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Psychosocial distress, perceived social support, and coping in women survivors of domestic violence seeking help from a women's helpline in urban India

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Abstract:

BACKGROUND: Domestic violence against women is a worldwide phenomenon and a major public health concern. The adverse effects on the physical and mental health of the women survivors of domestic violence are influenced by various psychosocial factors. This study aimed to understand psychological distress, perceived social support, and coping strategies among women survivors of domestic violence and its implications.

MATERIALS AND METHODS: It is a cross-sectional study conducted with 30 women survivors of domestic violence from urban Bengaluru who were registered with a women's helpline. Data were collected using a socio-demographic schedule, a self-reporting questionnaire assessing psychological distress, perceived social support scale, and ways of coping scale. Descriptive and inferential statistics were used to analyze the data.

RESULTS: Psychological distress was the highest among participants facing violence due to perpetrator using alcohol (M = 11.6, SD = 3.9) and (M = 11.73, SD = 3.5) dowry harassment. Perceived social support from family (M = 14.76, SD = 4.54) and friends (M = 11.85, SD = 4.7) was the highest among participants who reported that alcohol use was not a reason for violence.

CONCLUSION: It can be noticed that alcohol use, dowry harassment, and poor coping strategies were the main reasons for domestic violence, which has led to severe psychosocial distress among the women survivors.

Keywords:

Coping, Domestic violence, helpline, mental health, social support, urban, women survivors

Introduction

Women play an important role in the economic and social development of countries around the world.[1] However, according to research on women's status in society, the contributions of Indian women to their families are frequently disregarded in both urban and rural settings.[2] Around 35% of women experience violence at some point in their lives and are subjected to maltreatment in physical, sexual, or psychological contexts.[3]

Violence against women disrupts and underestimates their human rights and fundamental liberties. It is a multifaceted and complex problem, and there have been a number of theories over the years that attempted to describe this.[4] Violence

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against women has been defined as "any act of gender-based violence that results in, or is likely to result in physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life."[5]

Forms of domestic violence**:** Based on the literature, the four forms of domestic violence are as follows. 1) Physical violence is the intentional use of physical force with the potential for causing death, disability, injury, or harm.[6] 2) Sexual violence involves the use of physical force to compel a person to engage in a sexual act against his or her will.[7] 3) Emotional violence involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Emotional abuse can include humiliating, controlling what the victim can and cannot do, withholding information, isolating the victim from friends and family, and denying other basic resources.[8] 4) Intellectual violence refers to willful non-participation in discussions of importance, excusing oneself from such discussions.

Violence is a significant cause of morbidity from multiple mental, physical, sexual, and reproductive health outcomes. It also links with known risk factors for ill health such as alcohol and drug use, smoking, and unsafe sex.[9] According to Jahromi 2016, one out of every three women in the world is subjected to violence, coerced into sex, or sexually assaulted and one out of every five women is raped.[10] Physical and sexual abuse in and outside relationships are two common kinds of violence against women.[11]

It is, hence, reasonable to conclude that victims of domestic violence experience a range of psychosocial issues as well as mild to severe mental health issues. Depression, elevated suicide risk, loss of trust, low self-esteem, dread, anxiety, guilt, shame, tension, suspicion, somatic difficulties, and posttraumatic stress disorder are some commonly reported psychological repercussions.[12] Women in partnerships who suffer from physical abuse are more likely to experience psychological distress.[13,14]

Perceived social support relies on interpersonal networks and the extent to which an individual believes his or her needs for support, information, and feedback are fulfilled through interpersonal processes.[15] It consists of transactions with others that provide the recipient with emotional support, affirmation of self, appraisal of the situation, instrumental support, and information.[16] Many studies have shown that the size of informal social networks and the level of support recognized among their members predict mental health.[17,18] Social isolation and a lack of social support, however, have been associated with poor health outcomes for victims of violence.[19] There is a direct relationship between the mental health and the overall well-being of domestic violence survivors and families. Therefore, it is necessary to consider the psychological distress, social support, and coping strategies of survivors of domestic violence. To study these variables was the primary aim of this study.

