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RESEARCH ARTICLE

DOMESTIC VIOLENCE AND PSYCHIATRIC MORBIDITY

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ABSTRACT

Background: Women are integral to all aspects of society. They are worshipped, but when it comes to dealing with them, much still remains. Women bear the burden of responsibility associated with being wives, mothers and carers of others. There is a dearth of case-control studies. Domestic violence in women with psychiatric morbidity has not received sufficient attention. There are certain statistical and psychiatric considerations like:- Unipolar depression, predicted to be the second leading cause of global disability burden by 2020, is twice as common in women, depression is not only the most common women's mental health problem, but may be more persistent in women than men. Psychiatric morbidity as a determinant of domestic violence has received little attention. Indian culture is unique and there is limited work on domestic violence from Eastern Uttar Pradesh.
Objective: To study and compare married women with psychotic and non-psychotic and the nature of psychiatric morbidity in married women.
Method: 65 women attending psychiatry OPD department of SSL Hospital with 35 psychotic (Group 1) and 30 non-psychotic women (Group 2) were studied for the magnitude of domestic violence by husband. Domestic Violence Questionnaire of Indu *et al*. Psychiatric diagnosis in women was based on medical records.
Results: Significantly more women in Group 1 than Group 2 reported domestic violence (total/ psychological and physical) by husbands in past year (Group 1:80% total/ psychological violence; 65.7% physical violence) and non-psychotic women (Group 2:50% total/ psychological violence; 43.3% physical violence). Total domestic violence with Psychiatric morbidity was observed in 66.2%.
Conclusion: Women with psychotic illness have a higher reporting of domestic violence by husbands during the past year. As people with mental disorders are likely to be victims of violence. Mental disorder may increase vulnerability to domestic violence by increasing the likelihood of women being in unsafe relationships and environments and increase their vulnerability to violent victimization.

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INTRODUCTION

Violence against women is a social and public health problem. Its impact on the physical and mental health of women and their social functioning is pernicious (Ellsberg, 2008). A growing body of research confirms the prevalence of physical violence in all parts of the globe. As per the WHO multi-country study involving 10 countries, the proportion of ever-partnered women who ever experienced physical or sexual violence, or both, by their partners in their lifetime, ranged from 15-71% of women, with most sites falling between 29-62% (World Health Organisation, 2005). 65.8% had identified a domestic violence victim at least once in the past one year (Jacob, 2014). Estimates of domestic violence within India vary widely from 18% to 70%. Up to 45% of married men acknowledged physically abusing their wives, according to a 1996 survey of 6902 men in the state of Uttar Pradesh (UNICEF, 2000).

Most studies on domestic violence have been population-based. The relationship between domestic violence and psychiatric morbidity has not been sufficiently explored. 21% of domestic violence in women who attended an out-patient clinic in a North of England Hospital was reported. Women who were subjected to domestic violence tended to have more consultations and were more likely to complain of certain symptoms. (John *et al*., 2004) There is limited data from developing countries regarding the link between domestic violence and psychiatric morbidity. Links between domestic violence and sexually transmitted diseases have been reported. (Martin *et al*., 1999) Psychiatric symptoms in women are common and result in distress and varying degrees disability.

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The latter may adversely affect women's sexual behavior and ability to carry out the domestic chores. In a recent study (Babu and Kar, 2010) from Eastern India comprising 4 states, Bihar, Jharkhand, Orissa and West Bengal, age, education, occupation, marital duration and husband's alcoholism emerged as significant predictors of victimization and perpetration of all types of domestic violence. A higher level of family income was found to be highly protective against the risk of violence. In another study (Kaur and Garg, 2010) from a rural community from Northern India, an alcoholic husband emerged as the main cause for domestic violence. In a recent study, (Motevaliyan *et al*., 2014) from Tehran in Iran, of personality traits of 398 women who sought treatment at 4 hospitals, neuroticism was positively related to, while extraversion, agreeableness, and conscientiousness were negatively related to the severity of total wife abuse. Little attention to psychiatric morbidity as a risk factor victimization and/ perpetration of domestic violence. Besides, previous research in the country was impeded by the non-availability of a tool developed in India for quantifying domestic violence. Recently, the Domestic Violence Questionnaire has become available for use in India. (Indu *et al*., 2011)

Objectives of study

The main objectives of this study:

1. To compare domestic violence in married women with psychotic and non-psychotic illness.
2. To find out the different types of domestic violence in married women with psychotic and non-psychotic illness.
3. To identify the cause of domestic violence in married women with psychotic and non-psychotic illness.

