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Intimate Partner Violence and Psychiatric Morbidity among Ever Married Women in Urban Area

Sphurti Uday Chate[1], Girija Mahantshetti[2]

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Author's Affiliation:
[1]Tutor, Dept. of Community Medicine, BIMS, Belagavi; [2]Professor, Dept. of Community Medicine, JNMC,Belagavi

Correspondence
Dr Sphurti Uday Chate
sphurti.chate@gmail.com

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ABSTRACT

Background: Women facing violence is an important public health issue worldwide. A married women may experience violence within the family multiple times/ have overlapping of different types of violence namely physical, sexual, emotional/ psychological, controlling behavior culturally/ economically by her husband or in-laws. Intimate partner violence against women though prevalent , the women usually try to hide it and is thus one of the major causes of morbidity for women.

Objectives: To know the prevalence of intimate partner violence among ever married women in urban area of Belagavi and to assess the psychiatric morbidity among those experiencing IPV.

Methodology: The study was conducted in field practice area of Ashok nagar urban health centre area of Belagavi among 600 ever married women of reproductive age group of 15-49 years during January 2017 to December 2017. WHO based multicountry Intimate Partner Violence study questionnaire and Self Reporting Questionnaire 20 for psychiatric morbidity were used in the study.

Results: Prevalence of Intimate Partner violence: **59%.** Prevalence of psychiatric morbidity: **45.3%.**

Conclusions: Psychiatric morbidity was significantly higher in women experiencing partner violence in urban area. Preventive steps need to be taken.

Keywords: Intimate partner violence, psychiatric morbidity, married women, urban area

INTRODUCTION

The status of women has changed gradually from the Vedic period wherein they were respected and treated equal to men in all aspects to the medieval period where many social evils and practices of sati, purdah system were enforced. Yet heroic women and able administrators such as Jhansi Rani Lakshmibai and Kittur Rani Chennamma fought the British to safeguard the rights of their fellow beings. Today's modern independent women with constitutional rights have achieved great milestones in various fields but the crimes committed against women have increased.[1]

Gender based violence is the abuse of power of one gender over the other, which is an important public health issue worldwide and often married women are victims of violence from their current or former intimate partners i.e their husbands mainly. The World Health Organization has defined Intimate partner violence as the range of sexually, psychologically and physically coercive acts used against adult and adolescent women by current or former male intimate partners.

A married women may experience violence within the family multiple times/ have overlapping of different types of violence namely physical, sexual, emotional/psychological, controlling behavior culturally/ economically by her husband or in-laws.

Intimate partner violence against women though prevalent , the women usually try to hide it and is

thus one of the major causes of morbidity for women as the married women plays multiple roles as a daughter-in-law, cook, maid, mother, labourer as well as a wife; she is emotionally attached and dependent on the husband. Intimate partner violence by her husband has a long term and serious health implications both physically and mentally on her, thereby affecting the home environment and health status of all the family members especially affecting the growth of the children.

One of the important obstacles in the prevention of violence against women is the the lack of gender sensitive health research and reliable data on the magnitude of the problem and its consequences due to under reporting as the women themselves are not able to perceive several acts of their husbands/ relatives a s a form of violence and also due to fear of reprisal from husband.[2]

The study was thus conducted among the ever married women in urban area of Belagavi to know the prevalence of intimate partner violence and to assess the psychiatric morbidity among those experiencing Intimate Partner Violence.

METHODS

Following selection criteria were used to include women: 1) Ever married women aged 15-49 years and permanent residents of the study area (resident for atleast 1 year prior to the study) were included in the study; and 2)Ever married women who did not give consent for the study and those who were already diagnosed to have psychiatric morbidity due to known causes were excluded from the study.

The community based cross sectional study was conducted in the field practice area Ashok Nagar, Urban Health centre of Department of Community Medicine, KLE's Jawaharlal Nehru Medical College, Belagavi; to know the prevalence of Intimate Partner Violence among the ever married women and screen for psychiatric morbidity among them from January 2017 to December 2017.

Sample size was calculated by using the formula $n = 4pq/d^2$; where, n = sample size; p = 37% (prevalence of domestic violence)[3]; q = (100 - p) = (100 - 37) = 63; d = relative error 10% of p, i.e. 10% of 37% = 3.7 ≈ 4. The calculated sample size is 583 which is rounded to 600.

Out of the 7500 population of UHC, 1050 ever married women were aged between 15-49 years. Of whom 600 participants were chosen by simple random sampling method and data collected by house to house visit using the WHO based multi-country Intimate Partner Violence and Self Reporting Questionnaire 20. This was an interview based study. Informed written consent was taken from all the study participants after translating into the local language.(Kannada/ Hindi). Utmost care was taken to maintain the confidentiality and privacy of the selected women. All the 600 participants were interviewed and all of their responses were noted. 7 of them were hesitant initially but agreed to participate later. There were 4 locked houses initially, but in the course of 1 year duration their responses too were noted later. Hence the refusal rate was not present in our study. However the possibility of not revealing the truth of IPV by the participants cannot be ruled out.

