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HEALTH BEHAVIOURS OF WOMEN WHO EXPERIENCE DOMESTIC VIOLENCE

Zachowania zdrowotne u kobiet doświadczających przemocy domowej

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Abstract

The literature offers research reports on deleteriousness of domestic violence, causing health (physical/somatic and mental) problems, while there are no results of studies holistically (comprehensively) covering the women's health behaviours. Thus, the aim of this study was to examine health behaviours of women experiencing domestic violence. The subjects were divided into two groups. The study group (*V*) comprised 52 women aged 30–65 years (mean age of 40.15) receiving assistance of the *Crisis Intervention Centre* (*CIC*) because of experienced domestic violence. The reference group (*NV*) was well-matched in terms of socio-demographic characteristics and included 150 women who did not experience domestic violence. In order to evaluate health behaviours, the *Health Behaviours Inventory* (*HBI*) by Juczyński was used, which assesses intensity of four health behaviour categories: proper nutrition habits, prophylactic behaviours, health practices and positive psychological orientation. Women experiencing domestic violence scored significantly lower than controls in the *HBI* in terms of both the general index and all the *HBI* scales. *ANOVA* and *post-hoc* comparisons showed that the lowest general health behaviours index was for women exposed to violence inflicted by their fathers.

Results varied for particular scales, but the general trend was similar: the lowest scores were received by women exposed to violence by their fathers. The most deleterious/destructive was the impact of violence perpetrated by parents, especially fathers, as compared to violence by husbands or intimate partners. Along with preventing violence in the family, it may be worthwhile targeting significant health behaviours in the framework of interventions against domestic violence.

Keywords: domestic violence, health behaviours, women.

Streszczenie

W literaturze są doniesienia badawcze o szkodliwości przemocy domowej, powodującej problemy zdrowotne (fizyczne/somatyczne i psychiczne), brak natomiast wyników badań obejmujących w sposób holistyczny (całościowy) zachowania zdrowotne tych kobiet. Dlatego celem tej pracy było zbadanie zachowań zdrowotnych kobiet doświadczających przemoc domową. Zbadano dwie grupy kobiet. Grupa kryterialna (*V*) obejmowała 52 kobiety w wieku 30–65 lat (śr. w. 40,15) korzystających z pomocy Ośrodka Interwencji Kryzysowej (*OIK*) z powodu doznawanej przemocy domowej. Grupa kontrolna (*NV*) dobrze dopasowana pod względem cech socjodemograficznych składała się ze 150 kobiet niedoświadczających przemocy domowej. W celu zbadania zachowań zdrowotnych zastosowano *Inwentarz Zachowań Zdrowotnych* (*IZZ*) Juczyńskiego; narzędzie ocenia nasilenie czterech kategorii zachowań zdrowotnych: prawidłowych nawyków żywieniowych, zachowań profilaktycznych, praktyk zdrowotnych oraz pozytywnego nastawienia psychicznego. Kobiety doznające przemocy domowej uzyskały w *IZZ* wyniki istotnie niższe niż grupa kontrolna, zarówno w przypadku wskaźnika ogólnego jak i wszystkich skal *IZZ*. *ANOVA* i porównania *post-hoc* wykazały, że najniższy ogólny wskaźnik zachowań zdrowotnych uzyskały kobiety, przeciwko którym przemoc stosował ojciec.

Wyniki były zróżnicowane w poszczególnych skalach, ale trend ogólny był podobny: najniższe wyniki uzyskały kobiety doznające przemocy ze strony ojca. Najbardziej szkodliwy/destrukcyjny był wpływ przemocy doznawanej ze strony rodziców, zwłaszcza ojca, w porównaniu do przemocy doznawanej ze strony męża lub partnera. Może warto w ramach interwencji przeciwko przemocy w rodzinie skierować działania na istotne zachowania zdrowotne, oprócz przeciwdziałania tej przemocy.

Słowa kluczowe: przemoc domowa, zachowania zdrowotne, kobiety.

Introduction

Domestic violence

Lives of individuals exposed to domestic and/or intimate partner violence abound in unpleasant incidents and physical and psychological suffering (cf. Ellsberg et al., 2008; Rees et al., 2011; Tsirigotis & Łuczak, 2016; WHO, 2013).

The Centers for Disease Control and Prevention (CDC) define intimate partner violence (IPV) as physical, sexual, or psychological harm by a current or former spouse, or partner. Physical harm is an intentional use of physical force potentially causing death, disability or injury, which may include punching, hitting, burning, slapping, and use of a weapon. Sexual harm entails rape, other forms of sexual coercion and undesired sexual contact. Psychological harm comprises insults, diminishing, persistent humiliation, intimidation, threats of causing harm, or taking away children (Salzman et al., 2002; Schirk et al., 2015). IPV can be perpetrated by a current or former spouse, current or former boyfriend or girlfriend, dating partner or date (Basile et al. 2002; Brieding et al., 2008).

