INTERNATIONAL JOURNAL OF RESEARCH IN PSYCHIATRY

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Prevalence and correlates of domestic violence among patients with severe mental illness in a hospital setting in Lagos, Nigeria

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Abstract
Background: Domestic violence has far-reaching consequences, yet not much is known about its burden, perpetrators, and its correlates among patients with severe mental illness, including patients with schizophrenia, bipolar disorders, and major depression.
Aim: To determine the prevalence, perpetrators, and correlates of domestic violence directed against patients with severe mental illness in Lagos, Nigeria.
Method: A cross-sectional study was conducted among 180 randomly selected patients with severe mental illness at the outpatient clinic of Federal Neuropsychiatric Hospital, Lagos. Ethical approval was granted by the ethical committee of the hospital. The study involved the administration of a socio-demographic and clinical factors questionnaire, Mini International Neuropsychiatric Interview-PLUS, Positive and Negative Symptoms Scales, Hamilton Depression Rating Scale, Young Mania Rating Scale, and the Revised Conflict Tactics Scale to study participants. Data were analyzed using descriptive statistics, chi-square, Mann Whitney-U, and logistic regression at 5% level of significance.
Results: The prevalence of domestic violence among patients with severe mental illness was 46%. The perpetrators of domestic violence were spouses: 49%, siblings: 22%, paid caregivers: 10%, and others: 19%. The socio-demographic factors associated with domestic violence were being married (p <0.001) and working as a manager (p = 0.035). The clinical factors associated with domestic violence were older age at diagnosis (p = 0.007), longer illness duration (p = 0.022), and higher severity of schizophrenia (p <0.001).
Conclusion: This study revealed a huge burden of domestic violence among patients with severe mental illness. The outcome of this study reveals the need for a high index of suspicion, screening, and prompt intervention for patients with severe mental illness experiencing domestic violence. The need for relative psycho-education and support is also indicated.

Keywords: Domestic violence, Severe mental illness, Schizophrenia, Major depression, Bipolar disorder

Introduction
Domestic violence (DV) is a growing global public health concern due to its profound short- and long-term effects on victims [1]. The World Health Organization (WHO) defines DV as any behavior within a familial or intimate relationship that intentionally causes physical, sexual, or psychological harm [2]. These behaviors include physical aggression, sexual coercion, emotional abuse, and controlling actions such as stalking, deprivation of basic needs, and isolation from social networks. While initially framed as intimate partner violence (IPV), the definition has expanded to include abuse from other household members, reflecting the broader scope and increasing societal burden of DV.
Globally, DV affects a significant proportion of women. In 2018, the lifetime prevalence among women aged 15–49 was 27%, with 13% experiencing it within the past year. Regional disparities are evident, with low-income countries consistently reporting higher prevalence rates than high-income nations [1, 3]. For instance, Sub-Saharan Africa shows lifetime prevalence rates between 27% and 44%, compared to 20% to 25% in Europe[1]. These figures suggest that the consequences of DV are more pronounced in developing regions, where systemic challenges may exacerbate vulnerability.

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The consequences of DV is extensive, ranging from physical injuries and chronic health conditions to adverse r sexual and perinatal e outcomes [4, 5]. Beyond physical harm, DV is strongly linked to psychological complications, including substance use disorders, severe mental illnesses (SMIs), suicidal behaviors, and, in extreme cases, death [6, 7]. These outcomes reinforce DV as a major contributor to global disease burden and disability.

Severe mental illness connotes a subset of psychiatric disorders—such as schizophrenia, bipolar disorder, and major depressive disorder—characterized by persistent cognitive, emotional, and behavioral impairments that disrupt daily functioning [8]. Mental disorders account for 4.9% of global Disability Adjusted Life Years (DALYs), with a notable increase in Years Lost to Disability (YLD) over recent decades [9].

The relationship between DV and SMI is bidirectional: DV can precipitate or worsen mental illness, while individuals with SMI are at heightened risk of victimization [10, 11]. Victims with SMI often exhibit more severe symptoms, increased suicidal tendencies, and higher rates of substance abuse[10]. Studies indicate that one in four individuals with SMI have experienced DV in the past year—an incidence eleven times higher than in the general population [12]. Among female psychiatric patients, prevalence ranges from 15% to 22%, while among males, it ranges from 4% to 10% [13]. In low- and middle-income countries (LMICs), the burden is even greater. For example, 62% of Ethiopian women with chronic mental illness and 73% of Nigerian women with schizophrenia reported experiencing DV, with verbal abuse being the most common form [14, 15].