MATERIALS AND METHODS

Ethics clearance: The research proposal of the study was approved by the research committee of the Department and the Institute of Medical Sciences.

Study Design

Case-control study

Research approach

Cross-sectional survey approach was used to collect data.

Research design

Cross - sectional study

Sample: The sample was selected from the Out-Patient Department of Sir Sunder lal Hospital, Banaras Hindu University, Varanasi, in accordance with specified criteria.

Sampling

Non-probability purposive sampling technique was adopted in selecting the respondents. The total sample size was 65.
Group 1 comprised 35 women and Group 2 comprised 30 women selected from the Psychiatric OPD of Sir Sunder Lal Hospital (SSL), Banaras Hindu University, Varanasi. The women were married, aged between 16-40 years. Both group had psychiatric morbidity, Diagnosed as suffering from Axis –I disorder as per DSM IV TR (American Psychiatric Association, 2005) matched with the patient group on age, years of education, domicile and socioeconomic status (SES) and consented to participate in the study. Socioeconomic Scale (SES) scale of Kuppuswamy (Kuppuswamy, 1981; Mishra and Singh, 2003) was used for assessing SES.

Assessment of subjects: All patients of Group 1 were assessed in detail on a structured proforma on which details psychiatric history and diagnosis were recorded. All patients / subjects of Group I and 2 were assessed for domestic violence by husband during the past year by the Domestic Violence Questionnaire (DVQ) of Indu *et al*. (2011). The subjects were first introduced to the subject, rapport was established and confidentiality ensured. Consent for participation was taken on the prescribed proforma. Thereafter, the subjects were assessed on the DVQ.

Data collection

Data were collected through personal interview.

Investigator met each respondent and collected her perceptions on Domestic violence.

Data analysis

The data was analyzed by parametric and non-parametric tests.

RESULTS

65 married women, 35 patients with a Psychotic illness (Group 1) and 30 non-psychotic illness (Group 2) were recruited into the study from the SSL Hospital. Table 1A reveals that the socio-demographic characteristic of the mean age of subjects of Group 1 was 30.68 ±5.74 years, and of Group 2 was 31.60 ±6.12 years. The mean years of education of Group 1 was 10.31 ±4.61 years, and of Group 2 was 8.73 ±5.36 years. The mean duration of marriage of Group 1 was 10.97 ±7.28 years, and of Group 2 was 14.00 ±7.43years. There was no significant difference between Group 1 and 2 with respect to age, years of education, and duration of marriage (Table 1).

Table 1B reveals that 56.9% of the subjects had rural domicile, the remaining subjects 43.9% resided in urban areas. Majority of subjects 92.3% were house wives. Only 7.7% were employed in different occupations. All patients were Hindus (100%). 58.5% of the subjects belonged to Upper Middle socioeconomic status (SES), 38.8% belonged to Lower Middle SES. 72.3% of the subjects hailed from joint families, the remaining 27.7% were from nuclear families. Marriages of all the patients were arranged. There was no significant difference between group 1 and 2 with respect to domicile, occupation (Home-makers versus non-home makers), SES and type of family of the subjects.

Table 2A reveals that the mean age of onset of disease Group 1 was 25.49±7.46 years and Group 2 was 28.83±6.42 years. The

mean duration of illness of Group 1 was 46.86±47.42 months and Group 2 was 33.77±36.60 months.

Table 2B reveals that the most common diagnostic categories in Group 1 was schizophrenia (26.2%); These were followed by major depressive disorder with psychotic features (10.8%); Bipolar I disorder, most recent episode manic (7.7%); Bipolar I disorder, single mania episode (6%) and Brief psychotic disorder (6.6%). Group 2 was Generalized anxiety disorder 15.4%, Major depressive disorder without psychotic features (13.8%), Conversion disorder (9.2%), Obsessive compulsive disorder (6%) and Dissociative disorder (3.1%).

