study aimed to examine the relationship between violence perception, social support variables, and depression in IPV.

Methods

This cross-sectional study was conducted online between January and June 2023. Convenience sampling was then performed. Women in the 15-64 age groups living with their husbands/partners, who voluntarily agreed to participate, were included in the study. Women who were separated or divorced from their husbands during the study period were excluded from the study.

The formula of sample size with an uncertain universe was used to calculate the sample size of the study [19]. According to the results of the Domestic Violence against Women in Turkey Survey 2009, 36% of women age group–15-59 years were exposed to violence for any reason [20]. Based on these data, the minimum number of women to be included in the sample was calculated as 355, with t=1.96, p=0.36, and q=0.64 at the 95% confidence interval according to this formula: $n = t^2. (p.q)/ d^2.$ In addition, before starting this study, power analysis was performed using the G. Power 3.1 program. From the data collection dates, 503 women voluntarily participated in the study. However, as 18 women did not meet the inclusion criteria, the study was conducted with 485 women. At the end of the study, post-hoc power analysis was performed using the G power 3.1 program. According to the Pearson correlation coefficients between IPV and depressive symptoms in the current sample size (r=0.132-0.515), when the two-sided α error was 0.05, the statistical power varied between 0.83-0.99.

Data were collected using a questionnaire assessing socio-demographic characteristics (age, education level, employment status, marital status,

place of residence, income level, and family type), the Beck Depression Inventory, and the Intimate Partner Violence Against Women Scale.

Beck Depression Inventory (BDI): BDI developed by Beck et al. (1987) and adapted to Turkish by Hisli (1988) was used in this study [21]. The BDI is a 21-item Likert-type scale that measures vegetative, emotional, cognitive, and motivational symptoms of depression. A minimum score of 0 and a maximum score of 63 were obtained from the scale. The cut-off score of the scale was 17, which indicates that depression requires treatment. The internal consistency coefficient of the BDI has been reported to be 0.93 [21]. In this study, the coefficient is 0.92.

Intimate Partner Violence Against Women Scale (IPVAWS): This scale was developed by Deniz in 2019 specifically for Turkish culture to measure the type of violence, perceptions of social support related to violence, and common beliefs about violence related to spousal violence experienced by women [22]. The five-point Likert-type scale consists of 29 items and three sub-dimensions. These sub-dimensions were types of violence (18 items), perceptions of social support (6 items), and common beliefs about violence (5 items). In scoring the scale, items 12, 15, and 16, which were positive in terms of the need for social support in the face of violence, were reversed and scored. An increase in the scores obtained from the violence subscale indicates an increase in women's exposure to types of violence (physical, psychological, economic, and sexual), an increase in the scores obtained from the perception of social support subscale indicates a decrease in perceived social support, and an increase in the scores obtained from the beliefs about violence subscale indicates an increase in false beliefs about IPV. The internal consistency coefficient of the scale is reported to vary between 0.73 and 0.93 for the total score and the subscales [22]. In this study, the coefficients calculated for the total score and subdimensions of the scale were between 0.74 and 0.86. In this study, the total score of the violence subscale was dichotomised using the median as the cut-off point. Accordingly, those with a score ≤20 was coded as having no IPV, and those with a score >20 were coded as having IPV.

Data collection tools were transferred to Google Forms and applied online. To determine the validity and reliability of the data collection forms, 10 women who met the inclusion criteria were pretested using Google Forms. Women who were included in the pre-test were excluded from the study. After the pre-test process, the form was shared with the researchers' personal communication networks through free communication applications (WhatsApp) and social networks (Facebook and Instagram). On the first page of the online form, an information page was created for women to tick and confirm their participation in the study before accessing the questionnaire. On this page, the purpose of the study was explained, the possible benefits to be obtained were stated, information about confidentiality was given, participants were asked to voluntarily participate in the study and their consent was obtained. Participants were also asked to share the study form with other women to increase the sample size. Google Form remained open for women to fill out the questionnaire between January and June 2023.

The study data was evaluated using the SPSS (24.0, IBM Corp., Armonk, NY) software package. Descriptive statistics were used, including number, percentage, mean, and standard deviation. Skewness and kurtosis values were used to assess normal distribution. In the study, data were evaluated using Student's t-test, one-way analysis of variance (ANOVA), Pearson correlation and multiple linear regression analysis. It was checked that the necessary conditions for the correct use of multiple linear regression (normality, linearity, no multicollinearity, homoscedasticity, normality of the error distribution, and independence of the errors) were met. The results were evaluated at a 95% confidence interval and a significance level of $p < 0.05$.