Violence in the family (Domestic Violence, DV, and Intimate Partner Violence, IPV) is a common phenomenon, which more often affects women: violence against women is a global public health problem besetting about one-third of women worldwide (cf. Ellsberg et al., 2008; Rees et al., 2011; Tsirigotis & Łuczak, 2016; WHO,

2013). Violence in the family is a grave social and psychological problem with damaging consequences for both individuals who experience and resort to it, resulting, among others, in changed psychological functioning of the victim and, secondarily, also the perpetrator. Violence in the family may stem from the perpetrator's emotionality, personality or psychotic disorders. However, undoubtedly, it arises from disturbed relations between partners too (irrespective of the source of the disturbances) (Tsirigotis & Łuczak, 2016).

Although the terms domestic violence (DV) and intimate partner violence (IPV) are very similar, since they both assume exposure to violence by very close people, the study is going to focus on domestic violence as a broader term comprising violence not only inflicted by a partner, but also by other family members. Violence in the family may concern all family members; it may also be of the mutual character. Nevertheless, perpetrators of physical violence tend to be men (Kaufman & Jasinski, 1998). The gist of domestic violence is using an advantage of power or authority to harm the other family members. Browne and Herbert differentiate among physical, psychological and sexual violence with its active or passive forms and varying intensity. Victims of domestic violence suffer from anxiety, distress, helplessness, hopelessness, and despair. Their bodies and psyches sustain acute traumas being subject to destructive and persistent stress and threat (Mellibruda, 2007; Tsirigotis & Łuczak, 2016).

Different authors conceptualize domestic violence in similar ways. Domestic violence (DV) may be defined as male aggression toward a female partner (Martinez-Torteya et al., 2009). Domestic violence against women can be described as any act or omission which, considering gender, results in death, physical, sexual or psychological trauma and moral damage to women; it can be perpetrated by individuals with or without family ties being either related by natural bonds, affinity or express will, including sporadic relationships (Labronici, 2012). Due to its gravity, the problem has also drawn attention of international organisations. Thus, domestic violence is defined as all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit, or between former or current spouses or partners, whether or not the perpetrator shares, or has shared, the same residence with the victim (Council of Europe, 2011). The authors of the concept underline that the current residence of the perpetrator or the fact whether he is currently in a relationship with the victim are not the most important. The United Nations Declaration on the Elimination of Violence Against Women (UN, 1993) defines violence against women occurring in the family as: "Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation". A similar

phenomenon/term is battering relationship defined as the repeated use of physical, sexual or verbal force by someone against his intimate partner (Anderson et al., 2012).

Another interesting concept of the phenomenon, referring to domestic violence and abuse, has been proposed by British authorities. Domestic violence and abuse (DVA) is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or older who are or have been intimate partners regardless of gender or sexuality, which may include psychological, physical, sexual, financial, or emotional abuse (Home Office, 2013).

The literature distinguishes psychological, physical, sexual, and other forms of violence, but they all actually boil down to psychological violence: firstly, once any other type of violence occurs, it automatically also becomes psychological; secondly, consequences of every type of violence are psychological as well.

The most commonly accepted violence definition in Poland is provided by the national programme of prevention of violence in the family, describing violence as any intentional action using an advantage of power and directed at a family member, which infringes on his or her personal rights and interests, thus causing suffering and harm (Sasal, 1998). Another definition of domestic violence proposed by the Polish literature is actions or gross neglects by a family member against the others, using an existing advantage of power or authority, or such an advantage created by circumstances, and causing harm or suffering to the victims, infringing on their personal rights and, in particular, destroying their lives or (physical or mental) health (Mellibruda, 2007).

Violence against women is not unimportant as it leads to many undesirable and harmful consequences. Abused women run an increased risk of depression, anxiety, posttraumatic stress disorder and suicide, as well as somatic problems (Mathew et al., 2012; 2013; Tarzia et al., 2016). Physical violence causes injuries (e.g. bruises, knife wounds, fractured bones), headaches, back or pelvic pain and death. Psychological abuse typically goes hand in hand with physical abuse, entailing depression, anxiety, posttraumatic stress disorder and attachment disorders. Domestic violence has also been associated with increased negative psychological and behavioural outcomes, including smoking, drinking, taking drugs (i.e. substance abuse) or having unprotected sex, and other adverse mental and physical health outcomes (Mathew et al., 2012; 2013; Sutherland et al., 2016).

