Intimate Partner Violence, Lifetime Victimization, and Sociodemographic and Clinical Profile of Women with Psychiatric Illness at a Tertiary Care Psychiatric Hospital in India

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ABSTRACT

Background: Intimate partner violence (IPV) is one of the major public health problems. Little is known about the extent of violence experienced, its severity, or history of childhood abuse or exposure to intergenerational family violence in women with mental illness.

Methods: One hundred women seeking in-patients (IP) or out-patients (OP) services at a tertiary care psychiatric setting were recruited using consecutive sampling. IPV Questionnaire and Danger Assessment Questionnaire were administered.

Results: The data revealed a moderate level of IPV experienced by the women. In their childhood, more than one-third had undergone physical abuse by their fathers and witnessed violence by fathers toward mothers.

Conclusion: Screening for intimate violence is essential in women attending mental health settings.

Keywords: Intimate, violence, victimization, women, psychiatric, illness

Key Messages: Three-fourth of the women developed the psychiatric illness after marriage, and IPV could have been one of the stress factors for developing mental illness secondary to ongoing violence. Mental health professionals must routinely screen for IPV, provide the needed help, and connect the survivors to service organizations in the community.

Intimate partner violence (IPV) against women is a major public health concern around the globe and has been linked with significant mental health problems.[1–3] IPV is the second most risk factor for disability-adjusted life years globally in women aged 20–25 years.[4] WHO multi-country study on women's health and domestic violence against women revealed that IPV is widespread in all countries. In total, 13%–61% reported ever having experienced physical violence by a partner; 4%–49% reported having experienced severe physical violence by a partner; 6%–59% reported sexual violence by a partner at some point in their lives; and 20%–75% reported experiencing one or more emotionally abusive acts from a partner in their lifetime.[5] Clinical population research on violence experienced by female patients with psychiatric illness is limited. Chandra et al.[6] found that sexual coercion was reported by one-third of female patients with psychiatric illness, and the most common experience was sexual intercourse-related threats. In the gender context, women with pre-existing mental disorders are more at the risk of experiencing abuse/violence. Persons with common mental illness, especially women, were 2–5 times more likely to experience IPV than those without mental illness and less likely to seek help, especially from health professionals.[7] Female patients with psychiatric illness are at greater risk of IPV and but little is known about the clinical profile,

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HOW TO CITE THIS ARTICLE: Vranda MN, Naveen Kumar C, Muralidhar D, Janardhan N and Sivakumar PT. Intimate partner violence, lifetime victimization, and sociodemographic and clinical profile of women with psychiatric illness at a tertiary care psychiatric hospital in India. *Indian J Psychol Med.* 2021;43(6):525–530.

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Submitted: 17 Mar. 2020
Accepted: 9 Jun. 2020
Published Online: 11 Aug. 2020

ACCESS THIS ARTICLE ONLINE
Website: journals.sagepub.com/home/szj
DOI: 10.1177/0253717620938870

lifetime exposure, and its forms in the psychiatric settings.

The current research aimed toward assessing forms of IPV, severity, lifetime victimization, history of witnessing family violence, and services expected from mental health professionals at a tertiary care psychiatric hospital by women with mental illness (WMI).

Materials and Methods

The research was a cross-sectional study, and exploratory analysis was carried out to analyze the data. The study was carried out at National Institute of Mental Health and Neurosciences (NIMHANS), a tertiary care hospital located in Southern Bengaluru, India. The study was carried from January 2017 to June 2018. A sample of 100 women was recruited using consecutive sampling and the following inclusion and exclusion criteria: those aged 18–55 years, speak Kannada or English, availing services in OP and IP adult psychiatric care, under remission without active psychopathology, and who are vocal and able to participate in the interview were included. Those with intellectual developmental disorder, neurological disorders, organic psychiatric disorders, or history of substance abuse were excluded. Informed consent was obtained from all the participants at the time of recruitment. Consent was obtained from the family members to interview the patients. The study was approved by the Institute Ethical Committee. The patients were interviewed by a trained social worker of the primary project that aimed to assess the pattern of IPV among WMI and mental health professionals' knowledge, attitude, and preparedness to respond to IPV. Part of the larger study was published by Vranda et al.[31,32]

Operational Definitions

Physical violence includes the use of physical force against another—slapping, hitting, throwing objects, pushing, burning, strangulating, and beating, often leading to permanent injuries and sometimes even death.

