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DIFFERENTIAL PSYCHOPATHOLOGICAL PROFILE OF VICTIMS OF INTIMATE PARTNER VIOLENCE ACCORDING TO AGE

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In this paper, differential psychopathological consequences in battered women according to age were analyzed in a sample of 148 victims seeking psychological treatment at a Family Violence Centre. The younger victims exposed to intimate partner violence suffered more often from physical violence and were at higher risk for their lives than the older ones. Prevalence of post-traumatic stress disorder (PTSD) was higher (42%) in the younger victims than in the older ones (27%). Likewise, younger victims were affected by more depressive symptoms and lower self-esteem than the older ones. Severity of PTSD in the younger victims was related to the presence of forced sexual relationship, but in the older ones it was related to perceived threat to their lives. The implications of this study for clinical practice and future research in this field are discussed.

KeyWords: *Battered women. Age. Post-traumatic stress disorder. Psychopathology.*

En este artículo se han estudiado las repercusiones psicopatológicas de la violencia de pareja en la mujer en función de la edad en una muestra de 148 víctimas en un Servicio para Víctimas de Violencia Familiar. Los resultados pusieron de manifiesto que las víctimas más jóvenes sufrían maltrato físico más a menudo y estaban expuestas a un mayor riesgo para sus vidas que las víctimas de más edad. La tasa de prevalencia del TEPT era más alta en las víctimas más jóvenes (42%) que en las mayores (27%). Asimismo, las víctimas de menor edad mostraban más síntomas depresivos y tenían una autoestima menor que las más mayores. A su vez, la gravedad del TEPT en las víctimas jóvenes estaba relacionada con la presencia de relaciones sexuales forzadas; en las víctimas mayores, sin embargo, se relacionaba más con la percepción de amenaza para sus vidas. Por último, se comentan las implicaciones de este estudio para la práctica clínica y para las investigaciones futuras.

Palabras clave: *Mujeres maltratadas. Edad. Trastorno de Estrés Postraumático. Psicopatología.*

Women victims of intimate partner violence in its various forms (physical, psychological or sexual) constitute a substantial sector of the population. According to Spain's Ministry of Work and Social Affairs (Ministerio de Trabajo y Asuntos Sociales, 2002), at least 4% of Spanish women are habitually subjected to violence, and as many as 15% have been victims at some time in their life. Indeed, a recent study by Fontanil, Ezama, Fernández, Gil, Herrero and Paz (2005) estimates the rate of intimate partner violence on women at 20%.

Social alarm increases in response to analyses of the data on deaths at the hands of the partner or ex-partner, with rates of over 3 women per million. Moreover, the highest proportion of deaths occurs in the 15 to 24 age range (5 deaths per million) –that is, the youngest victims (Centro Reina Sofía, 2005).

This type of abuse is the most common cause of psychological suffering in women, as well as the main cause of the reduction of quality of life in the family context and for reasons of gender (Echeburúa & Corral, 1998).

Physical abuse is the most evident form of violence, given the injuries or illnesses it often causes, with the consequent increased probability of its being reported or of the social/health services being contacted. Contact with professionals in the police or judicial framework may enhance motivation to accede to specialist treatment, which permits the victim to distance herself physically and emotionally from the aggressor (Walker, 1984).

Violence by one's partner is associated with a sense of threat to life and to emotional wellbeing due to its serious psychological implications. Therefore, it

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constitutes a risk factor for mental health, in both the short and long term, as has been shown in numerous studies (see Amor, Bohórquez & Echeburúa, 2006; Soler, Barreto & González, 2005).

Abuse evolves on a rising scale as regards its severity and the frequency of the violent acts. Moreover, humiliating behaviour and attitudes of degradation are also intimidating. The victim thus becomes trapped in a violent circle, in which physical and/or psychological aggression occurs repeatedly and intermittently, interspersed with attitudes and behaviours of remorse or good treatment (Walker, 1984).