Several socio-demographic and clinical factors are associated with increased risk of DV among individuals with SMI. These include female gender, unmarried or divorced status, exposure to stressful life events, co-morbid substance use, frequent hospitalizations, poor response to treatment, and illness duration exceeding five years [14, 16]. The type of DV also varies by risk profile; physical violence is more prevalent among women and individuals with substance abuse or post-traumatic stress disorder [14, 16]. However, some studies report conflicting findings, such as no association between DV and marital status or illness duration.

Despite the high prevalence of DV among individuals with SMI, research has disproportionately focused on violence perpetrated by them rather than violence inflicted upon them. Additionally, most studies emphasize female victims, often overlooking male patients who may also be affected. The expanded WHO definition calls for broader research that includes abuse by non-intimate family members. Moreover, the conflicting findings reported in existing studies suggest the influence of methodological and cultural differences.

To address these gaps, it is essential to identify specific risk factors within representative low-resource settings such as Nigeria. Generating reliable data on the prevalence and correlates of DV among patients with SMI will support advocacy efforts, inform mental health policy, and guide resource allocation. Understanding the range of perpetrators—especially beyond intimate partners—will enable the design of targeted interventions. Identifying socio-demographic and clinical risk factors will facilitate the development of comprehensive biopsychosocial strategies aimed at improving quality of life, reducing stigma, and enhancing treatment outcomes. This study, therefore, sought to determine the prevalence, perpetrators, and correlates of domestic violence directed against patients with schizophrenia, major depression, and bipolar disorder in Lagos, Nigeria.

Method
This was a cross-sectional study conducted at the outpatient clinic of Federal Neuropsychiatric Hospital, Yaba, Lagos, the major psychiatric hospital, serving about twenty-one million people in Lagos, Southwest Nigeria [17].

The study participants were adult patients with SMI (any of the diagnoses of schizophrenia, major depression, or bipolar disorder) diagnosed based on ICD-11 diagnostic criteria and confirmed with the use of The Mini-International Neuropsychiatric Interview Plus (MINI Plus). The inclusion criteria comprised patients aged between 18 – 60 years, with a duration of illness of at least 2 years, and who consented to participate in the study. The exclusion criteria include individuals having illness severe enough to prevent assessment, such as a severely agitated patient, patients with severe communication problems or cognitive dysfunction who are not able to comprehend the interview, and patients with comorbid mental health disorders and/or medical conditions.

The sample size was calculated to be 180 from a finite population of 560 regular follow-up patients, utilizing a prevalence of 22% [13] (prevalence of domestic violence among patients with SMI) at a 95% confidence level in detecting a margin of error of 0.05.

Instruments
Socio-demographic and clinical factors questionnaire: A Pro-forma questionnaire was given to study participants to collect relevant socio-demographic and clinical information.

The Mini-Neuropsychiatric Interview - PLUS (MINI-PLUS) was used for the diagnosis of schizophrenia, depression, and mania. It is a relatively short and structured diagnostic tool comprising items that require a "Yes" or "No" response [18]. The MINI-PLUS has the advantage of ease of use and has acceptable psychometric properties. It has been widely used in Nigerian studies [19, 20].

Positive and Negative Symptoms Scale (PANSS) assesses schizophrenia severity using 30 items across three subscales: positive (7 items), negative (7), and general psychopathology (16) [21]. Each item is rated on a 7-point Likert scale (1–7), with total scores ranging from 30 to 210—higher scores indicate greater severity. It has high validity and reliability, and is widely used in Nigerian research [18, 22].

Hamilton Depression Rating Scale (HDRS17) is a clinician-administered tool used to assess depression severity over the past week [23]. It scores 17 of 21 items, with totals ranging from 0 to 52. Scores ≤7 indicate remission, 8–13 minor depression, 14–18 moderate, and ≥19 severe [24]. HDRS17 has acceptable psychometric properties and is widely used in Nigerian populations [24].