Health behaviours

Activities and actions favourable to life and development comprise health behaviours, which to a great extent determine (at least physical and mental) human well-being.

More and more health psychology studies focus on identifying determinants of health behaviours, which is reflected in designing models that explain mechanisms

responsible for the formation of intent to change health behaviours. Those worth mentioning are, among others, the Health Belief Model, Self-Efficacy Theory, Theory of Planned Behaviour, Protection Motivation Theory or Competence Model (Juczyński, 2001).

Theoretical models are based on finding subjective health behaviour determinants, i.e. beliefs, expectations or personality traits. The most commonly proposed factors determining health behaviours include: health locus of control (Seeman & Evans, 1962; Wallston & Wallston, 1978), sense of self-efficacy (Bandura, 1994; Schwarzer & Renner, 2000), coping strategies in difficult situations (Heszen-Niejodek, 1991, 1992; Krohne, 1986, 1992; Lazarus & Folkman, 1984; 1990; Miller, 1983, 1987) and optimism (Seligman, 2006).

The literature interchangeably uses many terms related to behaviours connected with health. Terms most commonly employed in the Polish literature are: health behaviours, medical behaviours, health activities, health habits, health-promoting behaviours, positive health behaviours, health-promoting lifestyle, health-promoting activities, health-damaging behaviours, health-threatening behaviours, promoting behaviours, prophylactic behaviours, behaviours in illness, behaviours in health, health practices. The situation is similar in the English-language literature, where relationships between behaviour and health are interchangeably referred to as, for example: health behaviours, medical behaviours, health-related activities, health practices, wellness behaviours, prophylactic health behaviours, illness behaviours, health-damaging behaviours (Korzeniewska, 1997; Puchalski, 1990; Słońska & Misiuna, 1993). The variety of used terms entails an abundance of definitions of health-related behaviours.

One of those worth closer look is the approach by Gochman (1988), who defines health behaviours as such personal attributes as beliefs, expectations, motivations, observations and other cognitive elements, personality characteristics, including emotional states and traits, explicit behavioural patterns, patterns and habits connected with health maintenance, recovery and improvement. Gochman's definition deserves special attention due to its comprehensive approach to health behaviours considering both individual awareness and beliefs, and the behavioural aspect.

Neglecting, or even lacking health habits, may be a manifestation or result of human suffering. And domestic violence undoubtedly causes suffering to people exposed to it.

While research on health disorders or problems (of physical and psychological nature) has already been conducted, studies on relationships between domestic violence and health behaviours have been extremely scarce (cf. Dutton et al., 2006; Breiding et al., 2008).

The international literature offers research reports on domestic violence causing health (physical/somatic and mental) problems in women experiencing it, but there are

no research results holistically covering health behaviours of the women. Thus, the aim of this study was to investigate health behaviours of women exposed to domestic violence. Therefore it has been hypothesized that women experiencing domestic violence display less health(y) behaviours.

Material and methods

Methods

The study is part of a more extensive research project, on psycho(patho)logy of women experiencing domestic violence, and thus the applied methodology or some other parts of the study may be similar (Tsirigotis & Łuczak, 2016, 2018a, 2018b).

Participants

Subjects were divided into two groups. The study (criterion, *V*) group comprised 52 women aged 30-65 years (mean age of 40.15) receiving assistance of the Crisis Intervention Centre (CIC) because of experienced domestic violence. The women presented to the CIC on their own initiative or were referred there by an interdisciplinary prevention of domestic violence team and all had a "Blue Card"* opened. The research was carried out by specialists (psychologists) at the commencement of the intervention, after providing women with information about the aim of the study and obtaining their consent to participate in it. The reference (control, NV) group was well-matched in terms of sociodemographic characteristics and was made up of 150 women not exposed to domestic violence.

Measures

The Health Behaviours Inventory (HBI) by Juczyński (2012) was employed to evaluate health behaviours of the subjects. The inventory assesses the general intensity of health-promoting behaviours and the intensity of four health behaviour categories: proper nutrition habits, prophylactic behaviours, health practices and positive psychological orientation. The subject marks on a Likert-like scale how often she performs listed activities. The instrument is characterized by satisfactory reliability and validity: Cronbach's *alfa* (α) is 0.85 and the content validity index ranges from 0.31 to 0.46 (Juczyński, 2012).

*"Blue Card" is an important part of the Polish system of intervention strategies against domestic violence functioning in Poland since 1998. It is completed at an intervention scene in the presence of the perpetrator.