The victim's first reactions to such events are characterized by feelings of humiliation, shame, worry and fear, which lead to a tendency to conceal the violence. The passage of time can bring a loss of control, confusion and feelings of guilt, which often (and given the context of being in love) hinder the victim from acknowledging herself as such. Finally, chronic emotional distress, perceived loss of control and the fear of suffering a further situation of victimhood within the judicial and legal –or even socio-family– framework, together with other personal factors, maintain the victim in the cycle of violence (Echeburúa & Corral, 1998; Sarasua & Zubizarreta, 2000).

Depression and post-traumatic stress disorder (PTSD) are the consequences most commonly detected in the long term (Amor, Echeburúa, Corral, Sarasua & Zubizarreta, 2001; Echeburúa, Corral, Amor, Sarasua & Zubizarreta, 1997). Indeed, comorbidity of the two disorders in victims of intimate partner violence is quite common (Cascardi, O'Leary & Schlee, 1999; Echeburúa, Corral & Amor, 2002; Stein & Kennwedy, 2001).

Severity of the effects of this victimhood process is related to the intensity of the abuse, but this abuse need not be of a physical nature, with psychological violence also identified as a good predictor of PTSD (Picó-Alfonso, 2005). However, even more numerous are studies in which the incidence of sexual assault within the couple constitutes the best predictor of this disorder (Amor, Echeburúa, Corral, Zubizarreta & Sarasua, 2002; Bennice, Resick, Mechanic & Astin, 2003; Dutton, Kaltman, Goodman, Weinfurt & Vankos, 2005; Kemp, Green, Hovanitz & Rawlings, 1995).

Specifically, PTSD has a high mean prevalence (between 45% and 60%) in intimate partner violence (Cascardi et al., 1999). But despite wide variations in the figures (due to the assessment criteria employed), there appears to be correspondence between the highest rates of PTSD and victims given assistance in women's shelters or safe houses.

The incidence of post-traumatic stress in victims of intimate partner violence, with a mean chronicity of 10 years and who seek specialist treatment without living in shelters, is situated around the mean for this disorder, that is, between 45% and 50% of the victims assessed (Amor et al., 2002; Echeburúa et al., 1997). In any case, according to the *DSM-IV-TR* criteria (APA, 2000) it is far higher than the estimated prevalence throughout life in the general population, for either women (13%) or men (6.2%) (Breslau, Kessler, Chilcota, Schultz, Davis & Andreski, 1998; Breslau, 2001).

The differential incidence of PTSD in relation to gender —the rate in women is double that for men— is basically explained by women's risk of being the victims of sexual violence or assault or other types of violence from males (Amor et al., 2006).

Beyond the psychopathological impact on victims of intimate partner violence, there is a decline in their quality of life and state of health, with a larger number of psychosomatic problems and increased frequency of visits to the GP (Campbell, 2002; Woods & Wineman, 2004). Moreover, intimate partner violence is ranked behind diabetes and childbirth problems as the third most common cause of loss of healthy life years in women (Labrador, Rincón, de Luis & Fernández-Velasco, 2004; Lorente, 2001).

In sum, victims of this type of abuse commonly present symptoms of anxiety and depression and low self-esteem, as well as poorer adaptation to everyday life and greater risk of suicide (Amor et al., 2002, 2006; Mertin & Mohr, 2000; Moscicki, 1989).

More detailed knowledge of the psychopathological profile of victims, as well as of the circumstances of the abuse and the factors involved in its maintenance, can permit the design of treatment programmes more likely to foster psychological recovery and break the link with the aggressor after a long history of abuse (Dutton, 1992; Echeburúa, Corral, Sarasua & Zubizarreta, 1996; Kubany, Hill, Owens, Lannce-Spencer, McCaig, Tremayne & Williams, 2004; Labrador & Rincón, 2002).

