Short Communication

Profiles of Victimized Outpatients with Severe Mental Illness in India

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Abstract

Persons with severe mental illness (PwSMI) are at risk of being victimized due to persistent cognitive, emotional, and behavioral symptoms, which can become potential threats for effective reintegration into the community. A total of 217 PwSMI, receiving outpatient psychiatric treatment from a tertiary hospital, were screened for abuse, and if they were identified as abuse, then information about contextual factors contributing to abuse, sociodemographic, family, and clinical and legal profiles was created. Overall, 150 PwSMI were victimized, of which 56% were females, 50.7% were married, 20.7% were educated up to middle school, and 31.4% were homemaker. The most common form of diagnosis was schizophrenia (43.3%), with a mean duration of illness of 14 years. All the victimized PwSMI were subjected to emotional abuse. PwSMI were more likely to be victimized by multiple family members due to poor knowledge and understanding about illness (24%). The majority of the PwSMI had disclosed abuse (62.7%) to nonformal sources (33.3%) with no documentation in the clinical file (82.7%). PwSMI experience ongoing abuse and are more likely to be re-victimized, which increases the need for regular screening and culturally sensitive and comprehensive community-coordinated care and support.

Keywords: Indian context, profiling, severe mental disorders, victimization

Introduction

Even though persons with severe mental illness (PwSMI) are at higher risk of victimization, studies have mainly focused on violence committed by them[1-5] because they are perceived as dangerous and unpredictable.[3,4] A study by Link and Phelan[6] indicates that cultural stereotypes of mental illness can affect the public's perception of it negatively, which, in turn, triggers fear and anxiety among those who try to defend themselves from perceived danger. This can result in the intentional or unintentional victimization of PwSMI.[7] Victimization increases the severity of PwSMI's psychiatric symptoms, increases their need for acute medical attention, and increases the costs of public health care. Therefore, to prevent the consequences, it is vital to examine the sociodemographic profile, prevalence and patterns of victimization, contextual factors, and legal profile of PwSMI.

Methodology

Study design, setting, and participants. A descriptive cross-sectional research design was used in this study. PwSMI, visiting a tertiary hospital's outpatient psychiatry department for follow-up, were recruited between December 2019 and June 2021. As per the International Classification of Diseases, Tenth Revision (ICD-10) criteria, the following individuals were included: bipolar affective disorder, schizophrenia, schizoaffective disorder, and recurrent depressive disorder, with a clinical global impression score[8] (≤4), and receiving adult psychiatric services on an outpatient basis from a tertiary hospital. In the study, the Composite Abuse Scale was administered to all eligible participants who consented to participate.[9] A convenient sample of 150 participants was recruited. All participants provided written informed consent, and the study was approved by the Institute Review Board (IEC (BEH.sc.DIV.)/2019).

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Instruments

Diagnostic Criteria for SMI: ICD-10 diagnostic criteria and reviews of case files.

Abuse Screening Tool. The Composite Abuse Scale.[9] On screening, PwSMI who experienced sexual, psychological, and physical abuse at least once in the past twelve months scored higher than the cutoff score.

Semi-structured interview schedule (SSIS). The SSIS was developed based on literature reviews and experts' recommendations and was validated by six experts working as mental health professionals. The Content Validity Index (CVI) score for the schedule was. 95. The validated schedule can be divided into five parts: Part A—sociodemographic profile, Part B—family profile, Part C—clinical profile, Part D—abuse profile, and Part E–legal profile.

Minimization of Bias

The recall and reporting bias for assessing abuse was minimized using a similar threshold for reporting violence (i.e. in the past 12 months) and using a standardized self-reported questionnaire. Additionally, it was minimized using the same setting for all interviews, that is, the outpatient department of the tertiary hospital.

Statistical analysis

IBM Statistical Package for the Social Sciences (SPSS) version 22 for Windows was used for the analysis. Categorical variables are described using frequency and percentage. The Shapiro–Wilk test was used to assess normality for continuous variables. A mean, standard deviation, and interquartile range (IQR) were calculated for normally distributed continuous variables and medians with IQR for nonnormally distributed continuous variables.