The Young Mania Rating Scale (YMRS) assesses manic symptom severity in bipolar disorder using 11 clinician-rated items. Four items are scored 0–8, and seven are scored 0–4, with total scores ranging from 0 to 60. Scores ≤12 indicate remission; higher scores reflect increasing mania severity. YMRS has acceptable reliability (Cronbach's alpha 0.72) and is widely used in Nigerian clinical research[25,26].

Revised Conflict Tactics Scale (RCTS) assessed domestic violence prevalence using a 39-item self-report tool across five categories: physical assault, injury, sexual coercion, psychological aggression, and negotiation. Responses ranged from 0–7, with 0 indicating no occurrence and 1–6 indicating past-year violence [27]. Lifetime prevalence (category 7) was omitted. The phrase "the person" was included to allow for non-spousal perpetrators. RCTS have strong psychometric properties and is widely used in studies done in Nigeria [28, 29].

Study procedure
On each clinic day, the researchers liaised with records officers to identify patients diagnosed with schizophrenia, major depression, or bipolar disorder. MINI PLUS was administered to confirm diagnoses. Eligible patients were selected through systematic random sampling. Interviews were conducted privately, and participants completed socio-demographic and RCTS questionnaires. PANSS, HDRS, and YMRS were administered accordingly. Clinical data were extracted from case files. Participants experiencing domestic violence were counselled and referred to support agencies.

Statistical analysis
Statistical analysis was conducted using SPSS version 26. Frequencies and percentages were used to describe categorical variables; mean and standard deviation for continuous data. Chi-square and Mann-Whitney U tests were used to assess associations with DV. Multivariate regression was used to determine predictors of DV among patients with SMI. Significance level was set at $p < 0.05$.

Ethical consideration
Ethical approval (FNPHY/HREC/2023/001/08/107) was obtained from the research and ethical committee of the Federal Neuropsychiatric Hospital, Yaba, Lagos. Participants gave written informed consent after receiving full details, including benefits, confidentiality, anonymity, and their right to withdraw at any stage.

Result
Socio-Demographic Variables of Respondents
As presented in Table 1, the mean age of the participants was 42.2 ± 11.03 years, with age range between 18 - 60 years. About two-thirds were middle-aged. More than half of the participants 103 (57.2%) were female, 53% were married, while 40% were single. Exactly half of the participants attained tertiary level of education, while another 42.2% attained secondary level of education. The majority (74.4%) of the respondents were employed, among whom proportionately more were service and sales workers 37 (31.4%), and craft and related trade workers 27 (22.9%).

Table 1: Socio-Demographic Variables of Respondents

Socio-demographic Variables		Frequency	Percentage (%)
Age (years)	Young age: 18-39 years	65	36.1
	Middle age: 40-59 years	110	61.1
	Elderly: ≥60 years	5	2.8
Mean± SD = 42.2±11.03			
Gender	Male	77	42.8
	Female	103	57.2
Ethnicity	Yoruba	111	61.7
	Igbo	38	21.1
	Hausa	7	3.9
	Others	24	13.3
Marital status	Single	72	40.0
	Married	96	53.3
	Separated/Divorced	5	2.8
	Widowed	7	3.9
Highest Level of Education	Primary	14	7.8
	Secondary	76	42.2
	Tertiary	90	50.0
Employment Status	Unemployed	61	33.9
	Employed	118	65.6
	Retired	1	0.5
Occupation Type (n=118)	Managers	13	11.0
	Professional	19	16.1
	Technicians & Associate Professional	7	5.9
	Clerical Support Workers	3	2.5
	Service & Sales Workers	37	31.4
	Craft & Related Trade Workers	27	22.9
	Plant & Machine Operators & Assemblers	1	0.8
	Elementary Occupation	11	9.3

Prevalence of domestic violence among patients with SMI
Eighty three (46%) of the study participants reported at lease an episode of domestic violence in the past one year has assessed using the RCTS.

Perpetrators of DV against patients with SMI
The perpetrators of DV against patients with SMI were predominantly their spouses (49%), while other perpetrators are siblings (22%), paid caregivers (10%), children (7%), parents (7%), and other relatives (5%).

Sociodemographic factors associated with DV against patients with SMI

Table 2 revealed a significant association between marital status and DV, with more married patients (60.4%) reporting domestic violence (p<0.001). Occupation was also significantly associated with DV (p=0.035), as more patients working as managers reported domestic violence relative to other occupations.