A useful source of data in this context is the "Psychological assistance for victims of gender violence" programme run by the Regional Government of Álava (*Diputación Foral de Álava*), a region in the Basque Country (northern Spain). The assistance offered is free and public, and was provided to 1,204

victims between 1997 and 2005). According to the data available from this programme, the rate of drop-out and rejection from the total of victims treated is not excessively high (31%). However, the younger victims tend to reject or drop out of the treatment programme in a much higher proportion (48%) than the older ones (27%) (see Table 1). Thus, in the younger victims there is a much greater risk of remaining in or returning to the violent relationship, which tends to aggravate their psychopathological situation and make them less likely to benefit from the social support network.

Given the lack of studies in this area, the aim of the present research was to analyze the demographic and psychopathological profile of the victims of intimate partner violence in accordance with their age (under and over age 30). It is a question, ultimately, of identifying differential factors for tailoring therapeutic programmes and reducing the percentage of drop-outs and the likelihood of rejection of the treatment.

METHOD

Participants

The total study sample included 148 gender-violence victims who had sought psychological treatment via the above-mentioned psychological assistance programme (*Diputación Foral de Álava*) in 2004 and 2005.

Selection criteria were as follows: a) women over age 18 and victims of physical and/or psychological abuse by their partner or ex-partner; b) not living in a women's shelter (safe house); c) no severe mental illness; and d) voluntary participation in the study after being duly informed (and having signed an informed consent document).

Assessment measures

a) Sociodemographic and abuse variables

The semi-structured interview for domestic abuse victims (*Entrevista semiestructurada para víctimas de maltrato doméstico*; Echeburúa, Corral, Sarasua and Zubizarreta, 1998; modified in 2003) is an extremely useful instrument that permits assessment of the abuse history, its most recent circumstances, and perceived threat to life. It therefore facilitates identification of the variables associated with abuse that is high-risk for both the victim and her children, as well as the coping strategies used. Also assessed are sociodemographic characteristics, psychopathological antecedents and health state, and finally, the legal (civil and penal) measures and sources of social and family support available.

b) Psychopathological variables

The PTSD Symptoms Severity Scale (*Escala de Gravedad de Síntomas del Trastorno de Estrés Postraumático, EGS*; Echeburúa, Corral, Amor, Zubizarreta & Sarasua, 1997) assesses the severity and intensity of the symptoms of this disorder according to the diagnostic criteria of the *DSM-IV-TR* (APA, 2000) in victims of different traumatic events. The scale has a Likert-type format, with values from 0 to 3 for frequency and intensity of the symptoms, and includes 17 items that correspond to the diagnostic criteria (5 refer to re-experience symptoms, 7 to those of avoidance and 5 to those of activation). Ranges are 0 to 51 on the global scale, 0 to 15 on the re-experience subscale, 0 to 21 on that of avoidance, and 0 to 15 on that of activation.

The scale has very high diagnostic efficacy (95.45%) if a global cut-off point of 15 is set and partial cut-off points of 5, 6 and 4 in the re-experience, avoidance and activation subscales, respectively. The psychometric properties are highly satisfactory (Echeburúa et al., 1997).

The *State-Trait Anxiety Inventory (STAI)* (Spielberger, Gorsuch & Lushene, 1970) is a self-report with 20 items related to trait-anxiety and another 20 related to state-anxiety. Range of scores is from 0 to 60 on each scale. The cut-off point set for the female population on the STAI-State is 31 (corresponding to percentile 75). Test-retest reliability is 0.81 on the trait-anxiety scale, much higher –as is logical– than on that of state-anxiety (r= 0.40). Internal consistency varies from 0.83 to 0.92, while convergent validity with other anxiety measures ranges from 0.58 to 0.79.