Statistical analysis

Statistical analysis of obtained scores used descriptive and statistical inference methods. Mean values of quantitative traits were computed as arithmetic means (M), whereas standard deviation (SD) was assumed as a dispersion measure. Considering the sizes of the groups (>100) and limit theorems, Student's t-test was applied to test differences. Analysis of Variance (ANOVA) was performed and post-hoc comparisons regarding the perpetrator were made using Tukey's Honest Significance Difference (HSD) test for unequal sample sizes to identify the perpetrator whose violence had the greatest impact on the women's health behaviours. The maximum acceptable type I error was assumed at $\alpha = 0.05$ for all the analyses. Asymptotic two-sided test probability p was computed, with $p \leq 0.05$ considered to be statistically significant. The statistical analyses applied the Statistica PL 13.3 for Windows statistical package (StatSoft, 2015).

Results

Table 1 presents sociodemographic data and Table 2 – data concerning domestic violence experienced by the studied women (*V* group). As mentioned in the methodology section, the reference group (*NV*) was well-selected/matched in terms of sociodemographic characteristics. The data showed that married women (50%) and women having higher education (40.38%) predominated. The studied women most often reported experiencing psychological (96.15%) and physical (80.77%) violence, with the husband (73.08%) or intimate partner (17.31%) as the most common perpetrators.

Table 1.
Socio-demographic characteristics of the study group

VARIABLE		n	%
Age	M± SD	40.15 ± 8.91	
	Range	30–65	
Marital status	Single	8	15.38
	Married	26	50.00
	Divorced	15	28.85
	Non-formalized relationship	3	5.77
Education	Primary	7	13.46
	Vocational	12	23.08
	Secondary	12	23.08
	Higher	21	40.38

Table 2.
Data concerning violence in the study group

VARIABLE		n	%
Types of Violence/Abuse*	Physical	42	80.77
	Psychological	50	96.15
	Sexual	18	34.62
	Economical	11	21.15
Perpetrator	Husband	38	73.08
	Intimate Partner	9	17.31
	Father	3	5.77
	Mother	2	3.84

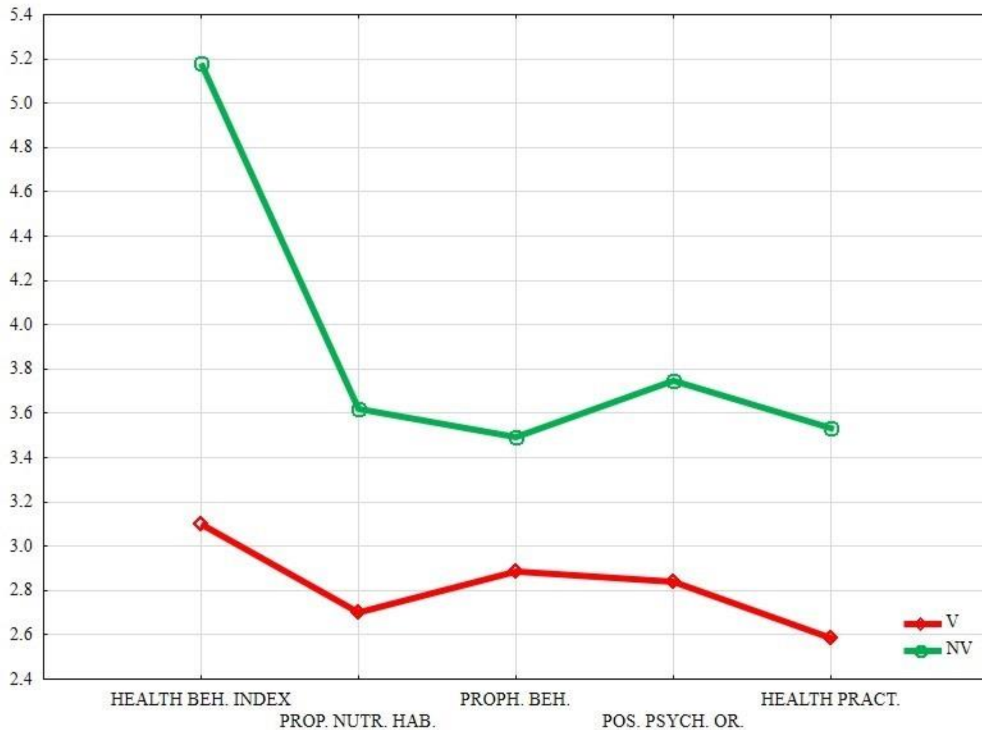
* The sum of percentages may exceed 100% because the participants could report more than one type of violence/abuse.