Table 2: Socio-Demographic Correlates of DV against patients with SMI

Variables (N=180)		Domestic violence		χ² (p-value)
		Yes (83)	No (97)	
Age (years)	Young age: 18-39 years	58 (52.7)	52 (47.3)	5.075 (0.074)
	Middle age: 40-59 years	23 (35.4)	42 (64.6)	
	Elderly: ≥60 years	2 (40.0)	3 (60.0)	
Gender	Male	33 (42.9)	44 (57.1)	0.573 (0.449)
	Female	50 (48.5)	53 (51.5)	
Marital Status	Single	20 (27.8)	52 (72.2)	19.094 (<0.001)
	Married	58 (60.4)	38 (39.6)	
	Separated/Divorced	3 (60.0)	2 (40.0)	
	Widowed	2 (28.6)	5 (71.4)	
Ethnicity	Yoruba	51 (45.9)	60 (54.1)	3.230 (0.702)
	Igbo	16 (42.1)	22 (57.9)	
	Hausa	3 (42.9)	4 (57.1)	
	Others	13 (54.2)	11 (45.8)	
Highest Level of Education	Primary	4 (28.6)	10 (71.4)	5.596 (0.111)
	Secondary	30 (39.5)	46 (60.5)	
	Tertiary	49 (54.4)	41 (45.6)	
Employment Status	Unemployed	26 (42.6)	35 (57.4)	1.318 (0.578)
	Employed	57 (48.3)	61 (51.7)	
	Retired	0 (0.0)	1 (100.0)	
Occupation Type (N=118)	Managers	11 (84.6)	2 (15.4)	13.013 (0.035)
	Professional	10 (52.6)	9 (47.4)	
	Technicians & Associate Professional	2 (28.6)	5 (71.4)	
	Service & Sales Workers	19 (51.4)	18 (48.6)	
	Craft & Related Trade Workers	8 (29.6)	19 (70.4)	
	Elementary Occupation	6 (54.5)	5 (45.5)	
	Others	1 (25.0)	3 (75.0)	

Bold p-values - significant at 0.05 significance level; χ²– statistic from Chi-Square Test

Clinical factors associated with DV against patients with SMI

Table 3 shows that severity of schizophrenia (p<0.001), age at diagnosis (p=0.007), and duration of illness (p=0.022) were significantly associated with domestic violence, with higher mean values among those who experienced domestic violence.

Table 3: Clinical Correlates of DV against patients with SMI

Variables (N=180)		Domestic violence		χ² (p-value)
		Yes (83)	No (97)	
Diagnosis	Depression	25 (54.3)	21 (45.7)	3.971 (0.226)
	Bipolar Disorder	14 (53.8)	12 (46.2)	
	Schizophrenia	44 (40.7)	64 (59.3)	
Previous Hospital Admission	None	52 (47.3)	58 (52.7)	6.036 (0.192)
	Once	15 (38.5)	24 (61.5)	
	Twice	7 (50.0)	7 (50.0)	
	Thrice	8 (72.7)	3 (27.3)	
	> 3 times	1 (16.7)	5 (83.3)	
Severity of Depression (N=46)	Moderate	15 (62.5)	9 (37.5)	5.199 (0.247)
	Moderately Severe	10 (50.0)	10 (50.0)	
	Very Severe	0 (0.0)	2 (100.0)	
Severity of Manic Symptoms (N=26)	Mild	14 (56.0)	11 (44.0)	3.472 (0.086)
	Moderate	0 (0.0)	1 (100.0)	
		Yes (Mean Rank)	No (Mean Rank)	U (p-value)
Severity of Schizophrenia		63.43	41.51	836.5 (<0.001)
Age at Diagnosis		101.77	80.86	3090.5 (0.007)
Duration of Illness		100.08	82.30	(3230.5) 0.022

Bold p-values - significant at 0.05 significance level; χ²– statistic from Chi-Square Test; U – statistic from Mann Whitney-U Test

Predictors of DV among participants with SMI

Regression analysis revealed that none of the examined sociodemographic or clinical variables demonstrated statistically significant predictive value for domestic

violence among patients with SMI, as detailed in Table 4.