The *Beck Depression Inventory (BDI)* (Beck, Rush, Shaw & Emery, 1979) (Spanish version by Vázquez & Sanz, 1997) is a 21-item self-report (range: 0-63 points) that measures the intensity of depressive symptoms and gives more importance to the cognitive components of depression than to behavioural and somatic ones. The most commonly used cut-off point for discriminating between the healthy and depressed population is 18 (Beck, Brown & Steer, 1996). Reliability coefficient by the two-halves method is 0.93. From the perspective of

Table 1
Drop-out and rejection rate according to age in the Álava gender-violence treatment programme

1997-2005	<30 years (N= 222)	≥ 30 years (N= 982)
Rejections	47 (21.17%)	99 (10.08%)
Drop-outs	60 (27.02%)	168 (17.10%)
Total	107 (48.20%)	267 (27.18%)

convergent validity, correlation with the clinical assessment of depression ranges from 0.62 to 0.66.

The *Hamilton Rating Scale for Depression* (HRSD) (Hamilton, 1960) (Spanish version by Conde & Franch, 1984) is a hetero-applied instrument for assessing depressive symptomatology, and especially somatic and behavioural components. It tends to be used as a complement to the *BDI*. The cut-off point set is 18 points. Its psychometric properties are satisfactory —it has an inter-observer reliability of 0.90 and a convergent validity coefficient of 0.60; moreover, it is highly sensitive to therapeutic changes.

The *Self-Esteem Scale (SES)* (Rosenberg, 1965; Spanish version by Fernández-Montalvo & Echeburúa, 1997) is designed to assess a person's degree of satisfaction with themselves. This self-report has 10 general items scored 1 to 4 on a Likert-type scale (range: 10-40 points). Cut-off point in the adult population is 29, higher scores meaning higher self-esteem. Test-retest reliability is 0.85, and the alpha coefficient of internal consistency is 0.92. Convergent and discriminant validity are also satisfactory (see Zubizarreta, Sarasua, Echeburúa, Corral, Sauca & Emparanza, 1994).

The Maladjustment Scale (*Escala de Inadaptación, IG)* (Echeburúa & Corral, 1995) is a 6-item self-report (range: 0-30) that measures the extent to which the abuse situation affects different areas of everyday life (work, social life, leisure time, intimate relationship and the possibility of having one, and family relationship), as well as its effects at a global level. The cut-off point set is 12 on the total scale and 2 on each one of the items, and the higher the score, the greater the maladjustment. In the present research we used the item that reflects the degree of global maladjustment to everyday life (range: 0-5 points). The psychometric properties of reliability and validity were satisfactory, and are described in Echeburúa, Corral and Fernández-Montalvo (2000).

Procedure

The women participating in this study were assessed when they contacted the "Psychological assistance for victims of gender violence" programme" (*Diputación Foral de Álava*, Basque Country). The assessment protocol was applied in three sessions by a team of clinical psychologists trained to work in gender violence and supervised by those responsible for the programme (the two first authors), who have extensive experience in domestic violence.

The assessment phase formed part of a clinical intervention. Therefore, the assessing therapist herself subsequently implemented the treatment programme.

The set of victims selected was divided in two groups according to age, with a cut-off point of 30 years, so as to distinguish between younger and older victims.

RESULTS

In this section we present the results obtained in the comparison between the two groups for all the variables studied. First of all we analyze the demographic characteristics and clinical history; secondly, the abuse variables; and thirdly, the psychopathological characteristics. This last point refers to three factors: a) the presence or absence of PTSD and level of severity of the symptoms (according to the PTSD Symptoms Severity Scale); b) emotional distress, according to the tests of anxious (STAI-S) and depressive (BDI and HRSD) symptomatology, of self-esteem (SES) and of maladjustment (IG); and c) emotional distress, as a function of perceived threat to life, existence of sexual violence in the relationship and family support received.

Demographic characteristics and clinical history

The group of young victims (<30 years) is made up of 63 women (X= 25.19; SD= 3.15; with a range of 18 to 29 years) and the older group (≥30 years) of 85 women (X= 43.16; SD= 9.76; with a range of 30 to 69 years).