Table 3 and Figure 1 show HBI score comparisons of women exposed to and not exposed to domestic violence. Women experiencing domestic violence obtained significantly lower HBI scores ($p < 0.0000$) than controls not experiencing domestic violence, in terms of both the general index and all the HBI scales.

Table 3.
Comparisons of HBI scales scores of women experiencing (V) and not experiencing (NV) domestic violence

VARIABLES/SCALES	V GROUP		NV GROUP		"t" test	*p*
	M	SD	M	SD		
Proper Nutrition Habits	2.669	0.850	3.691	0.745	-2.902	> 0.0000
Prophylactic Behaviours	2.885	0.704	3.492	0.771	-2.423	> 0.0000
Positive Psychological Orientation	2.840	0.781	3.745	0.785	-1.697	> 0.0000
Health Practices	2.583	0.720	3.532	0.770	-1.373	> 0.0000
General Health Behaviours Index	3.097	1.604	5.178	1.239	-2.015	> 0.0000

Figure 1.
HBI scores of women experiencing (V) and not experiencing (NV) domestic violence



Since it had been established in previously conducted research (Tsirigotis & Łuczak, 2018a) that psychological effects of violence may differ depending on the perpetrator, Analysis of Variance (ANOVA, Table 4) was conducted, while multiple post-hoc comparisons using Tukey's Honest Significance Difference (HSD) for unequal sample size were made to identify the perpetrator whose violence had the greatest impact on the studied women's health behaviours (Table 5, Figure 2). As shown in Table 5 and Figure 2, the lowest general health behaviours index was obtained by women exposed to violence by their fathers, with the result being significantly lower than that of women experiencing violence inflicted by other important men in their lives, *i.e.* husbands or intimate partners. In general, it may be stated that it was those women who scored lower in almost all scales (apart from Health Practices scale, where no statistically significant differences were found). In other words, women exposed to domestic violence by their husbands or intimate partners (typically) scored higher in the HBI scales than women experiencing violence by their fathers. Apart from the said exception (Health Practices), it was only for Positive Psychological Orientation and only women exposed to violence by their mothers that received scores comparable to those of women abused by their husbands and intimate partners (also in that case women maltreated by their fathers scored the lowest).

Table 4.
ANOVA of scores in HBI scales regarding the perpetrator

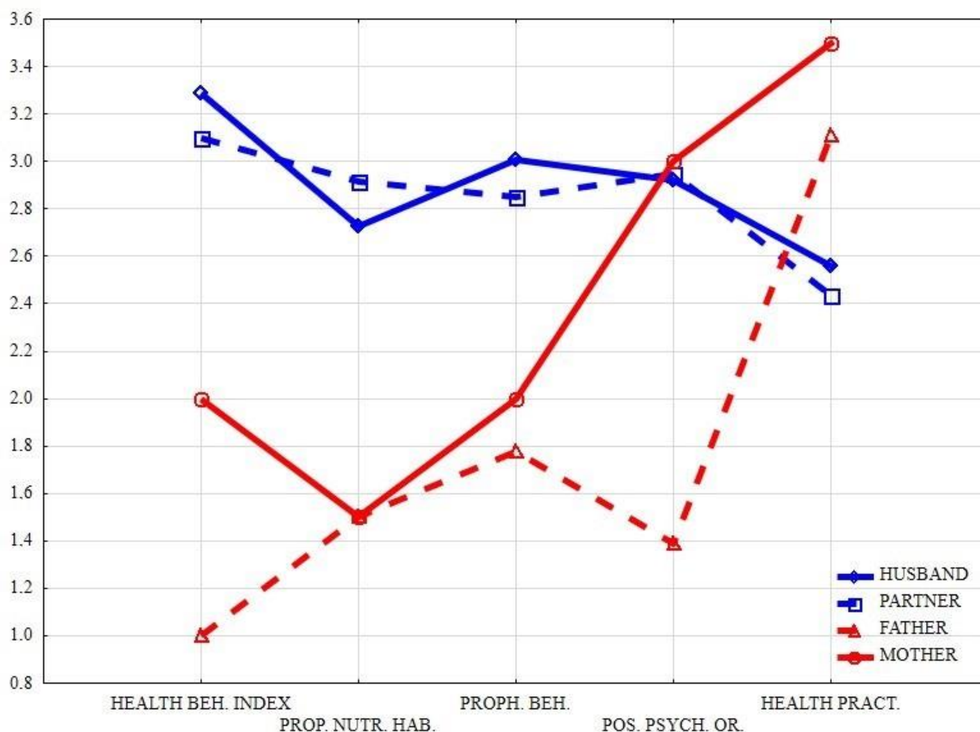
VARIABLES / SCALES	SS Efect	df Efect	MS Efect	SS Error	df Error	MS Error	*F*	*p*
Proper Nutrition Habits	6.183	3	2.061	31.044	48	0.647	3.186	0.03
Prophylactic Behaviours	5.015	3	1.672	20.515	48	0.427	3.911	0.01
Positive Psychological Orientation	6.713	3	2.238	24.673	48	0.514	4.353	0.008
Health Practices	1.927	3	0.642	24.767	48	0.516	1.245	0.05
General Health Behaviours Index	15.803	3	5.268	116.716	48	2.432	2.166	0.05