Sexual violence involves the violation of an individual's bodily integrity, including coercing sexual contact, rape, as well as any unwelcoming sexual behaviors. This includes forcing unwanted sexual acts, withholding sexual intimacy, making degrading comments about someone's sexuality or attractiveness, and rape.

Psychological violence includes the use of controlling behaviors, isolating from families and friends, denying social contacts, threatening, humiliating, insulting, manipulating, withdrawing affection, and using abusive language that cause the victim to feel afraid, humiliated, confused, powerless, inadequate, or overwhelmed.

Emotional violence is defined as withholding/controlling the access to financial resources, not allowing the victim to work, and withholding necessities.

Lifetime victimization is defined as multiple traumatic victimization experiences that occur across the developmental periods, that is, in both childhood and adulthood. In this study, we assessed multiple forms of violence experienced from childhood to adulthood by multiple perpetrators.

Materials

Sociodemographic and clinical profile: The researchers prepared a sociodemographic data sheet to collect the background information. It covered demographic information, duration of abuse, history of lifetime victimization, previous help sought to prevent violence, and expectations from mental health professionals.

Danger Assessment Questionnaire: This is a six-item questionnaire developed by this research team (**Figure 1**). It assesses the level of danger women face and considers what she should do next to safeguard herself and her children. The questionnaire has been translated and back-translated for linguistic validity. It was content-validated by the experts. It was pilot tested with 30 women, and necessary modifications were made. The items are in a dichotomous format.

Screening of IPV Questionnaire[8]: This consists of 58-items, with four domains: physical violence (18 items), psychological violence (23 items), economic violence (seven items), and sexual violence (ten items). It assesses the different forms of violence experienced by women from their partners. The responses for each item are "Never," "Rarely," "Sometimes," "Usually," and "Always," on a 5-point Likert scale. Higher scores indicate a higher level of violence. The scale has good face validity, and as for consensual validity, the scale was validated by ten mental health experts from NIMHANS (i.e., three additional professors of psychiatry, four assistant professors of psychiatric social work, and three assistant professors of clinical psychology) who found it to be useful in assessing domestic violence among women.

Statistical Analysis

Descriptive statistics was used to analyze the sociodemographic variables. Welch's 't' test was used for categorical variables and Pearson's correlation coefficient was used to examine the relationship between continuous variables. For analysis, Statistical Package for the Social Sciences (SPSS) version 20 was used.

FIGURE 1.

Nature of Danger Experienced by Women on the Danger Assessment Scale

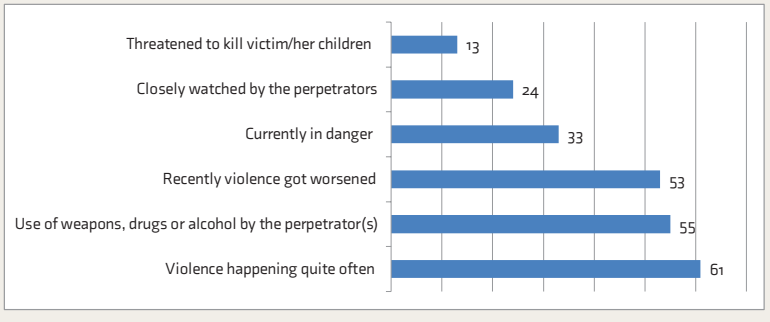

TABLE 1.