As regards the demographic variables, the percentage of single women in the younger group (22%) is, as would be expected, significantly higher than in the older group (2%) (χ^2= 42.87; p<0.001). Likewise, the percentage of victims in the younger group who do not live with the aggressor is significantly higher (76%) than in the older group (41%) (χ^2= 6.17; p<0.05).

As far as occupation is concerned, a significantly higher percentage of victims (52%) in the older group are in paid employment than in the younger group (36%) (χ^2= 17.6; p<0.01). In the rest of the variables studied (socio-economic level and educational level), in both groups medium levels predominate in either factor, with no significant differences.

With regard to clinical history, a small proportion of the victims have suffered or witnessed abuse in their family of origin, both in the younger group (24%) and the older group (21%). State of health is good in general —86% and 75%, respectively— and more than 70% of women in both groups have social and family support. In none of the variables described were significant differences found.

However, the majority of the victims perceive the circumstances of the abuse as a situation of risk to their physical integrity: 67% of the younger victims and 56% of the older ones. This difference is not significant (t= 1.57; n.s.).

Abuse variables

In general, and for the total sample, the victims assessed have been subject to severe and chronic abuse. The majority have experienced continuous physical and psychological abuse (55%) over a period of 1 year or more (94%), and more than a third have suffered sexual violence or assault within the relationship. The abuse has often continued even during pregnancies (74%) and extended to the children (52%).

From a comparison of the two groups, the results obtained in relation to the circumstances of the abuse are shown in Table 2.

A significantly higher percentage of the younger victims (71%) (χ^2= 12.34; p<0.001) than the older victims (42%) have suffered physical abuse. Likewise, a larger proportion of them (71%) (χ^2= 5.18; p<0.05) report the abuse, despite having a shorter history of victimhood –less than 5 years in 82% of cases. In contrast, the older victims tend to have suffered abuse for a period of longer than 10 years (54%) (χ^2= 56.6 p<0.001).

Abuse has continued during pregnancy in the majority of cases, regardless of age, but is significantly more common in the younger women (91.43%) (χ^2= 25.55; p<0.001).

Finally, threatening the victim with a weapon as a coercive measure during violent episodes is also more common in the case of the younger victims (48%) (χ^2= 5.86; p<0.05) than in that of the older women (28%).

Psychopathological variables

a) Post-traumatic stress disorder

Of the total sample, 33% present PTSD. More specifically, the proportion of victims in the younger group affected by this disorder (41%) is higher than that of the older women (27%). From a dimensional perspective, level of severity in those presenting PTSD is high in either group, with scores far above the cut-off point, but no significant differences are found between them (Table 3). Cohabitation with the aggressor is independent of the frequency of PTSD in both the younger group (χ^2= 0.51; n.s.) and the older group (χ^2= 0.25; n.s.).

b) Emotional distress: anxiety, depression, self-esteem and maladjustment

As regards the level of emotional distress, the differences between the two groups appear in depression and in self-esteem. Specifically, the younger victims are more depressed than the older victims, in both the

Table 2
Results obtained in the abuse variables

	Younger victims (N= 63)		Older victims (N= 85)		χ^2
	N	**%**	**N**	**%**	
Type of abuse					
Physical and psychological	45	71.40	36	42.40	
Psychological only	18	28.60	49	57.60	12.34***
Sexual violence					
Yes	25	39.70	27	31.80	
No	48	76.19	48	41.27	0.99 (n.s.)
Duration of abuse					
Less than 1 year	6	9.50	3	3.50	
1-4 years	46	73.00	18	21.20	
5-10 years	10	15.00	18	21.20	
Over 10 years	1	1.60	46	54.10	56.60***
Abuse during pregnancy (n= 109)					
Yes	32	91.43	49	66.22	
No	3	08.57	25	33.78	25.55 ***
Abuse of children (n= 108)					
Yes	12	37.50	44	57.89	
No	20	62.50	32	42.11	3.75 (n.s.)
Threatened with weapon					
Yes	30	47,62	24	28,23	
No	33	52,38	61	71,77	5,86*
Injuries (n= 81)					
Yes	25	55,55	17	47,22	
No	20	44,45	19	52,78	0,55 (n.s)
Reported abuse					
Yes	45	71,40	45	52,90	
No	18	28,60	40	47,10	5,18 *