Table 5.
Post-hoc comparison regarding the perpetrator (*Tukey's HSD for unequal sample sizes*)

	PROPHYLACTIC BEHAVIOURS			
PERPETRATOR	HUSBAND M = 3.004	PARTNER M = 2.850	FATHER M = 1.778	MOTHER M =2.000
HUSBAND		ns.	0.002	ns.
PARTNER	ns.		0.01	ns.
FATHER	0.002	0.01		ns.
MOTHER	ns.	ns.	ns.	
	PROPER NUTRITION HABITS			
PERPETRATOR	HUSBAND M=2.726	PARTNER M = 2.917	FATHER M = 1.503	MOTHER M = 1.500
HUSBAND		ns.	0.01	ns.
PARTNER	ns.		0.01	ns.
FATHER	0.01	0.01		ns.
MOTHER	ns.	ns.	ns.	
	POSITIVE PSYCHOLOGICAL ORIENTATION			
PERPETRATOR	HUSBAND M = 2.921	PARTNER M = 2.950	FATHER M = 1.389	MOTHER M = 3.000
HUSBAND		ns.	0.01	ns.
PARTNER	ns.		0.01	ns.
FATHER	0.01	0.01		0.01
MOTHER	ns.	ns.	0.01	
	HEALTH PRACTICES			
PERPETRATOR	HUSBAND M = 2.557	PARTNER M = 2.433	FATHER M = 3.111	MOTHER M = 3.500
HUSBAND		ns.	ns.	ns.
PARTNER	ns.		ns.	ns.
FATHER	ns.	ns.		ns.
MOTHER	ns.	ns.	ns.	

	GENERAL HEALTH BEHAVIOURS INDEX			
PERPETRATOR	HUSBAND M = 3.289	PARTNER M = 3.100	FATHER M = 1.000	MOTHER M = 2.000
HUSBAND		ns.	0.01	ns.
PARTNER	ns.		0.04	ns.
FATHER	0.01	0.04		ns.
MOTHER	ns.	ns.	ns.	

Figure 2.
HBI scores of women experiencing domestic violence concerning the perpetrator



Discussion

It may be slightly difficult to compare the results with results of other studies as a vast majority of (if not all) research to date has concerned mainly (or exclusively) health problems and not necessarily health behaviours of women exposed to domestic violence.

Based on the results received in this study, it can be concluded that the intensity of health behaviours and most their categories was lower in women experiencing domestic violence, which may be another element and manifestation of their suffering; it may also be a reflection of their worse psychological functioning and adaptation.

Moreover, this issue is so important that domestic violence against women is also deleterious for their children: domestic violence against women was related to children's internalising and total behavioral problems (Holmes, 2015).

Based on results presented in Table 3 and Figure 1, women exposed to domestic violence looked after their health to a smaller extent than those not experiencing domestic violence, displaying in general lower intensity of health behaviours. They ate a poorer, *i.e.* less healthy diet, showed fewer prophylactic behaviours (e.g. followed health recommendations and looked for information about health less), employed health practices less (e.g. sleeping, leisure or physical activity habits) and showed less positive psychological orientation, such as avoiding too strong negative emotions, stressors, tension or depressing situations, which actually comes as no surprise considering experienced violence. Similar results were received in one of the few projects carried out in that area (Mathew et al., 2012, 2013).

The issue of nutrition habits of women exposed to domestic violence is quite important as improper nutrition habits in the form of consuming unhealthy foods/products etc. commonly occur in their case (cf. Mathew et al., 2012; Pengpid & Peltzer, 2020; Sanz-Barbero et al., 2019). Moreover, eating disorders are as common in them and a low level of social support was found to be significantly associated with high risk of eating disorders (cf. Schirk et al., 2015). And feeling supported is very important for the psychological well-being of these women, as we shall see later in this work. It is hypothesized that social isolation increases the risk of both domestic violence victimisation and negative health outcomes (Breiding et al., 2008).