Results

The mean (SD) age of the women who participated in the study was 30.54 (9.11) years (median: 27 Min-Max: 15-64). The relationship between women's descriptive characteristics and IPVAWS and BDI scores are presented in Table 1. It was found that IPVAWS and BDI scores showed significant differences in terms of marital status, education level, employment status, economic status, family type, and place of residence ($p<0.05$).

Table 1: The relationship between women's descriptive characteristics and IPVAWS and BDI scores (N=485)

Characteristics		N (%)	IPVAWS scores Mean (SD)	BDI scores Mean (SD)
Marital Status	Married	342 (70.5)	45.80 (13.81)	10.90 (10.65)
	Single	143 (29.5)	42.68 (11.43)	13.09 (10.01)
	t/p		2.384(0.017)	-2.181(0.010)
Level of education	Primary School	103 (21.2)	49.38 (17.35)	12.64 (11.99)
	High School	174 (35.9)	45.86 (14.25)	11.50 (10.62)
	University and above	208 (42.9)	41.84±8.39	9.68±9.34
	F/p		12.533(0.000)	3.127(0.045)
Employment status	Yes	220 (45.4)	43.16 (10.72)	9.68 (9.18)
	No	265 (54.6)	46.31 (14.85)	12.02 (11.32)
	t/p		2.627(0.007)	2.465(0.012)
Family Type	Nuclear family	383 (79.0)	43.44 (10.98)	14.39 (12.58)
	Extended family	102 (21.0)	50.30 (18.53)	10.05 (9.63)
	t/p		4.757(0.000)	3.774(0.000)
Economic situation	Income less than expenditure	147 (30.3)	46.93 (15.76)	14.14 (11.62)
	Income equal to expenditure	258 (53.2)	44.56 (12.30)	10.12 (9.77)
	Income more than expenditure	80 (16.5)	42.17 (10.18)	7.85 (6.87)
	F/p		3.567(0.029)	11.662(0.000)
Place of residence	Village	70 (14.4)	52.00 (18.59)	14.72 (12.65)
	District	191 (39.4)	44.14 (12.35)	11.19 (10.61)
	Province	224 (46.2)	43.29 (11.12)	9.59 (9.24)
	F/p		12.619(0.000)	6.652(0.001)

BDI: Beck Depression Inventory; SD: Standard Deviation; IPVAWS: Intimate Partner Violence Against Women Scale; t: student t-test was used; F: one-way analysis of variance

The distribution of the scores obtained by the participants from the IPVAWS and BDI is shown in Table 2. The total scores were found to be 44.88 (13.22) for the IPVAWS and 10.9 (10.46) for the BDI. IPV and depression were found in 45.6% and 24.9% of the women, respectively.

Table 2: Distribution of mean scores of IPVAWS and BDI (N=485)

IPVAWS	Mean (SD)	Median	Min-Max
Total scores	44.88 (13.22)	41	29-116
Subscale score			
Violence exposure	24.25 (10.52)	20	18-76
Social Support Perception	14.96 (4.72)	16	6-28
Beliefs About Violence	5.66 (1.97)	5	5-24
BDI	10.9 (10.46)	8	0-51
Depression according to the BDI	**N**	**%**	
None (BDI score <17 points)	364	75.1	
Present (BDI score ≥17 points)	121	24.9	
IPV according to IPVAWS			
None	264	54.4	
Present	221	45.6	

BDI: Beck Depression Inventory; SD: Standard Deviation
IPVAWS: Intimate Partner Violence Against Women Scale

The results of the Pearson correlation analysis between the BDI and IPVAWS total and subscale scores are shown in Table 3. Significant positive correlations were found between age (r=0.246)

the subscale scores of IPVAWS (r=0.515), perception of social support (r=0.132), beliefs about violence (r=0.215), and BDI total scores (p< 0.01).

Table 3: Results of Pearson's correlation analysis between BDI and age and IPVAWS total and subscale scores (N=485)

			BDI total score
Age		r	0.246
		p	0.043
IPVAWS	Total scores	r	0.495
		p	<0.001
Subscale score	Violence exposure	r	0.515
		p	<0.001
	Social support perception	r	0.132
		p	0.003
	Beliefs about violence	r	0.215
		p	<0.001

The multiple linear regression results obtained after adjusting for sociodemographic variables (age, marital status, education level, employment status, income, family type and place of residence) is shown in Table 4. In the presence of sociodemographic variables revealed that there was a statistically significant relationship between the violence types subscale scores of the IPVAWS and the total score of the BDI. An increase in the violence subscale score by 1 point was found to cause a 0.49 increase in BDI scores (p < 0.001). However, opposite results were obtained regarding the relationship between social support perception and common beliefs about violence subscale scores and the total BDI score (p > 0.05) (Table 4).