* p<0.05; *** p<0.001

Table 3
Results obtained on the PTSD Symptoms Severity Scale

PTSD	Younger victims (N= 63)		Older victims (N= 85)		χ^2
	N	**%**	**N**	**%**	
Yes	26	41.27	23	27.06	3.29+
No	37	58.73	62	72.94	
	X	**SD**	**X**	**SD**	
Global scale	27.88	7.39	26.17	6.16	0.87(n.s.)
Re-experience	9.08	2.79	8.26	3.09	0.97(n.s.)
Avoidance	10.00	3.69	9.35	69.40	0.70(n.s.)
Increase in activation	9.81	2.40	8.61	3.15	1.50(n.s.)

* + p<0.10

cognitive (t= 2.54; p<0.05) and behavioural (t= 2.43; p<0.05) dimensions of depression, as well as presenting significantly lower self-esteem (t= 3.51; p<0.01) (Table 4). In a similar way to the case of PTSD, cohabitation with the aggressor is independent of the severity of emotional distress experienced, in both the younger (e.g., BDI: t= 1.33; n.s.) and the older group (e.g., BDI: t= 0.78; n.s.).

On the other hand, victims suffering from PTSD, regardless of age group, present greater emotional distress than those not affected by this clinical condition. Thus, they have higher levels of anxiety (t= 6.87; p<0.001) and of depression —in both cognitive (t= 8.23; p<0.001) and behavioural components (t= 7.44; p<0.001)—, as well as judging themselves more negatively (t= 6.25; p<0.001). Furthermore, they are more maladjusted to everyday life (t= 6.93; p<0.001) (Table 5).

c) Perceived threat to life, sexual aggression and family support from a psychopathological perspective

The younger victims with a subjective perception of a threat to their life during situations of abuse do not, however, experience greater psychological distress (in relation to the psychopathological variables assessed) than the victims without this perception. Thus, there are no differences between the two in symptoms of either PTSD (t= 0.79; n.s.) or depression (t= 0.01; n.s.), nor in those of anxiety (t= 0.01; n.s.) or maladjustment (t= 0.29; n.s.).

Nevertheless, perceived risk to life tends to be related to a higher level of overall severity of PTSD symptoms (t= 1.67; p<0.10), but also to significantly higher self-satisfaction (t= 2.12; p<0.05) in the older victims.

Also, the presence of sexual violence or assault during the situation of abuse is related to greater severity of the PTSD symptoms in the younger group, and to greater maladjustment to everyday life in the older group (Tables 6 and 7).

Finally, family support is not related to either severity of PTSD (t= 0.01; n.s.) or level of emotional distress (STAI: t= 0.58; n.s.; BDI: t= 0.03; n.s.; IG: t= 0.23; n.s.) in the victims aged under 30. However, the older victims without family support have lower self-esteem (X= 27.62) than those who perceive the presence of a support network (X= 31.08) (t= 2.38, p<0.05).

Table 4
Results obtained in psychopathological variables

Scales	Younger victims (N= 63)		Older victims (N= 85)		t
	X	SD	X	SD	
Anxiety (STAI-S)	34.81	11.67	33.65	12.43	0.57 (n.s.)
Depression (BDI)	20.00	10.50	15.68	09.98	2.54*
Depression (HRSD)	23.46	9.96	19.42	10.02	2.43*
Self-esteem (SES)	26.89	5.42	30.22	5.92	-3.51**
Global maladjustment	3.35	1.33	3.11	1.51	1.02 (n.s.)