Results

Sample description

Of the 150 patients recruited, 56% were female, 50.7% were married, 20.7% were educated up to middle school (classes V–VIII), and 31.4% were homemaker. The most common form of diagnosis was schizophrenia (43.3%) with a mean (standard deviation (SD)) duration of illness of 14 years (7.38) and the presence of medical or psychiatry comorbidity (83.9%) (the demographic and clinical characteristics of the patients are given in Table 1).

Prevalence and severity of abuse

Figure 1 shows that in the preceding year, all the patients reported emotional abuse. The annual prevalence rate of severe combined abuse was 94%, followed by 92.7% reporting physical abuse, and 54% of the patients were harassed.

Table 2 indicates the severity of abuse. Overall, the abuse was quite severe, with the composite total abuse mean score

Table 1: Demographic, family, and clinical characteristics of the sample (*n*=150)

Variables	*n* (%)
Gender	
Male	66 (44)
Female	84 (56)
Marital status	
Single	49 (32.7)
Married	76 (50.7)
Separated	7 (4.7)
Divorced	10 (6.7)
Widowed	8 (5.3)
Education	
Not formally educated	20 (13.3)
Primary school	18 (12)
Middle school	31 (20.7)
High school	25 (16.7)
PUC	19 (12.7)
Graduation	28 (18.7)
Postgraduation	8 (5.3)
Others	1 (0.7)
Occupation	
Unemployed	32 (21.3)
Self-employed	33 (22)
Part-time employed	8 (5.3)
Full-time employed	24 (16)
Student	6 (4)
Homemaker	47 (31.3)
Monthly income	
Rs. 1051–Rs. 2101	28 (18.7)
Rs. 2102–Rs. 3503	61 (40.7)
Rs. 3504–Rs. 7007	51 (34)
Rs. 7008 and above	10 (6.7)
Religion	
Hindu	106 (70.7)
Muslim	29 (19.3)
Christian	15 (10)
Domicile	
Rural	68 (45.3)
Urban	82 (54.7)
	Mean±SD
Age	36.16±9.168
Duration of marriage	8.45±11.23
Family types	
Nuclear	103 (68.7)
Joint	46 (30.7)
Extended	1 (0.7)
Living arrangement	
Alone	10 (6.7)
With family	138 (92)
Others	2 (1.3)
Primary caregiver	
Parent	64 (42.7)
Spouse	59 (39.3)
Others	26 (17.3)
Self-management of illness	1 (0.7)

Contd...

Table 1: Contd...

Variables	*n* (%)
Availability of support	
Yes	122 (81.3)
No	28 (18.7)
Sources of support	
Family	99 (66)
Others	1 (0.7)
Any	22 (14.7)
Type of support	
Financial	1 (0.7)
Emotional	39 (26)
Any	82 (54.7)
Primary diagnosis	
Schizophrenia	65 (43.3)
Bipolar disorder	54 (36)
Schizoaffective disorder	12 (8)
Recurrent depressive disorder	19 (12.7)
Comorbidity	
Present	26 (83.9)
Absent	5 (16.1)
Medical comorbidity	
Hypothyroidism	16 (10.7)
Obesity	12 (8)
Others	19 (12.7)
Psychiatric comorbidity	
Psychosis	10 (6.7)
Nicotine dependence syndrome	29 (19.3)
Others	18 (12)
Any of the above	16 (10.7)
Hospital admission	
Yes	107 (71.3)
No	43 (28.7)
Relapse of symptoms	
Yes	118 (78.7)
No	32 (21.3)
Causes of relapse	
Nonadherence to medication	41 (27.3)
Family-related conflict	36 (24)
Others	11 (7.3)
Any	30 (20)
Noncompliance with treatment	
Yes	114 (76)
No	36 (24)
Causes of noncompliance	
Partial insight	20 (13.3)
Stigma	20 (13.3)
Lack of money	13 (8.7)
Side effects of medicine	8 (5.3)
Any	53 (35.3)
	Mean±SD
Illness duration	14±7.38

being the highest, that is, 32.18 with the interquartile range between 15 and 92.