Table 4: Logistic Regression of Correlates for D.V among adult patients with SMI

Variables		B	Odd Ratio	95% C.I.	p-value
	Constant	-0.595	0.552		0.851
Marital Status	Single	-1.058	0.347	0.016-7.613	0.502
	Married	-0.336	0.715	0.043-11.848	0.815
	Separated/Divorced	0.384	1.468	0.020-106.354	0.860
Widowed (Reference)					
Occupation Type	Managers	1.979	7.238	0.233-224.703	0.259
	Professional	0.271	1.311	0.074-23.233	0.854
	Technicians & Associate Professional	-0.338	0.713	0.022-23.309	0.849
	Service & Sales Workers	-0.171	0.843	0.054-13.279	0.903
	Craft & Related Trade Workers	-0.168	0.845	0.051-14.018	0.906
	Elementary Occupation	-0.282	0.754	0.027-21.037	0.868
Others (Reference)					
Severity of Schizophrenia		-0.037	0.964	0.928-1.001	0.057
Age at Diagnosis		0.067	1.069	0.970-1.179	0.178
Duration of Illness		0.029	1.030	0.950-1.117	0.475

Omitted categories are reference categories

Discussion

The prevalence of domestic violence among patients with SMI in this study was 46% with about 60% being females. This rate is within the range of 30% to 50% prevalence of domestic violence perpetrated against psychiatric patients reported in systematic reviews [12, 13]. However, it is notably lower than the IPV prevalence of 75% reported among females with schizophrenia in South-southern Nigeria [7], and also lower than the 62% reported among Ethiopian women with chronic mental illness [23]. The disparity may be attributed to the broader inclusion of male victims and exploration of other perpetrators of domestic violence within the family, beyond intimate partners, in this study. These findings highlight the need for gender-sensitive approaches in psychiatric care, as contextual factors affect DV prevalence. Notably, 40% of men with SMI experienced DV, challenging the misconception that only women are victims and emphasizing the importance of supporting male patients as well.

In this study, spouses were identified as the most prevalent perpetrators of domestic violence, accounting for 49% of reported cases. This finding aligns with existing literature indicating that IPV is the most common form of domestic violence globally [1, 30]. Additionally, the study corroborates previous research identifying relatives as the second most frequent perpetrators of domestic violence [30]. These results reinforce the persistent and disproportionate burden of IPV within psychiatric populations and underscore the need for targeted interventions that address familial and spousal dynamics.

Marital status was significantly associated with DV, with 60.4% of married and 60% of separated/divorced individuals reporting DV in this study. This aligns with an Ethiopian study which identified divorce as a major risk factor for DV among women with SMI [14]. In contrast, a previous study focusing solely on IPV found no association between marital status and DV [12]. Differences in study scope may explain the divergent findings; the previous study focused solely on IPV, while this study included various family perpetrators. This further highlights the importance of inclusive definitions of DV when assessing risk factors in psychiatric populations.

While employment status was not associated with DV, working in managerial roles was significantly associated with DV. Although studies have reported inconsistent associations between employment status and DV [29, 31], no prior studies were identified that explored occupation type and DV among SMI patients. This novel finding suggests occupational roles may influence DV risk, possibly due to stressors, social dynamics, or family expectations.

In this study, older age at diagnosis was found to be significantly associated with domestic violence among patients with SMI. This contrasts with the findings of a recent systematic review and meta-analysis [13], which reported a stronger association between younger age at illness onset and experiences of DV in this population. The discrepancy may be attributable to differences in how age-related variables are defined and measured. Specifically, age at onset does not necessarily equate to age at diagnosis, particularly in low-resource settings such as Nigeria, where delayed help-seeking and systemic barriers often result in a prolonged and complex pathway to care [32]. Older age at diagnosis may reflect a period of greater social integration prior to the emergence of psychiatric illness, potentially increasing exposure to interpersonal relationships and environments where DV can occur. It is also plausible that experiences of DV may have preceded the onset of mental illness, contributing to or exacerbating psychiatric vulnerability. These considerations highlight the need to examine not only the timing of diagnosis but also the broader psychosocial context surrounding illness trajectories.