* p<0.05; **p<0.01

Table 5
Relation between PTSD and other psychopathological variables

Scales	PTSD (N= 49)		NO PTSD (N= 99)		t
	X	SD	X	SD	
Anxiety (STAI-S)	42.61	7.76	29.95	11.66	-6.87***
Depression (BDI)	25.82	8.74	13.41	8.57	-8.23***
Depression (HRSD)	28.69	8.04	17.40	8.98	-7.44***
Self-esteem (SES)	24.94	5.21	30.72	5.32	-6.25***
Global maladjustment	4.22	0.85	2.71	1.41	-6.93***

*** p<0.001

Table 6
Relation between presence of sexual violence and psychopathological variables in the younger victims (N= 63)

Scales	Abuse with sexual violence (N= 25)		Abuse without sexual violence (N= 48)		t
	X	SD	X	SD	
Global PTSD Severity Scale	22.16	9.79	16.84	10.149	-2.06*
Anxiety (STAI-S)	34.56	11.52	34.97	11.930	-0.13*
Depression (BDI)	21.64	9.85	18.92	10.910	-1.00*
Depression (HRSD)	24.12	9.09	23.03	10.590	-0.42*
Self-esteem (SES)	27.08	5.72	26.76	5.290	-0.22*
Global maladjustment	3.52	1.19	3.24	1.420	-0.82*

* p<0.01

Table 7
Relation between presence of sexual violence and psychopathological variables in the older victims

Scales	Abuse with sexual violence (N= 27)		Abuse without sexual violence (N= 48)		t
	X	SD	X	SD	
Global PTSD Severity Scale	17.07	11.46	13.33	8.72	-1.66*
Anxiety (STAI-S)	36.07	12.70	32.52	12.20	-1.23*
Depression (BDI)	17.44	9.31	14.86	10.26	-1.11*
Depression (HRSD)	20.70	9.44	18.83	10.31	-0.80*
Self-esteem (SES)	29.44	7.93	30.59	4.75	-0.82*
Global maladjustment	3.63	1.21	2.86	1.50	-2.23*

* p<0.01

DISCUSSION AND CONCLUSIONS

In the present study we analyze a sample of women victims of habitual abuse (physical and/or psychological) by their partner or ex-partner who sought psychological treatment from a programme of specialist psychological care.

Greater social sensitization with respect to the problem of gender violence has improved victims' access to care resources. However, younger victims do not access programmes so frequently, and are more likely to reject or drop out of them than older victims.

With this in mind, we compared two groups of victims on the basis of age (under and over age 30), so as to explore their differential characteristics, with a view to encouraging requests for help, reducing drop-out from programmes and, in turn, preventing high-risk situations.

In general, and as in other studies (Amor et al., 2002; Fontanil, Méndez, Cuesta, López, Rodríguez, Herrero & Ezama, 2002), we found severity levels of the violence experienced by victims who seek help, regardless of age, to be high. The majority (55%) have been physically assaulted, more than a third have been forced to have sex, and somewhat more than half have suffered injuries. Likewise, half have witnessed direct abuse of their children.

As regards age, greater proportions of the younger victims (compared to the older ones) have suffered physical abuse, have reported the violence and live apart from the aggressor. Likewise, precisely because they are younger, they have a shorter history of victimhood, but even so it is a chronic problem (73% have suffered abuse for between 1 and 4 years). It is probable that the younger victims have less tolerance to violent behaviour, so that they are more likely to face up to their aggressor, thus increasing the risk to them.

The younger victims have been exposed to greater physical risk. Thus, they have suffered physical violence in the vast majority of cases (71%), which has continued even during pregnancies (in 91% of cases); moreover, almost half (48%) of these victims have been threatened with some type of weapon. In fact, subjective perception of threat to life is present in the majority of cases (67%), though it is not significantly higher than in the case of the older victims (56%).