Abuse profile

There were fewer than half of the patients who reported abuse by multiple family members, such as their parents (18.7%),

Table 2: Severity of abuse (as per the Composite Abuse Scale; *n*=150)

Types of abuse	Mean±SD (range)
Physical abuse	5.63±4.024 (0-24)
Emotional abuse	21.45±5.805 (10-44)
Harassment	2.13±2.163 (0-9)
Severe combined abuse	4.88±3.583 (0-18)
Composite (total) abuse	32.18±12.695 (15-92)

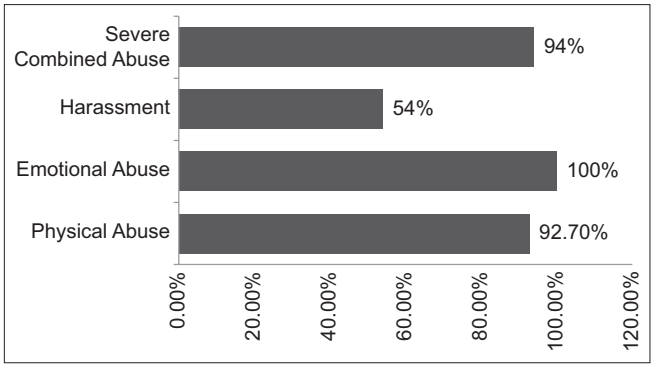

Figure 1: Prevalence of abuse among persons with severe mental illness

spouse (14.8%), and at home (42.7%). A lack of knowledge and understanding of the illness was the most significant precipitating factor for abuse (24%). A change in weight is the most severe physical impact of abuse (34%), a psychological impact is a negative perception of themselves (32.7%), family life is negatively affected by difficulty connecting emotionally with family members (42.7%), social life is negatively affected by withdrawal and isolation (42%), and professional life is negatively affected by work productivity (22.7%). Furthermore, most patients (62.7%) disclosed abuse to nonformal sources (33.3%), such as close family members, friends, and colleagues. According to the patients, emotional support was the most common reason for disclosure (20%). Nevertheless, the majority of clinical files or medical records (82.7%) did not include any documentation about the disclosure of abuse (the contextual factors for abuse are described in Table 3).

Legal profile

A small number of patients (13.3%) reported perpetrators having any first information report (FIR) or court case against them, mainly due to property disputes (9.3%). The majority of patients (80%) were unaware of their legal rights. The legal details are given in Tables 3 and 4.

Conclusion

The PwSMI who were identified as abuse in this study reported the highest mean frequency of emotional abuse. Several studies have identified the possibility that PwSMI are exposed to emotional abuse as most of them live with their families, and emotional abuse is often passively accepted and normalized in interpersonal relationships in these cultures.

Table 3: Abuse profile of PwSMI (*n*=150)

Variables	*n* (%)
Perpetrator	
Multiple Perpetrators	45 (30)
Parents	28 (18.7)
Spouse	38 (14.8)
Siblings	22 (14.7)
Others	17 (11.3)
Setting	
Home	64 (42.7)
Neighborhood	30 (20)
Common public places	26 (17.3)
Mental hospital	18 (12)
Any of the above	12 (8)
Precipitating factors	
Poor knowledge and understanding about illness	36 (24)
Persistent psychiatric symptoms	34 (22.7)
History of violence perpetrated by the participant	30 (20)
Caregiver's personality	27 (18)
Others	14 (9.3)
Any of the above	9 (6)
Impact on physical health	
Changes in weight	51 (34)
Somatic complaints	45 (30)
Bruises and injuries	30 (20)
Others	16 (10.7)
No impact	8 (3.1)
Impact on psychological health	
Negative feeling about themselves	49 (32.7)
Feeling insecure and unsafe	43 (28.7)
Negative perceptions toward life	35 (23.3)
Others	16 (10.7)
No impact	7 (4.7)
Impact on family life	
Difficulty to emotionally connect with family	64 (42.7)
Conflict with family	37 (24.7)
Difficulty to perform roles and responsibilities	28 (18.7)
Others	15 (10)
No impact	6 (4)
Impact on social life	
Withdrawal and isolation	63 (42)
Decrease social interaction	48 (32)
Decrease use of social media	17 (11.3)
Others	14 (9.3)
No impact	8 (5.3)
Impact on professional life	
Negatively affecting work performance	34 (22.7)
Negatively affecting relationship with colleagues and authorities	16 (10.7)
Loss of a job	13 (8.7)
Others	8 (5.3)
No impact	79 (52.7)
Reasons for nondisclosure	
Fears and apprehensions	19 (12.7)
Victim blaming	15 (10)
Guilt and shame	13 (8.7)
Any of the above	9 (6)
Abuse recorded in the file	
Yes	26 (17.3)
No	124 (82.7)