Prophylactic behaviours require future-oriented thinking, predicting and planning. Planning assumes some relative stability and predictability, which is difficult to achieve in life shared with the perpetrator: more often than not, one does not know what and when is going to provoke his anger and aggression resulting in violence.

The women's positive psychological orientation was lower, which may be due to the fact that frequently experienced violence leads to a sense of helplessness and powerlessness in individuals exposed to it, who often do not see a chance to stop it or a way out of that very adverse situation. The sense of helplessness and powerlessness is also frequently intentionally created, fuelled, maintained and heightened by the perpetrator who in that way, on the one hand, traps his victim (to further abuse her) and, on the other hand, ensures impunity to himself.

Health neglects in women experiencing domestic violence were also found in other studies (Tsirigotis & Łuczak, 2018b) and comprised, among others, disregarding physician's instructions and recommendations for coping with particular complaints and failure to take actions related to disease prevention, which may ultimately contribute to worsened symptoms and signs or even death. The neglects also include premature treatment discontinuation, tendency to forget about appointments or procedures, as well as taking medications irregularly or giving them up completely, which

is characteristic of men. Women exposed to domestic violence neglect their health more, despite the fact that women in the general population find it more difficult to avoid contact with physicians, regardless of their condition, as, for example, many contraceptives are only available on prescription, women are more "accustomed" to and "trained" in using healthcare, if only due to necessary regular OB/GYN check-ups, and more frequently and willingly look for help when facing health, life, and/or psychological problems (Brannon, 2011; Kane, 1991; Tsirigotis et al., 2011, 2013). Experienced violence makes women neglect many things, including their (physical and mental) health, which has already been strained (cf. Anderson et al., 2012; Ellsberg et al., 2008; Rees et al., 2011).

It is possible that they neglect their affairs rushing to meet the needs of the perpetrator of violence, whose needs always have to take priority. Probably, focusing on the perpetrator leaves no room for thinking about oneself, also in the context of looking after one's health and safety. Experienced anxiety connected with dependence on the perpetrator, hence unpredictable environment of the individual exposed to violence, may also lead to undertaking risky and health-threatening behaviours.

Based on the data shown in Table 5 and Figure 2, violence inflicted by parents, particularly fathers, interfered with, disturbed or even damaged the women's health behaviours the most, although the negative effects varied.

In general, the fewest health behaviours were displayed by women experiencing violence by their fathers (the lowest general score) and mothers, and the most – by those exposed to violence by their husbands. The pattern of those negative effects is very similar to that of the impact of domestic violence on the women's resilience (Tsirigotis & Łuczak, 2018a), hence an attempt at explaining the phenomenon can take a similar course. The above-mentioned ANOVA and multiple post-hoc comparisons proved that violence inflicted by fathers weakened or damaged the women's health behaviours to the largest extent. The most deleterious impact on their health behaviours was exerted by their fathers' violence. It is interesting as fathers were not the most often mentioned as those perpetrating violence against the women (the most commonly indicated were husbands and intimate partners). Even without referring to Freud's concept (1916) that God is a grand sublimation of father, it is a well-known fact that the father is a very important person to every human and thus violence inflicted by him is more strongly experienced and has more profound consequences, which may be exemplified and reflected in low intensity of health behaviours. In other words, violence perpetrated by the father may severely weaken/damage health behaviours because the father is one of the very significant others and attachment to, emotional ties with and expectations of him are higher, hence greater disappointment, disenchantment, frustration and psychological distress caused by violence inflicted by him. It should be noted that violence by the mother did not have such a strong impact on the studied women's psychological resources.

When looking at particular categories of the examined health behaviours, it can be said that women experiencing domestic violence by their parents ate a less healthy diet than women exposed to violence by their husbands or intimate partners too. Nutrition habits are a behavioural area deeply set in family standards, and family life is very often based, for example, on meals eaten together, which also constitute a crucial element of all kinds of family celebrations. A view exists that older generations used to care less (or even still care less) about healthy eating than younger ones. Thus, maybe violence inflicted by parents (family of origin) left such an imprint also in the form of eating a less healthy diet. Furthermore, to women exposed to domestic violence by their parents (in childhood), food (no matter what kind) could be a certain escape and/or pleasure compensating for suffering experienced at home (perpetrated by their parents), which may persists in their adult life as improper nutrition habits too. In turn, violence by husbands or intimate partners against already adult women can be assumed not to have such a deeply deleterious impact on their nutrition habits (which, as can be seen, are poorer anyway than in women not exposed to domestic violence).