Longer duration of illness emerged as a significant correlate of domestic violence (DV) among the study population. This finding contrasts with a previous study that reported no association between illness duration and DV [33]. However, the disparity may be attributed to methodological differences, as the earlier study focused exclusively on women and assessed only IPV, thereby limiting its scope. In the present study, the broader inclusion of both genders and a wider definition of DV perpetrators may have contributed to the observed association. Long illness duration likely reflects prolonged exposure of family members to caregiving responsibilities, which may intensify psychological stress and caregiver burden over time. This sustained strain can increase the risk of frustration, emotional exhaustion, and, in some cases, abusive behavior toward the patient. These findings highlight the need for

mental health services to incorporate caregiver support and education as part of comprehensive treatment plans.

This hospital-based, cross-sectional study focused on outpatients, thus limiting generalizability and causal inference. It also didn't explore temporal dynamics between the onset of DV and the emergence of identified risk factors. Nonetheless, utilizing a random sampling technique reduced bias, and the adoption of standardized tools ensured reliable assessment. The findings provide useful baseline data for future research in similar clinical and cultural settings.

Conclusion

This study highlights a significant burden of domestic violence among patients with serious mental illness, with nearly half affected, often by family caregivers. This underscores the need for routine DV screening in psychiatric care and targeted advocacy to protect this vulnerable group. Caregiver stress may contribute to abuse, emphasizing the importance of psychoeducation and structured support. Integrating DV response into mental health services is vital for improving patient safety and outcomes.

Refernces

1. Sardinha L, Maheu-Giroux M, Stöckl H, Meyer SR, García-Moreno C. Global, regional, and national prevalence estimates of physical or sexual, or both, intimate partner violence against women in 2018. Lancet. 2022;399(10327):803–13.
2. World Health Organization. WHO Multi-Country Study on Women's Health and Domestic Violence Against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva, Switzerland; 2005.
3. Devries KM, Mak JY, García-Moreno C, Petzold M, Child JC, Falder G et al. Global health. The global prevalence of intimate partner violence against women. Science. 2013;340(6140):1527–8.
4. Mirela-Simona PO. Domestic violence and its consequences on health. Manag Heal. 2009;3:11–4.
5. Onoh R, Umeora O, Ezeonu P, Onyebuchi A, Lawani O, Agwu U. Prevalence, Pattern and Consequences of Intimate Partner Violence During Pregnancy at Abakaliki Southeast Nigeria. Ann Med Heal Sci Res. 2013;3(4):484–91.
6. Ellsberg M, Jansen HA, Heise L, Watts CH, Garcia-Moreno C. Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. Lancet. 2008;371(9619):1165–72.
7. Devries KM, Mak JY, Bacchus LJ, Child JC, Falder G, Petzold M, et al. Intimate Partner Violence and Incident Depressive Symptoms and Suicide Attempts: A Systematic Review of Longitudinal Studies. PLoS Med. 2013 May;10(5):e1001439.
8. Kessler RC, Chiu WTW, Demler O, Merikangas KR, Walters EE, Merikangas KR, et al. Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005;62(6):617–27.
9. GBD 2019 Mental Disorders Collaborators. Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. The Lancet Psychiatry. 2022;9(2):P137-150.
10. Khalifeh H, Moran P, Borschmann R, Dean K, Hart C, Hogg J, et al. Domestic and sexual violence against patients with severe mental illness. Psychol Med. 2015;45(4):875–86.
11. Ehrensaft MK, Moffitt TE, Caspi A. Is domestic violence followed by an increased risk of psychiatric disorders among women but not among men? A longitudinal cohort study. Am J Psychiatry. 2006;163(5):885–92.
12. Teplin LA, Mcclelland GM, Abram KM, Weiner DA. Crime Victimization in Adults With Severe Mental Illness Comparison With the National Crime Victimization Survey. Arch Gen Psychiatry. 2005;62:911–21.
13. Khalifeh H, Oram S, Osborn D, Howard LM, Johnson S. Recent physical and sexual violence against adults with severe mental illness: a systematic review and meta-analysis. Int Rev Psychiatry. 2016;28(5):433–51.
14. Zerihun T, Tesfaye M, Negussie D, Bekele D. Intimate partner violence among reproductive-age women with chronic mental illness attending a psychiatry outpatient department: cross-sectional facility-based study, Addis Ababa, Ethiopia. BMJ Open. 2021;11:1–7.
15. Afe TO, Emedoh TC, Ogunsemi O, Adegbohun AA. Intimate partner violence, psychopathology and the women with schizophrenia in an outpatient clinic South-South, Nigeria. BMC Psychiatry. 2016;16(1):197.
16. Tsigebrhan R, Shibre T, Medhin G, Fekadu A, Hanlon C. Violence and violent victimization in people with severe mental illness in a rural low-income country setting : A comparative cross-sectional community study. Schizophr Res. 2014;152(1):275–82.
17. United Nations. Population Division World Urbanisation Prospects [Internet]. 2018 [cited 2020 Nov 25]. Available from: population.un.org
18. Odinka PC, Ndukuba AC, Muomah RC, Oche M, Osika MU, Bakareet MO, et al. Positive and negative symptoms of schizophrenia as correlates of help-seeking behaviour and the duration of untreated psychosis in south-east Nigeria. South African J Psychiatry. 2014;20(4):166–71.
19. Popoola AO, Adewuya AO. Prevalence and correlates of depressive disorders in outpatients with breast cancer in Lagos, Nigeria. Psychooncology. 2012;21(9):675–67.
20. Adewuya AO, Afolabi MO, Ola BA, Ogundele OA, Ajibare AO, Oladipo BF, et al. Relationship between depression and quality of life in persons with HIV infection in Nigeria. Int J Psychiatry Med. 2008;38(1):43–51.
21. Kay SR, Fiszbein A, Opler LA. The positive and negative syndrome scale (PANSS) for schizophrenia. Schizophr Bull. 1987;13(2):261–76.