Table 3A reveals that majority of subjects with respect to spousal violence reported by their husbands. All subjects reported psychological violence. Domestic Violence was reported significantly more by Group1 (23.28±22.96) than by Group 2 (09.03±17.30). Physical violence was reported significantly more in Group 1 (7.60+8.33) than in group 2 (2.60+5.37). There was a statistically significant difference in severity of spousal violence reported between the 2 Groups, more in Group 1 than in Group 2, both for total / psychological and for physical violence. Table 4 reveals that domestic chores was most common (83.7%) followed by, Unable to be a good sex partner (46.5%) then dowry, Other family members complain about her behavior, Slow, unsatisfactory (34.8%).

Table 1A: Socio-demographic characteristics of the sample

Variable	Psychotic N=35		Non psychotic N=30		t	df	P
	Mean	SD	Mean	SD			
Age (years)	30.68	5.74	31.60	6.12	-0.62	63	0.537
Education (years)	10.31	4.61	8.73	5.36	1.27	63	0.206
Duration of marriage (years)	10.97	7.28	14.00	7.43	-1.65	63	0.103

Table 1B: Socio-demographic characteristics of the sample

Variable	Psychotic N=35		Non psychotic N=30		Total N=65		$\chi 2$	Df	P
	N	%	N	%	N	%			
Religion									
Hindu	35	100	30	100	65	100			
Type of marriage									
Arranged	35	100	30	100	65	100			
Domicile									
Rural	19	54.3	18	60.0	37	56.9	0.21	1	0.643
Urban	16	45.7	12	40.0	28	43.1			
Type of family									
Nuclear	10	28.6	22	73.3	18	27.7	0.02	1	0.864
Joint	25	71.4	8	26.7	47	72.3			
Occupation of wife									
Professional & Semi professional/ Skilled & semi skilled	2	5.7	3	10.0	5	7.7	0.41	1	0.518
Home maker	33	94.3	27	90.0	60	92.3			
Occupation of Husband									
Professional /Semi professional	1	2.9	4	13.3	5	7.7	5.68	5	0.338
Clerical/shop owner/farmer	17	48.6	8	26.7	25	38.5			
Skilled worker	5	14.3	5	16.7	10	15.4			
Semi- skilled worker	7	20.0	7	23.3	14	21.5			
Unskilled worker	5	14.3	5	16.7	10	15.4			
Unemployed	0	0.0	1	3.3	1	1.5			
Socioeconomic status									
Upper	1	2.9	2	6.7	3	4.6	2.18	3	0.535
Upper middle	21	60.0	17	56.7	38	58.5			
Lower middle	12	34.3	8	26.7	20	38.8			
Upper lower	1	2.9	3	10.0	4	6.2			

Table 2A: Clinical characteristics of the sample: Age of onset and duration of illness

Variable	Psychotic N=35		Non psychotic N=30		t	df	P
	Mean	SD	Mean	SD			
Age of onset (years)	25.49	7.46	28.83	6.42	-1.92	63	0.059
Duration of illness (month)	46.86	47.42	33.77	36.60	0.85	63	0.396
Duration of treatment (month)	33.34	44.56	22.30	22.16	1.23	63	0.223

`Table 2B : Clinical characteristics of Group : Diagnostic distribution

Diagnosis	Group 1 N=65	
	N	%
PSYCHOTIC (GROUP 1)	**35**	**53.8**
Schizophrenia	17	26.2
Major depressive disorder with psychotic features	7	10.8
Bipolar I disorder, most recent episode manic	5	7.7
Bipolar I disorder, single mania episode	3	6.0
Brief psychotic disorder	3	4.6
NON-PSYCHOTIC (GROUP 2)	**30**	**46.2**
Generalised anxiety disorder	10	15.4
Major depressive disorder without psychotic features	9	13.8
Conversion disorder	6	9.2
Obsessive compulsive disorder	3	6.0
Dissociative disorder	2	3.1