From a psychopathological perspective, more than a third of all the victims assess present a post-traumatic stress disorder, though this is a figure somewhat lower than the mean for other studies, according to the review by Cascardi et al. (1999). More specifically, in the groups studied here, the prevalence of PTSD in the younger victims (42%) tends to be higher than that found in the older victims (27%).

As regards the remaining psychopathological variables associated with emotional distress (anxiety, depression, self-esteem and maladjustment), the results obtained in the total sample are similar to those of other studies (Camphell, Sullivan & Davidson, 1995; Campbell & Soeken, 1999; Echeburúa et al., 1997; Sato & Heiby 1992), and much higher than those obtained in women who have not been victims (Matud, 2004; Zlotnick, Jonson & Kohn, 2006).

In this study the level of anxiety is high, but similar in the two age groups. However, there is a differential profile of depressive type in each group. The younger victims present more depressive symptoms and feel less dissatisfied with themselves than the older ones. Depression is related to feelings of confusion, shame or guilt, and to a lack of confidence in one's own possibilities for facing the future.

Moreover, contact with the judicial system (in both the civil and penal frameworks), more common in the younger women —since most of them report the abuse and do not live with the aggressor—, frequently constitutes a risk factor for their emotional stability (Sarasua & Zubizarreta, 2000). Specifically, the regime set up for children's visits (in which the father-child relationship has priority and the children's experience as indirect –or sometimes direct– victims goes unnoticed) creates a new situation of abuse due to the manipulation of the children, and prevents the victim "uncoupling" from the aggressor.

Finally, a series of characteristics have been identified that can have differential effects on the emotional impact in each age group.

In the victims aged under 30, those who have been sexually abused present more severity of PTSD symptoms than those who have not been subject to this type of abuse; in the older victims, those who have been subject to forced sexual relations, despite not suffering greater psychological impact (perhaps because they do not perceive this as rape *per se*), nevertheless feel more maladjusted in their everyday life.

However, in the older victims it is the perceived threat to life variable that tends to increase the severity of PTSD symptoms; on the other hand, they also have more satisfactory levels of self-esteem. Although this finding may appear contradictory, it should be borne in mind that victims tend to minimize the severity of the abuse. Those who truly perceive the risk tend to hold the perpetrator solely responsible for the violent behaviour

and for the possibility of change, and in the long term, seeing as they do not feel guilty, they have greater perceived control and self-confidence.

In sum, the younger victims experience objectively more serious abuse, and greater psychological impact, but when they seek therapeutic help they drop out prematurely. The emotional effects are often attributed to factors external to the violence experienced. This circumstance may affect perceived threat to life in the older victims. Therefore, the victims who do seek help, despite being in a worse situation, do so by virtue of having made contact with the judicial system.

In the older victims –those with a longer history of abuse– their experiences and the changes in their conception of the meaning of "partner" or "love" help them to see and understand for themselves the factors that help to sustain the violent circle, and ultimately to acknowledge their own victimhood. This cognitive process facilitates the request for help, the process of psychological recovery —especially in relation to self-perception— and an adaptive appraisal of the sources of support available. The factors described may be involved in reducing the possibility of rejection of or drop-out from the intervention.

Finally, it should be borne in mind that the present research has some limitations. One of these concerns the fact that only self-report measures were used. Another, more significant limitation is related to the age groups involved. The under-30s group is poorly represented, since those that attend are few in number, and even then they often reject or drop out of the programme, so that we do not have access to all the necessary data. It would be useful to be able to work with a larger sample of young victims, both cohabiting with the aggressor (in this study there are only 15 participants aged under 30 years, reflecting the current reality) and living separately (the majority of those attending treatment), which would allow us to explore in more depth the "cohabitation" variable. For these reasons, this study can be considered as of an exploratory nature, and the conclusions drawn should be re-examined in the light of future research.

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