Pilot study was conducted on 10% of the sample size (60) in Rukmini Nagar and the questionnaire was validated and required changes made in the questionnaire and was modified accordingly.

The study was approved from Institutional Ethics Committee for Human Subject's Research, Jawaharlal Nehru Medical College, Belgaum and the ethical clearance was obtained on 16th of October 2016.

The data was tabulated, coded and master chart was prepared in Microsoft excel sheet. Data was analyzed using Statistical Package for Social Sciences (SPSS), version 22.0 and the prevalence was expressed in terms of numbers and percentages. Statistical analysis was done using Chi- Square test to find out the association between Intimate Partner Violence and the psychiatric morbidity. A probability value (p value) of less than 0.05 was considered as significant at 95% confidence interval.

RESULTS

The study participants belonged to various socio-demographic characteristics as shown in table 1. Majority of the ever married women 274 (45.66%) belonged to 21-30 years age group; followed by 41-49 years 154 (25.67%); 31-40 years 142(23.67%) and only 30(5%) were less than 20years of age. 554(92.4%) of the study participants were educated whereas only 46(7.6%) were illiterate. 500(83.4%) were housewives and most of the women 162(27%) belonged to class III socioeconomic status according to modified BG Prasad Classification. 545 (90.8%) were married women whereas 38(6.3%) were widows; 12(2%) were separated and 5(0.9%) were divorced.

Table 2 shows the distribution of study participants based on experience of intimate partner violence. 58.5% of the ever married women had experienced any form of violence in their lifetime whereas 41.5% did not among the total 600 study participants.

Table 1: Distribution of study participants based on sociodemographic characteristics (N=600)

Sociodemographic details	Participants (%)
Age group	
<20	30 (5)
21-30	274 (45.66)
31-40	142 (23.67)
41-49	154 (25.67)
Education	
Illiterate	46 (7.6)
Educated	554 (92.4)
Occupation	
Housewives	500 (83.4)
Working	100 (16.6)
Socioeconomic status	
Class I	93 (15.5)
Class II	138 (23)
Class III	162 (27)
Class IV	154 (25.7)
Class V	53 (8.8)
Marital status	
Married	545 (90.8)
Divorced	5 (0.9)
Widow	38 (6.3)
Separated	12 (2)

Table 2: Distribution of study participants based on experiencing intimate partner violence (N=600)

Intimate partner violence	Participants (%)
Present	351 (58.5)
Absent	249 (41.5)
Total	600 (100)

Table 3: Distribution of study participants based on psychiatric morbidity among women experiencing intimate partner violence (N=351)

Psychiatric morbidity	Participants (%)
Present (SRQ>7)	159 (45.3)
Absent (SRQ≤ 7)	192 (54.7)
Total	351 (100)

Table 4: Association of intimate partner violence and psychiatric morbidity

Intimate partner violence	Psychiatric morbidity		Total
	Present	Absent	
Present	159 (45.3%)	192 (54.7%)	**351** (58.5%)
Absent	0 (0%)	249 (100%)	**249** (41.5%)
Total	159 (26.5%)	441 (75.5%)	**600** (100%)

Chisquare=153.462 , Df=1, p<0.0001

Based on the self reporting questionnaire used for screening the 351 women facing IPV for psychiatric morbidity showed that SRQ scores were >7 for 45.3% of them who thus had psychiatric morbidity as shown in table 3. Remaining 54.7% of them did not have any psychiatric morbidity.

According to the table 4, the association between IPV and psychiatric morbidity screening by SRQ 20 was found to be statistically significant with chisquare value 153.462 at degree of freedom 1 with p value < 0.0001 95% confidence interval.

Thus Psychiatric morbidity was significantly higher in women experiencing partner violence.

DISCUSSION

In the present study, 45.66% of the women belonged to 21-30 years of age group. A similar study conducted in Karad showed that 43.9% of urban women were in 21-30 years age group.[2] The mean age for the women was 33±9.6; which is similar to a study conducted in Kolkata that showed the mean age of women was 28.52±5.44 years.[5]

In the present study, only 7.6% participants were illiterate, whereas in another study conducted in Kolkata, 30.9% were illiterate.[5] Most of the other studies showed that illiterate participants were more when compared to literate.[2,4]

In our study 83.4% of the of the married women were housewives. Two other studies showed majority (58.5%) and 92.31% were homemakers, which was similar to our study.[4,5]

In the present study, 27% belonged to class III Socioeconomic status followed by 25.7% in class IV; 23% in class II, 15.5% class I and only 8.8% in class V. In other studies, 38.85% belonged to the lower middle class.[43] and 54.3% urban participants to lower socio-economic class.[2]