Materials and Methods

Study design and setting

It was a cross-sectional descriptive study. The population of the study was all women survivors of domestic violence approaching Vanitha Sahaya Vani (women's helpline) in Bengaluru city of Karnataka state, India.

Study participants and sampling

A total of 680 people approaching Vanitha Sahaya Vani were contacted in three months. Out of the 680, 216 men and few women were sent to the senior citizen's helpline. One hundred and fifty women came for purely marital and family issues (not comprising violence), 50 women approached for property and legal issues, and 20 women reported to have filed FIR for sexual assault or physical assault by outsiders, hence, referred back to the police station by the agency. A total of 244 women facing domestic violence approached the helpline. Based on the inclusion and exclusion criteria, 30 women survivors of domestic violence were selected for the study.

Eligibility criteria

The inclusion criteria for the study were (i) women above 18 years of age approaching Vanitha Sahaya Vani, (ii) women who reported to be experiencing domestic violence such as physical violence, sexual violence, emotional violence, and intellectual violence, and (iii) women who could converse in Kannada, Hindi, or English.

Data collection tools and technique

1. **Socio-demographic schedule:** A semi-structured interview schedule was prepared by the researcher to study various socio-demographic details. The schedule had 15 items consisting of personal, family details of the respondents, and details of the perpetrator(s) of violence.
2. **Self-reporting questionnaire (SRQ):** This instrument was developed by the WHO in 1994.[20] It is a good measure of general psychological distress, especially in developing countries. It consists of 20 questions with just two responding categories—yes or no. The total score corresponds to the sum of all affirmative responses (yes), based on thirty days recall period. The total maximum score is 20. The total of affirmative responses can be used as an index of psychological distress or mental health problems. Studies have validated the use of the SRQ in India and the cutoff

score is 7. Hence, the cutoff score 7/8 to determine probable and non-probable cases of psychiatric morbidity. A score of 7 or below is considered to represent non-cases. A score of 8 and above indicates evidences of psychological distress.

3. **Perceived social support scale:** This was developed by Procidano and Heller in 1983. It is a 40-item self-reporting measure, composed of two subscales, social support from family and friends.[15] Each subscale measures close and diffuses social support. The response category of each of the items is "yes," "no," and "don't know." For each of the items, the response is indicated for perceived social support as + 1, so that the scores range from 0 to 20 for each subscale. The higher the individual's score on the scale, the greater the perceived social support is.
4. **Ways of coping scale:** This was developed by Susan Folkman and Richard Lazarus in 1980.[21] It has 66-item self-report measures of both adaptive and maladaptive coping skills. It has eight subscales such as confrontive coping, distancing, self-controlling, seeking social support, accepting responsibility, escape avoidance, planful problem solving, and positive reappraisal. The scale is measured on a four-point Likert scale: 0 does not apply or not used; 1, used somewhat; 2, used quite a bit; and 3, used a great deal.

Ethical consideration

The study was approved by the Institutional Ethical Committee, NIMHANS, Bengaluru. Permission was taken from the women's helpline in Bengaluru which is working with the survivors of domestic violence. The informed consent was taken from the clients after explaining the purpose of the study. The confidentiality of the information was ensured, and the information collected was for research purpose only.

Statistical analysis

Descriptive statistics were used to describe the socio-demographic data, patterns of violence, ways of coping, psychological distress, and perceived social support. T-test was used to explain the significant differences in various dimensions of coping, perceived social support, and psychological distress with respect to selected socio-demographic variables.

Results

Table 1: Socio-demographic profile: 65% of the participants were in the age group of 20—30. 46.6% of the participants were educated up to 12th standard, and 75% stayed in the nuclear family. 36.7% were married between 6 and 10 years. 66.7% of the participants reported husband or partner to be the perpetrator of violence.

Table 1: Socio-demographic details of participants

Socio-demography	Results	Percentage %
Age distribution	Age group 20–30 years	65
Religion	Hindu	80
	Muslim	13.3
	Christian	6.7
Education	Higher primary school	23
	12th standard	46.6
	Under graduation	27
	Postgraduation	7
Type of family	Nuclear family	75
Domicile	Urban	77
Duration of marital life	6–10 years	36.7
Family size	Three members	53.3
Relationship of the perpetrator with respondent	Husband/partner	66.7
	In-law	20
	Son/brother	13.3
Occupation of the perpetrator	Semiskilled	53.3

Table 2: Majority of the participants reported poor appetite (80%), inadequate sleep (77%), and often suffering from headaches (73%), and 60% of them felt they were worthless. Majority (80%) reported trouble in thinking clearly, 80% of them indicated difficulty in making decisions, and 63.3% had the thought of ending their lives.