Sociodemographic Profile of the Sample

Sociodemographic Details	Variables	*N* = 100	Percentage
Education	Not literate	9	9
	School education	49	49
	College education	42	42
Occupation	Homemaker	71	71
	Working woman	29	29
Marital status	Married	55	55
	Others: (33 divorced/separated, 9 widows, and 3 unmarried)	45	33
Children	Yes	76	76
	No children	21	21
	Unmarried	3	3
Psychiatric diagnosis	Affective disorders	62	62
	Non affective disorders	38	38
Onset of psychiatric illness	Before marriage	17	17
	After marriage	83	83
Mean age and SD of the victims	Mean age: 34.42; SD 8.97		
Mean income and SD	Mean: 8620.69; SD: 10910.88		
Mean number of children and SD	Mean: 1.78; SD: 0.6		

Results

Descriptive Statistics

The age of the participants ranged from 18 to 55 years, with a mean of 34.2 (SD = 8.97). The majority (91%) were educated. A total of 49% had a primary school education. Three-fourths of the women were homemakers. The mean family income was Rs 8620.69 with SD 10910.88. A total of 55% of women were married, and two-thirds (33%) were either separated/divorced. The majority (76%) had children. The mean number of children was 1.79 with SD: 0.66. A total of 62% of women were diagnosed with affective disorders (such as bipolar affective disorder, postpartum psychosis, and depression) and the onset of the psychiatric illness was after the marriage for the 83% of the women (**Table 1**).

The mean scores and SD of domains of IPV Questionnaire revealed that all the women experienced moderate to severe levels of physical, emotional, economic, and sexual violence by their partners (**Table 2**). The mean danger assessment score was 2.39, with SD of 2.06, indicating a moderate level of danger from the perpetrators. Half of the women (53%) experienced IPV once a week, and one-fourth (24%) experienced IPV every day. Item analysis of the nature of danger assessment revealed that the majority of (61%) reported that they have been experiencing violence quite often at the hands of the perpetrators (see **Figure 1**).

More than one-third (40%) had witnessed physical violence toward their mothers from their fathers in their childhood, which was reported to be traumatic in nature for the women. More than 58% had undergone physical abuse by their fathers during their childhood. A small proportion (9%) had undergone childhood sexual abuse, and the perpetrators were known family members. Half of the women with IPV reported that their children were subjected to violence by the perpetrator.

In the past, nearly half of the women (52%) had left the home and lived temporarily with their family members and then returned to their abusive partners. Thirty-one women attempted to leave an abusive relationship. Out of this, presently, 13 women were living separately, three were legally separated, and rest 15 women were temporarily living with family members. One-fourth of the women reported a past history of suicide attempts. Overall, 70% of the women reported to have suicidal ideas secondary to the ongoing IPV (**Table 3**).

Those women who reported IPV from perpetrators who consumed alcohol experienced significantly higher physical violence ($P < 0.001$), emotional violence ($P < 0.001$), and economic violence ($P < 0.001$) compared to those who reported IPV from perpetrators who were nonconsumers of alcohol. Those women with IPV who had attempted to leave the violent relationship in the past experienced significantly higher sexual violence ($P < 0.001$) compared to those women who made no attempts to leave the violent relationship in the past (**Table 4**). There was a nonsignificant negative relationship between age, income, and the total number of children of women reporting IPV with the domains of physical vio-

TABLE 2.

Extent of Interpersonal Violence Experienced

Statistics	Physical Violence	Emotional Violence	Economic Violence	Sexual Violence	Total Domestic Violence Score
Mean	48	61	17	23	149
Std. deviation	13	15	5	6	33
Obtained minimum score	18	24	7	9	73
Obtained maximum score	75	90	33	46	223
Actual minimum score	18	23	7	10	58
Actual maximum score	90	115	35	50	290

lence, emotional violence, and sexual violence (**Table 5**).

About 90% of women with IPV wanted counseling services to overcome psychological distress secondary to violence, 40% each wanted stress management intervention, police aid, and treatment to abusive partner for alcohol problems. A total of 22% of women wanted shelter care facilities; a small percentage (10% each) expected family counseling services to prevent ongoing violence and teaching anger management skills to abusive partners from the Mental Health Professionals (MHPs).