Table 4: Legal profile of PwSMI (*n*=150)

Variables	*n* (%)
Any FIR or court cast against the participants	
Yes	16 (10.7)
No	134 (89.3)
Any FIR or court case against the perpetrator	
Yes	20 (13.3)
No	130 (86.7)
Reasons for FIR or court case	
Property dispute	14 (9.3)
Neighborhood Conflict	11 (7.3)
Divorce	6 (4)
Domestic violence	5 (3.3)
Participant awareness about legal rights	
Yes	30 (20)
No	120 (80)
Participant awareness about community resources	
Yes	38 (25.3)
No	112 (74.7)
Type of community resources aware about	
Legal help	16 (10.7)
Social service organization	9 (6)
Psychological help	7 (4.7)
Religious institution	6 (4)
Accessibility to community resources	
Yes	14 (9.3)
No	136 (90.7)
Barriers to community resources	
Lack of information about resources	42 (28)
Considered not useful	31 (20.7)
Fear of consequences	27 (18)
Others	20 (13.3)
Any of the above	16 (10.7)

It reflects a sign of being nurtured for and supported by the family.[10,11] Studies show that PwSMI experience multiple forms of abuse, and in 90 percent of cases, it results in physical injuries and weight changes, further degrading their quality of life, which was consistent with the present study's findings.[5,12] PwSMI who are subjected to abuse feel helpless and powerless when they cannot defend themselves. Abuse negatively impacts their self-esteem. The possible explanation could be that people with chronic and severe mental illness may have interpersonal skill deficits due to abuse, which could impact their social life. In many cases, difficulty interacting effectively leads to fear of judgment in social situations, which ultimately leads to social withdrawal and isolation.[13,14] The present study found that interpersonal conflicts and stressful events in life increase psychological distress at work, which is consistent with previous findings.[15,16] El Missiry *et al*.[17,18] and Karni-Vizer, and Salzer[19] identified family members as the most common perpetrators, indicating that the majority of the time abuse occurs at home since PwSMI become socially isolated after developing mental illness, making them vulnerable to abuse. A lack of knowledge and understanding about illness was identified as the precipitating factor for abuse in the present study. A family with inadequate knowledge

and awareness about mental illness may not manage PwSMI effectively at home, resulting in a negative attitude toward them, according to Ahmed and Baruah.[20] Several studies have reported that PwSMI are more comfortable disclosing abuse to significant others because of their proximity, desire for care and support,[21,22] and greater access to support within a community.[23,24] The present study also indicated that the majority of PwSMI disclosed about abuse to seek emotional support. The experience of repeated victimization and severe injuries resulting from violence,[18,25] the desire to be validated emotionally, sympathy, love, and support were factors associated with disclosure and higher chances of seeking help.[26] According to the present study, most of the PwSMI clinical files or medical records did not include documentation of abuse in terms of screening, disclosure, and interventions after disclosure, which indicates that mental health professionals do not frequently inquire about abuse.

Based on the legal profiles of the PwSMI in the present study, very few reported FIRs or court cases against the perpetrator. There is a lifetime prevalence of violent crimes against PwSMI between 10.1% and 66.7%,[10,27,28] but fewer than half of these crimes are reported to police. A number of factors may cause underreporting, including fear of retribution, difficulty in seeking justice, and insensitivity among legal professionals, which result in the re-traumatization of PwSMI.[29,30] The majority of PwSMI in the present study were unaware of their legal rights and available resources in their community. Sharma argues[31] that PwSMI can seek help proactively when they are victimized if the government and civil rights organizations working to prevent violations of their rights collaborate on creating awareness about laws and community resources, such as shelters, counseling centers, and self-help groups.

In the present study, abuse was assessed only once, so the temporal relationship between mental illness and abuse or the outcome of abuse and its correlates could not be examined. It is evident from the present study that mental health services must improve their response to violence experienced by PwSMI. It is also important to train mental health professionals on how to identify victimization and how to respond to abuse experienced by PwSMI on a culturally and gender-sensitive basis.

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Conflicts of interest

There are no conflicts of interest.

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