Table 4: Multiple linear regression analysis results for IPVAWS and BDI total score after adjustment (N=485)

IPVAWS Subscale	BDI total score							
	B	SE	β	t	p	%95 CI		R^2
						Lower	Upper	
Violence exposure	0.49	0.05	0.50	10.68	<0.001	0.40	0.59	0.27
Social support perception	0.12	0.09	0.05	1.37	0.170	-0.05	0.29	
Common beliefs about violence	-0.09	0.24	-0.02	-0.38	0.700	-0.56	0.38	

BDI: Beck Depression Inventory; IPVAWS: Intimate Partner Violence Against Women Scale; B: Regression coefficient; SE: Standard error; β: Standardized regression coefficient; CI: Confidence Interval; R^2: Adjusted variance.

Discussion

This study, which aimed to examine the relationship between IPV and depression, found that one in four women exhibited depressive symptoms that required treatment, and one in two women experienced IPV. These findings support the results of studies reporting that IPV and depression are serious public health problems at global and regional levels [3,7,20,23]. According to a global estimate based on data from 2000 to 2018, more than a quarter of women aged 15–49 years who have a partner have experienced physical and/or sexual violence since the age of 15 years. Even in Central Europe (16%), Central Asia (18%), and Western Europe (20%), the three regions with the lowest lifetime prevalence estimates of IPV have high rates [23]. Turkey is no exception in terms of the prevalence of gender-

based IPV perpetrated against women by male partners worldwide. According to official data, the lifetime rate of physical and/or sexual IPV in Turkey is 38%, and the rate of physical and/or sexual IPV in the last 12 months is 11% [20]. As one author noted, Turkey has become a laboratory of violence that requires further research and comprehensive policies on gender equality [24].

Intimate partner violence (IPV) is a chronic stressor that can lead to persistent feelings of threat [24]. This prolonged stress response can activate the hypothalamic-pituitary-adrenal (HPA) axis, increasing the release of stress hormones such as cortisol, and potentially triggering psychopathological conditions [25]. Additionally, IPV-related traumatic experiences can negatively impact cognitive functioning [26], reduce self-worth and self-esteem [27], and foster beliefs about powerlessness in changing violent situations [28]. These factors can contribute to feelings of helplessness and hopelessness, predisposing individuals to various mental disorders including depression [29]. Research has consistently demonstrated a strong association between IPV and a range of mental health problems such as depression, anxiety, PTSD, and suicidality [11,12,15,26]. The severity of IPV has been positively correlated with an increased risk of clinical depression [30]. The findings of this study show that IPV alone can increase depressive symptomatology, which is in line with previous research [4,5,15]. It is important to note that the relationship between IPV and depression may vary across cultures. A systematic review suggested that cultural values can mediate this association [31]. Factors such as help-seeking behaviors, coping strategies, racism, perceived social support, and individual beliefs can influence both the intensity and course of the link between IPV and depression [30,31]. These findings underscore the importance of developing culturally sensitive interventions to address IPV and to promote mental health outcomes. Such interventions should consider cultural contexts and individual differences to effectively support those affected by IPV and mitigate its impact on mental health.

Social support is considered a factor that may alleviate the negative mental health consequences of IPV, including depression [13,30,32,33]. Social support is thought to reduce the risk of depression by increasing women's psychological resilience and their capacity to cope with the emotional effects of IPV [30,32,34]. It has also been reported that social support may mediate the relationship between IPV and depressive symptoms [35]. The presence, quality, and perceived impact of social support may moderate its effect on depression [32]. A supportive social environment increases women's capacity to cope with violence, improves their sense of safety and well-being, and facilitates coping [34]. One study reported that social support was associated with increased resilience. The same study found that women who believed their community was supportive and that they could easily find money in an emergency may be more likely to be resilient, while women who received negative reactions when they disclosed IPV may have decreased resilience [33]. Another study stated that women with a strong support network (such as family members, friends, neighbors, and health professionals) have a higher sense of self-efficacy and ability to seek help and are therefore more likely to leave a violent relationship and establish an independent life [30]. Women with inadequate social support or who receive conflicting messages from close supporters (e.g., continuing to live with their partner or not receiving clear advice to leave their partner) are less likely to engage in problem-focused coping with IPV and experience more mental health symptoms [32]. On the other hand, a systematic review has shown that the effects of social support on mental health could not be the same for all IPV survivors and that socioeconomic background, culture, and IPV survivors' perception of abuse may influence decisions to access social support and use referral services [34]. Unlike previous studies [30, 32, 33], this study did not find a strong relationship between social support and depression. In societies where false beliefs shaped by cultural and societal norms (such as legitimization and normalization of violence) are prevalent, services aimed at preventing violence are inadequate [13, 31-33]. Most victims of violence do not receive formal (such as government, health workers, and official social organizations) or informal (e.g., family members, relatives, and neighbors) social support for reasons such as expectations of sacrifice imposed by patriarchal family structures [3], belief that violence is something to be hidden