The range of services expected from the MHPs varied from counselling services, police help, stress management, deaddiction treatment, and anger management skills for the abusive partner.

TABLE 3.

History of Suicidal Behaviors

Suicidal behavior		*N* = 100	Percentage
Past history of suicidal attempts	Yes	35	35
	No	65	65
No. of attempts (*n* = 35)	One time	13	37
	More than once	22	63
Methods used to commit suicide (*n* = 35)	Consumption of pesticides and other chemicals	7	20
	Hanging	13	37
	Drug overdose	15	42
Presently having suicidal ideas	Yes	70	70
	No	30	30

Discussion

This study aimed to assess the extent and severity of IPV, lifetime victimization, and services expected from MHPs at a tertiary care psychiatric hospital in India. Majority of the women experienced moderate IPV by their partners

TABLE 4.

Relationship Between Background Variables and Severity of Interpersonal Violence

Psychosocial Variables	Physical Violence			Emotional Violence			Economic Violence			Sexual Violence		
	Mean SD	Welch's *t*	P	Mean SD	Welch's *t*	P	Mean SD	Welch's *t*	P	Mean SD	Welch's *t*	P
Perpetrator consumes alcohol	51.17 ± 12.80	3.63	**0.001***	64.07 ± 14.16	2.49	**0.015***	18.55 ± 5.02	2.81	**0.006***	23.59 ± 5.80	−0.105	0.92
Perpetrator does not consume alcohol	40.9 ± 13.30			56.13 ± 15.68			15.46 ± 5.07			23.7 ± 8.42		
Past attempts made to leave an abusive relationship	49.8 ± 12.36	1.34	0.19	62.9 ± 12.09	0.83	0.41	18.13 ± 5.38	1.01	0.32	25.06 ± 6.06	2.27	**0.025***
No attempt made to leave an abusive relationship	46.18 ± 5.0			60.37 ± 17.60			17.08 ± 5.00			22.0 ± 6.92		
Previous history suicidal behavior	47.44 ± 16.18	0.33	0.75	60.36 ± 19.31	−0.59	0.56	17.7 ± 5.45	0.21	0.83	22.9 ± 7.27	−0.74	0.46
No previous history of suicidal behaviors	48.45 ± 12.29			62.43 ± 12.04			17.54 ± 5.10			24.03 ± 6.24		
Married	46.85 ± 14.27	0.99	0.32	60.29 ± 16.69	1.06	0.29	17.10 ± 5.13	−1.10	0.27	23.63 ± 6.56	−0.02	0.99
Others	49.6 ± 13.07			63.40 ± 12.6			18.26 ± 5.29			23.65 ± 6.79		
Homemakers	47.9 ± 13.47	0.21	0.83	61.46 ± 14.31	−0.23	0.87	17.54 ± 4.47	−0.24	0.81	24 ± 6.38	0.83	0.41
Working	48.55 ± 14.65			62.24 ± 16.85			17.86 ± 6.77			22.73 ± 7.25		
Women with affective disorders	48.29 ± 14.05	0.20	0.84	61.7 ± 14.9	0.06	0.95	18.23 ± 5.26	1.58	0.12	24.45 ± 6.7	1.57	0.12
Women with non-affective disorders	47.7 ± 13.34			61.57 ± 15.29			16.51 ± 4.9			22.23 ± 6.17		

*P <0.001.

TABLE 5.

Inter-correlation Among the Domains of Interpersonal and Background Characteristics

Variables	Physical Violence	Emotional Violence	Economic Violence	Sexual Violence
Victim's age	−0.05	0.06	−0.04	−0.12
Income	0.16	0.33	0.08	−0.07
Total number of children	−0.05	−0.09	−0.00	−0.02

and known family members. Three-fourth of the women (83%) developed psychiatric illness after marriage, and IPV could have been one of the stress factors for developing mental illness secondary to ongoing violence. This finding is in concordance with recent findings that[9,10] reported that women who have experienced domestic abuse have three times the risk of developing a mental illness, including severe conditions. A recent systematic review and meta-analysis of cohort studies on IPV against women and health outcomes revealed a positive association between IPV and subsequent depressive symptoms and increased symptoms of post-postpartum depression. There was also a bidirectional relationship between recent IPV and hard drug and marijuana use.[11]