Table 3: Mean scores of self-controlling (M = 10.9), accepting responsibility (M = 5.23), and positive reappraisal (M = 9.6) were close to the average score as reported in the validation of the scale while seeking support was more than the average (M = 12.87).

Table 4: Mean score of perceived social support from family is M = 13.23, which indicated that participants had higher perceived social support from family compared to perceived social support from friends (M = 11.73).

Table 5: Psychological distress was the highest among participants facing violence due to perpetrator using alcohol (M = 11.6, SD = 3.9).

Discussion

The study results summarize that psychological distress was the highest among women facing domestic violence due to inadequate coping skills and lack of social support. The results of the study corroborate with numerous Indian and Western studies. Reviere *et al*. in 2007[22] reported that among low-income African–American women who had experienced intimate partner violence and who had suicidality showed less adaptive coping methods, while those who did not have suicidality showed efficacious behavioral coping and used greater social support. The present study findings showed differences in types of coping

Table 2: Item-wise distribution on psychological distress

Item no.	Item description	Yes (f)	Yes (%)	No (f)	No (%)
1	Often has headaches	22	73.33	8	26.66
2	Appetite is poor	24	80	6	20
3	Sleeps badly	23	76.66	7	23.33
4	Is easily frightened	15	50	15	50
5	Hands shake	0	0	30	100
6	Feels nervous, tense	25	83.33	5	16.66
7	Digestion is poor	2	6.66	28	93.33
8	Has trouble thinking clearly	24	80	6	20
9	Feels unhappy	30	100	0	0
10	Cries more than usual	20	66.66	10	33.33
11	Finds it difficult to enjoy daily activities	22	73.33	8	26.66
12	Finds it difficult to make decisions	24	80	6	20
13	Her daily work is suffering	14	46.66	16	53.33
14	Is unable to play a useful part in life	16	53.33	14	46.66
15	Has lost interest in things	25	83.33	5	16.66
16	Feels she is a worthless person	18	60	12	40
17	Thought of ending life has been on her mind	19	63.33	11	36.66
18	Feels tired all the time	13	43.33	17	56.66
19	Has uncomfortable feelings in the stomach	2	6.66	28	93.33
20	Is easily tired	4	13.33	26	86.66

F: Frequency, %: Percentage

Table 3: Mean scores on pattern of coping

Type of coping	*n*	Min	Max	Mean	SD	Score range	Avg score
Confrontive coping	30	1	13	8.10	3.02	0–18	9
Distancing	30	2	12	7.30	3.22	0–18	9
Self-controlling	30	6	13	10.90	2.04	0–21	10.5
Seeking support	30	10	15	12.87	1.43	0–18	9
Accept responsibility	30	2	6	5.23	0.90	0–12	6
Escape avoidance	30	4	13	10.40	2.91	0–24	12
Planful problem solving	30	2	11	7.57	3.43	0–18	9
Positive reappraisal	30	5	17	9.60	2.88	0–21	10.5

n: Total number, SD: Standard deviation

Table 4: Mean scores for perceived social support

Source of perceived social support	*n*	Min	Max	Mean	Std. Dev	Score range	Avg Score
PSS family	30	3	18	13.23	5.35	0–20	10
PSS friends	30	1	17	11.73	4.44	0–20	10

PSS: Perceived social support, *n*: Total number, SD: Standard deviation

between homemakers and skilled workers, but it did not account for statistically significant difference across the groups. It should also be noted that culture practices do influence the coping patterns of individuals in addition to their learned skills and behaviors. Such cultural beliefs and practices as "treating husband as God," "giving preference to male children," "men being the head of the family," "involving women mainly in household work," "not involving women in family decision making," " women should not get remarried," "women should eat after serving food to all other family members," etc., make women more vulnerable not only to domestic violence but also to stress-related mental illnesses in addition to physical health problems.[23-25] Even though there have been many positive changes in such beliefs about women in Indian contexts, and there are several government initiatives and programs for women's empowerment, it should be noted that women are still treated as a vulnerable group in various communities of Indian society.[26]