In the present study, 90.8% participants were married, 0.9% were divorced, 6.3% were widows and 2% of the married women lived separately from their husbands, which was similar to a multisite national study done which showed that 96% women were married and 4% widowed, separated or divorced.[6]

In our study, 58.5% of the ever married women experienced domestic violence in their lifetime which is similar to the prevalence (55.83%) seen in Latur study[7] and 54% in a study conducted in Kolkata.[5] but much higher than that found in other studies such as 40% in multi site Indian study,[6] 40.38% in Burdwan[4], 42.8% in Delhi,[8] 49.9% in Pune[9], 50.9% in Maharashtra[10]; and less than that found in urban western Maharashtra[10] which showed 68.7% prevalence with 31.3% women who never experienced domestic violence, compared to our study in which 41.5% of women who did not experience any domestic violence.

WHO study in 10 countries between 2000 and 2003 done by interviewing privately 24,097 women showed that 15% to 71%, was the lifetime prevalence of physical or sexual partner violence, or both.[11] In a survey of 5109 women of reproductive age in the Rakai District of Uganda in 2003 it was

observed that 30% had experienced physical abuse from their recent partner. Risk factors for domestic violence were male partner's alcohol consumption and human immunodeficiency virus (HIV) status. 70% of men and 90% of women considered wife beating as justifiable.[12]These could be some of the causes of intimate partner violence apart from sociodemographic characteristics such as lower literacy, low socioeconomic status, early marriage, mother in law's influence, dowry etc. in our study majority of the women experiencing IPV had husbands who were alcoholic.

Among the 351 women experiencing domestic violence, the psychiatric morbidity was found to be present with SRQ score >7 in 159 (45.3%) married women, whereas it was absent in 192 (54.7%) of them. In a multisite national study, 40% of the women reported experiencing 'any violence' during their marriage, among whom 56% had SRQ scores indicating poor mental health.[6]

In a study conducted in Delhi, 12% of women with domestic violence had poor mental health status,[8] while in a study conducted in Nanded, 58.5% had mild to severe depression among women experiencing domestic violence.[10]

A prospective cohort study conducted among the African American 569 female victims of Intimate partner violence (IPV) had 36%(461 prevalence was associated with increased mental health symptoms such as depressive symptoms, posttraumatic stress disorder (PTSD) and suicidality.[13]

A similar study to assess the prevalence of intimate partner violence and minor psychiatric morbidity among aboriginal women in Taiwan and analyze their association showed that 126 of 840 (15%) of the women ever experienced physical abuse perpetrated by an intimate partner. IPV was significantly associated with suicidal ideation and depression by multiple logistic regression.[14]

Another North Indian study of 3,642 couples in developing country showed that 12% had physical violence and that domestic violence by physical trauma, psychological stress or transmission of STIs influenced gynecologic morbidity.[15]

A WHO cross-sectional study done among 883 married women of rural Vietnam aged 17–60 years to know whether the health impact of IPV in a developing country were similar to those observed in western developed countries showed that 81 (9.2%) faced physical or sexual violence and 26 (32.1%) had been exposed to controlling behaviors whereas the combined violence exposure was associated with 8 to 15 times more ill health risk.[16]

In our study, association of IPV with psychiatric morbidity was found to be statistically significant and in a similar study of Intimate partner violence faced by women was also found to be associated with psychiatric morbidity conducted among Delhi women which showed similar results.[8]

The reason for a higher psychiatric morbidity among the women with IPV could have been lack of awareness or help seeking behavior, lack of social or economic support, fear of society norms and considering IPV as fate/ duty by the married women leading to increased mental health issues among the women.

The study being a highly sensitive issue, many women were hesitant to open up and disclose their private life experiences. Under reporting cannot be ruled out due to fear, family honor, unwillingness to disclose violence, culture or traditional beliefs.

In our study 593 participants were interviewed and all of their responses were noted after taking them into confidence with respect. This probably could be due to them being more comfortable with a female interviewer. 7 participants were initially hesitant but gave their responses as no IPV later. But the possibility of them lying or not disclosing cannot be ruled out.

However this differed from other studies wherein the refusal rates ranged from 14% to 44%. About 50–57% of 1268 women had IPV according to a Washington based study. Out of the 83% screened, only 25% were asked and 86% disclosed only if enquired respectfully, and confidentially.[17]A similar Spanish study done by a telephone interview had response rate of 56.4% and 43.6% refusal rate.[18]

CONCLUSION

The present community based study, reported a higher prevalence of (58.5%) domestic violence among the ever married women of reproductive age group residing in urban area. The prevalence of psychiatric morbidity among the women experiencing domestic violence was 45.3%.Psychiatric morbidity was significantly higher in women experiencing partner violence in urban area thereby affecting the entire family's emotional and psychological growth. Preventive steps need to be taken by creating awareness and further health programmes need to be encouraged with respect to domestic violence.

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