22. Fakorede OO, Ogunwale A, Akinhanmi AO. Premorbid adjustment amongst outpatients with schizophrenia in a nigerian psychiatric facility. South African J Psychiatry. 2021;27(0):a1492.

23. Hamilton. M. A rating scale for Depression. J Neurol Neuro surg Psychiatry. 1960;23:56–62.

24. Agbir TM, Audu MD, Adebowale TO, Goar SG. Depression among medical outpatients with diabetes: A cross-sectional study at Jos University Teaching Hospital, Jos, Nigeria. Ann Afr Med. 2010;9(1):5–10.

25. Mohammadi Z, Pourshahbaz A, Poshtmashhadi M, Dolatshahi B, Barati F, Zarei M. Psychometric Properties of the Young Mania Rating Scale as a Mania Severity Measure in Patients With Bipolar I Disorder. Pract Clin Psychol. 2018;6(3):175–82.

26. Onyeama M, Agomoh A, Jombo E. Bipolar disorder in Enugu, South East Nigeria: demographic and diagnostic characteristics of patients. Psychiatr Danub. 2010;22(1):S152-S157.

27. Straus MA, Hamby SL, Boney-McCoy S, Sugarman DB. The revised conflict tactics scales (CTS2) development and preliminary psychometric data. J Fam Issues. 1996;17(3):283–316.

28. Benebo FO, Schumann B, Vaezghasemi M. Intimate partner violence against women in Nigeria: A multilevel study investigating the effect of women's status and community norms. BMC Womens Health. 2018;18(1):1–17.

29. Okenwa LE, Lawoko S, Jansson B. Exposure to Intimate Partner Violence Amongst Women of Reproductive Age in Lagos, Nigeria : Prevalence and Predictors. J Fam Viol. 2009;24:517–30.

30. Laisser RM, Nyström L, Lindmark G, Lugina HI, Emmelin M. Screening of women for intimate partner violence: a pilot intervention at an outpatient department in Tanzania. Glob Health Action. 2011;4:7288.

31. Alawode OO. Socioeconomic Determinants of Domestic Violence Against Women in Nigeria: Empirical Evidence from National Demographic and Health Survey Data. Sci Front. 2024;5(4):175–87.

32. Adeosun II, Adegbohun AA, Adewumi TA, Jeje OO. The Pathways to the First Contact with Mental Health Services among Patients with Schizophrenia in Lagos, Nigeria. Schizophr Res Treatment. 2013;2013:1–8.

33. McPherson MD, Delva J, Cranford JA. A longitudinal investigation of intimate partner violence among mothers with mental illness. Psychiatr Serv. 2007;58(5):675-80.