As for another category of health behaviours, i.e. prophylactic behaviours, the pattern of score distribution is similar to that of the general score, i.e. health behaviours as a whole. Thus, also in that case, the effect of violence inflicted by parents, especially fathers, was the most destructive and the impact of violence by partners, in particular husbands, was the least harmful. As already mentioned, prophylactic activities require future-oriented thinking, predicting and planning as the essence of prophylactic activities is that beneficial effects occur further in the future rather than directly and immediately. Violence experienced in childhood and the resulting suffering could inhibit/arrest development of such future-oriented thinking abilities, especially thinking oriented at future or even distant effects of currently performed activities/actions. In turn, violence inflicted by partners did not have such a deleterious impact on adult women in that scope.

As regards positive psychological orientation, violence perpetrated by fathers again caused the most harm: psychological orientation was the least positive in women exposed to violence by fathers too. As mentioned earlier, positive psychological orientation includes avoiding too strong negative emotions, stressors and tension or depressing situations. Certainly, it is violence by such a close and significant person as the father which ensures that too many of those extremely unpleasant states occur. At this point, however, it is worth drawing attention to an interesting issue, namely: the negative impact of violence by the husband, intimate partner or mother is similar and much weaker than the adverse influence of violence by the father. Based on the above observations, one may venture to state that women found the greatest psychological support or the least severe lack thereof in their mothers, husbands or intimate

partners, as positive psychological orientation is one of the important psychological resources.

Results concerning the negative influence of particular perpetrators on health practices were even more interesting since – although the differences were not statistically significant – their distribution differed from the general pattern or patterns for the other scales. As far as the category is concerned, it was violence by the husband and intimate partner rather than by parents that proved to be more deleterious, although violence by the father appeared to be more harmful also in that case. The results may suggest that daily (life and) contact with a person committing violence (husband, intimate partner) at least limits the chance to follow health practices, such as everyday (healthy) sleeping, leisure or physical activity habits. Daily life is almost totally subordinated to the perpetrator's whims, e.g. fear of violent behaviours (such as outbursts of fierce anger or aggression), thinking how to protect oneself against them, escape or prevent them etc. As for that category, it can be seen that the most freedom (and maybe an imperative) to follow health practices is given by the mother (despite inflicted violence), which may also arise from a retained stereotype that a woman has to look after herself (even at the youngest age).

Undoubtedly, further research is necessary to dispel doubt and answer questions that remain or arise.

Care of one's health and health behaviours are undoubtedly connected with the healthcare system and specialists. When faced with symptoms and/or a disease, women exposed to domestic violence most often first seek help of a general practitioner (primary care physician) because, among others, it is easier to admit (to oneself and others) to having physical or somatic problems rather than psychological or family ones. Not long ago questions about domestic violence were treated by the physicians as "opening Pandora's box" (Sugg & Inui, 1992). Thus, maybe it is worth sensitising also those healthcare practitioners to domestic violence manifestations and offering them help in the form of appropriate training or consultation. Maybe they should be encouraged to ask at least one question (if not more) concerning domestic violence as part of a customary/routine patient history taking; they may use the occasion to advise women about available information sources, offering, for example, assistance of social workers, psychologists, doctors or other specialists depending on the needs.

If health behaviours are seen as expression of self-care and – indirectly – also care of significant others, based on the above observations, it may be assumed that women exposed to domestic violence may be unable to show even the most basic care (of themselves and their significant others).

The authors hope that the research results and conclusions of this study are going to be useful in offering help to both women experiencing domestic violence and their families.

Conclusions

Domestic violence adversely or even destructively affects health behaviours of women exposed to domestic violence, which concerns all health behaviour categories. It may be stated that domestic violence causes (physical/somatic and psychological) disorders and intensifies/aggravates/worsens them through health neglects or even behaviours against health.

The most deleterious/destructive was the impact of violence perpetrated by parents, especially fathers, as compared to violence by husbands or intimate partners.

As for positive psychological orientation, however, the negative effect of violence by mothers was similar to the negative impact of violence by husbands and intimate partners and weaker than that of violence by fathers.

In turn, in the case of health practices, the relationship was opposite: adverse influence of violence inflicted by husbands or intimate partners was stronger than that of violence by parents, both mothers and fathers, although violence by the latter still exerted a more considerable negative impact.

The differentiation of the deleterious effects of violence experienced in time perspective, from childhood to adulthood, is clearly visible here.

Thus, along with preventing violence in the family, it may be worthwhile targeting significant health behaviours in the framework of interventions against domestic violence.

Limitations

The (V) sample size may be a possible limitation, but it should be kept in mind that women often have qualms about revealing experienced violence and that the "Pandora's box" phenomenon may occur.

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