A few studies have reported that childhood exposure to family violence is associated with increased risk of IPV[12,13] and a significant risk factor for further victimization and poor health outcomes in adulthood.[14,15] In the current research, more than three-fourth of WMI had witnessed abuse of their mothers by their fathers and more than half had undergone physical abuse by their fathers in childhood. Bensley et al.,[16] in a study conducted on 3,527 women, revealed that women reporting childhood physical abuse or witnessing interparental violence had a fourfold to sixfold increased risk of physical IPV, and threefold to fourfold increase in the risk of emotional abuse from partner.

Those WMI whose husbands use alcohol experienced significantly higher IPV than the WMI whose husbands did not use alcohol. Similarly, past research had found that the husband's use of alcohol was one of the major factors for violence toward women.[17–22]

McFarlane et al.,[23] in their community-based research, revealed that irrespective of service used, women who returned to the abuser reported higher danger and associated lethality risk compared to women who did not return. Additionally, the severity of physical abuse was significantly higher for women returning to the abuser who had been in a shelter but not for women who received a protection order. Further, leaving an intimate partner and estrangement from an intimate partner are risk factors for femicide among women victims. WHO[24] reported that women with a past history of attempts to leave the abusive relationships experienced higher sexual violence than those who made no such attempts.[25] According to our findings, women who returned to live with the abusive partners, after temporary separation, reported significantly higher danger of lethality compared to WMI who did not return to their abusive partners. Women who separated from their abusive partners after cohabitation experienced increased risk of femicide, particularly when the abuser was highly controlling. Other studies have revealed the same risks were posed by estrangement[26,27] but ours further explicates the findings by identifying highly controlling male partners as presenting utmost danger in this situation.

Implications

In light of our findings, it is important to mandatorily screen all WMI in tertiary psychiatric care for IPV. Asking simplistic questions may not be a sufficient intervention on the part of a clinician, as evidence exists that victims of IPV minimize the extent of the abuse when it is disclosed to clinicians.[28,29] Also, the key to safe and appropriate intervention is that women most likely to minimize the disclosure of violence may also be those who have experienced the most severe violence and those who have the most accepting attitudes toward violence.[30] The findings of a part of our larger research[31] revealed that at the patient level, many WMI undergoing IPV chose to conceal their abuse from MHPs, fearing retaliation from their partners if they get to know about the disclosure. At the professional level, lack of privacy was another important barrier for disclosure, where women reported that MHPs discussed the abuse in the presence of their violent partner. Hence, MHPs need to maintain privacy and confidentiality while doing an assessment. Safety planning with survivors should incorporate risk information that the clinician has gleaned from screening, and intake procedure suggests that incorporating risk assessments and safely planning of the predictions made by women regarding their safety can be extremely useful. In addition to planning for a woman's physical safety, effective safety planning should always include an assessment of her mental state or psychological stability. In India, Vranda et al.[32] developed and standardized a comprehensive culturally appropriate guide, first of a kind, *Psychosocial First Aid Intervention and Support for Women Survivors of Intimate Partner Violence/Domestic Violence—A Guide for Health Care Professionals* based on research. It is a unique effort to equip health care providers with skills and guidance as to how to respond to IPV/domestic violence against women in clinical settings. From the clinical standpoint, large-scale, longitudinal, prospective studies are required to know about the mental health outcomes of the victims.

Limitations

The study was confined to one tertiary psychiatric hospital; hence, the generalizability of the result is limited.

Conclusion

Despite progress in legislation, policies, and programs, WMI are continuing to experience violence. The promotion of women's mental health requires appropriate public and private recognition of the problem and preventive, proactive measures.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The study was financially supported by intramural NIMHANS funding (NIMH/Proj-VMN/00559/2016-17).

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