[24,36], protection of family honor, belief that seeking help is futile, and not being taken seriously [3, 24]. Traditional gender beliefs are also known to legitimize, support, and perpetuate violence against women [24]. Factors associated with IPV in Turkey include poverty, inadequate social support and employment opportunities, male dominance at the community level, and cultural acceptance of violence [13]. Turkey was the first and only country to withdraw from the Istanbul Convention, a unique and progressive international landmark agreement on violence against women [37]. According to the, We Will Stop Femicides Platform Association, after the withdrawal of the Convention, the rate of women killed by their intimate partners increased by 25%, women's shelters decreased, access to support services became difficult, an environment of impunity was created for perpetrators of violence against women, and some perpetrators were pardoned [38]. All of these factors may limit sources of social support for the women in this study, reduce the perceived impact of support, and minimize the potential protective effects of social support on depression symptoms.

According to Do et al. [39], the association between IPV and mental health symptoms is moderated by partners' cultural beliefs about abuse. The more a woman believes that her husband is justified in his abusive behavior, the stronger the relationship between IPV and mental health symptoms. Conversely, the more a woman believes that nothing can be done about an abusive husband or that abuse is a private matter, the smaller the relationship between IPV and mental health symptoms [39]. Women living in Turkey mostly believe that men have no justification for being violent and that violent men should be punished [24]. However, believing that nothing can be done to stop the violence, hiding the violence they experience out of shame, believing that they will be blamed and condemned, remaining silent, submitting, and being patient are among the commonly reported beliefs and attitudes of women in Turkey [3, 24]. In addition, in Turkish society, where a male-dominated culture and the perception that "husbands love and beat" are dominant, violence is often covered up on the grounds of family privacy [24]. In Latin, Asian, African, and Haitian cultures, family problems, including IPV, are often considered private, and IPV is perceived as a way of life that should be kept secret rather than something that should be questioned [36,40]. The lack of a significant relationship between beliefs about IPV and depression in this study may be influenced by the fact that women in Turkey believe that there is nothing they can do about IPV, and view violence as a private family matter.

The strengths of this study are that it was conducted with a large sample group, violence, and depression were examined using valid and reliable measurement tools, and the relationship between exposure to violence and depressive symptoms was evaluated using multiple regression analysis. However, when interpreting the research findings, it should be noted that they were obtained based on the Declaration of Helsinki. However, the fact that this study was conducted online may distinguish it from studies conducted using traditional methods. However, since it is known that Internet samples vary according to gender, socioeconomic status, geographical region, and age, we believe that our findings present an important cross-section of society.

Conclusion

Depression and IPV are common problems among Turkish women living in Turkey. Approximately one in every four women had depression and one in every two women had experienced IPV. IPV is an independent factor affecting the mental health of women. As the severity of IPV increases in women, their depressive symptoms also increase. Our findings suggest that beliefs about violence and perceived social support have no significant effects on mental health in Turkey. In addition to screening and preventing IPV in women and its effects, health professionals should keep in mind the possible underlying exposure to IPV in women with depressive symptoms. Further research and comprehensive policies are needed to prevent and reduce the effects of IPV and depression.

Ethical Consideration

Before starting the study, approval was obtained from the Marmara University Faculty of Health Sciences Ethics Committee (2023/06).

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Conflict of interest
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Authors' contributions
M. Demirgöz Bal: Concept and design of the study, obtaining approval for performing the study, collecting of data, entering data into SPSS software, and drafting the manuscript.
Ö. Aşcı: Concept and design of the study, searching the literature, data analysis, and drafting of the manuscript. All authors read and approved the final version of the manuscript.

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