Table 3 A: Domestic violence (spousal) in women: severity and pattern

Variable	Psychotic N=35		Non psychotic N=30		t	df	p
	Mean	SD	Mean	SD			
Domestic violence	23.28	22.96	09.03	17.30	2.78	63	0.007
Psychological	15.68	16.47	6.36	12.09	2.56	63	0.013
Physical	7.60	8.33	2.60	5.37	2.82	63	0.006

Table 4. Perceived Causes of domestic violence

Variable	Psychotic N=28		Non psychotic N=15		Total N=43		$\chi 2$	Df	P
Presenting cause	N	%	N	%	N	%			
Domestic chores	23	82.1	13	86.6	36	83.7	3.27	1	0.070
Dowry	10	35.7	5	33.3	15	34.8	1.29	1	0.256
Unable to be a good sex partner	12	42.8	8	53.3	20	46.5	0.44	1	0.507
Other family members complain about her behavior	12	42.8	3	20	15	34.8	5.36	1	0.021
Slow, unsatisfactory	10	35.7	5	33.3	15	34.8	1.29	1	0.256

DISCUSSION

The present study is from SSL Hospital which caters to a huge population from eastern Uttar Pradesh, Bihar, Madhya Pradesh and even Nepal. This region is densely populated with a relatively low level of literacy and psychological sophistication. The frequency, pattern and magnitude of domestic violence by husbands during the past year in patients with gynecological morbidity presenting at the gynecology OPD of a tertiary care hospital was examined in comparison with healthy matched controls. Domestic violence was reported by 42% of the sample. It was reported significantly higher in the group of women with gynecological morbidity (52%) than in the healthy group (32%). Domestic violence in 32% of the women of the healthy group compares well with the figures reported in population- based surveys from different parts of the country ranging from 18 to 70%. (UNICEF, 2000) It may be noted that women with gynecological morbidity reported both a higher frequency as well and severity of domestic violence by their husbands. This finding suggests that women with gynecological morbidity are at higher risk for experiencing domestic violence than normal healthy women, and is in keeping with reports from developed countries. (Schei and Bakketeig, 1989) A recent Indian study also reported somewhat similar findings. Compared with women whose husbands reported no violence, those who had experienced both physical and sexual violence and those who experienced sexual violence only, had elevated odds of experiencing gynecological symptoms. (Stephenson *et al*., 2006)

The 42 perpetrators, 26 of the Group 1 and 16 of Group 2, were studied in detail for presence of psychiatric morbidity. It is interesting to see that almost 2/5 (59.5%) of the perpetrators had a diagnosable mental disorder. This figure is much higher that the reported prevalence of psychiatric morbidity in general population studies ranging from 9.5 to 370/1000 in the country; and in Uttar Pradesh from 18 to 81.6/1000. (Chandrasekaran and Sudhir Kumar, 1999) The list of Axis I disorders included alcohol and drug abuse, Impulse disorder SOS, bipolar disorder and paranoid schizophrenia. There is a wealth of literature (Nambi, 2011; Babu and Kar, 2010; Kaur and Garg, 2010) regarding an association between alcohol abuse and domestic violence. Among the Axis II disorders passive aggressive, obsessive compulsive, histrionic, narcissistic, paranoid and antisocial disorders were seen. The total psychiatric morbidity, though higher in the women with gynaecological morbidity, than healthy women, was not statistically significant. This needs further study.

The findings of this study have practical implications. First, there is little recognition amongst health planners that psychiatric morbidity could be a cause of domestic violence. Second, Domestic violence can be prevented by early detection and treatment of Axis I disorders. Some help can be also offered to husbands with Axis II disorders. In addition, women can be taught to cope better with the maladaptive trait of their husbands. Surprisingly, the Protection of Women from Domestic Violence Act (2005) does not recognize psychiatric morbidity in perpetrators as a cause of domestic violence. In the Act, there is provision for a special order "Not to consume alcohol or drugs which lead to DV in the past", but none for medical treatment of the same. The strength of the study is the case-control design and use standardized culturally appropriate instruments for evaluation.

Limitation

The main limitation of the study is the women with psychiatric illness.

Recommendation

A similar study with large sample can be use to make a broad generalization.
A study can be replicated among different areas.
A study can be conducted to find out the domestic violence and gynaecological morbidity.

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