A study among 406 Caucasian and African–American women on violence, coping, and social support concluded that women did not experience uniform patterns of violence. Social support is a protective factor, and women used pray as a coping strategy. Hence, they are less likely to seek mental health help from professionals.[27]

Our study also explores the significant differences between coping age, family type, socioeconomic status, occupation, the perpetrator relationship with the respondent, and reasons for violence. The high-income group showed more negative coping strategy, while low-income group showed all types of coping. This could be because of the close social networks that people with low income get associated with for meeting their cultural, social, and financial needs. Another theoretical understanding is that adversities including poverty and lack of amenities can make people more resilient, adaptive, and socially well-connected. Positive coping of seeking social support was the highest among those reporting in-laws as perpetrators of violence. In the case of husband or son/brother being the perpetrator, the participants showed the following coping strategies: confrontive coping, distancing, self-controlling, seeking social support, accepting responsibility, escape avoidance, and positive reappraisal. Participants in the

Table 5: Comparison of coping, social support, and psychological distress with respect to alcohol use by perpetrator as a reason for violence

	Response	*n*	Mean	Std. Dev	*t*	*P*
Confrontive coping	Yes	9	9	0	12.564	0.001
	No	21	7.71	3.56		
Distancing	Yes	9	9	1.5	5.41	0.027
	No	21	6.57	3.50		
Self-controlling	Yes	9	12	1.5	0.673	0.419
	No	21	10.42	2.08		
Seeking support	Yes	9	13.33	0.5	7.939	0.009
	No	21	12.66	1.65		
Accepting responsibility	Yes	9	5.33	0.5	0.967	0.334
	No	21	5.19	1.03		
Escape avoidance	Yes	9	12.33	1	17.144	0.000
	No	21	9.57	3.07		
Planful problem solving	Yes	9	9	3	1.28	0.268
	No	21	6.95	3.48		
Positive reappraisal	Yes	9	10.66	2	1.767	0.194
	No	21	9.14	3.11		
Psychological distress	Yes	9	11.66	3.90	0.004	0.949
	No	21	11.42	3.93		
Perceived social support family	Yes	9	9.66	5.63	0.79	0.382
	No	21	14.76	4.54		
Perceived social support friends	Yes	9	11.44	3.97	0.335	0.567
	No	21	11.85	4.72		

n: Total number, SD: Standard deviation, T: *T*-test, *P*: Statistical significant

age group of 30–50 showed all types of coping, while the respondents in the age group of 20–29 largely sought support and accepted responsibility for the situation. This was similar to the results of earlier studies.[27,28]

Perceived social support from family for the respondents was higher than perceived social support from friends. Perceived social support from family was the highest among the age group of 20–29 years with those homemakers who stayed in the nuclear family reporting the highest perceived social support from family. However, earlier studies from India have reported that perceived social support was inadequate from the same age group[28,29]. The study findings and the available literature indicate that psychological distress, coping patterns, and social support systems are interconnected, so understanding them together seems to be the right approach toward better interventions.[30-32]

We have also found that psychological distress was the highest among the participants facing violence due to the perpetrator using alcohol. The same thing has been corroborated with many other Indian and Western studies that alcohol intake may alter the mood of the perpetrator and subsequently involve in violence.

Limitations

The study was conducted in only one organization catering to women in distress and at a single point of time with the respondents. The experiences of the respondents were not corroborated by other significant family members, and the sample size was small. Hence, the study findings cannot be generalized.

Conclusion

The study concludes that women facing violence for the reason of dowry take the blame on themselves, and in the initial years of their marriage, they adopt negative coping strategies, which may cause significant psychological distress. Apart from mental health, domestic violence also has a serious impact on physical health of women, particularly during their reproductive health. This negative effect of domestic violence hampers adequate and healthy family functioning and overall well-being of women. Thus, there is an urgent need for providing psychosocial care to women facing such stressful situations across the county.

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Conflicts of interest

There are no conflicts of interest.

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