Indian Journal of Clinical Psychiatry
An Official Journal of **Association of Clinical Psychiatry**
(Indian Psychiatric Society- Uttar Pradesh State Branch (IPS-UPSB))

RESEARCH ARTICLE
doi: 10.54169/ijocp.v5i01.07

Violence Against Women and Mental Health: Assessing the Severity and Its Psychiatric Implications

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Abstract

Background: Violence against women is a significant public health issue and a breach of human rights, particularly infringing on women's rights to life. The United Nations defines violence against women as any act of gender-based violence that results in physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life. Estimates published by WHO indicate that globally, 1 in 3 (30%) of women worldwide have been subjected to either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime. The national statistics using a modified Conflict Tactics Scale estimate that 40% of women face lifetime domestic violence in India. Violence significantly impacts women's physical, mental, sexual, and reproductive health. In terms of mental health, violence is associated with depression, post-traumatic stress disorder (PTSD), anxiety disorders, sleep disturbances, eating disorders, and suicide attempts, particularly when experienced during childhood.

Aim: To assess the severity of violence among women seeking mental health care and to assess the relationship between different mental health conditions and exposure to violence

Method: Using the convenience sampling, participants were selected in a tertiary care hospital. Assessment tools include Severity of Violence Against Women Scale and MINI Plus. SPSS v20 was used to analyze the data. The objectives were to assess the severity of violence among women seeking mental health care and to assess the relationship between different mental health conditions and exposure to violence.

Results: Among 154 participants, the most prevalent psychiatric morbidities were Suicidality (41.6%), Dysthymia (14.3%), and Other specified depressive disorder (12.3%). Mild violence was reported by 37.7% of participants, moderate violence by 35.1%, and sexual aggression or serious violence by 7.8%. There were no significant associations were found between violence severity and age, occupation, marital status, religion, or socio-economic status ($p > 0.05$). From our study no correlation was found between severity of violence and psychiatric morbidity ($p = 0.112$).

Conclusion: Most women in our study had a lifetime history of exposure to mild to moderate violence. There was no association between the severity of violence and the presence of psychiatry morbidity. There is a need to explore other factors that mediate the link between exposure to violence and psychiatric morbidity among women.

ARTICLE INFO

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Dates:
Received: 03-03-2025
Accepted: 13-03-2025
Published: 30-06-2025

Keywords:
Gender-based violence, Severity of violence, Psychiatry morbidity, Mental health

How to Cite:
Gowdar TM, Prasad GC, Ghattargi S. Violence Against Women and Mental Health: Assessing the Severity and Its Psychiatric Implications. Indian Journal of Clinical Psychiatry.2025;5(1):34-40.
doi: 10.54169/ijocp.v5i01.07

Introduction

Violence against women is a significant public health issue and a breach of human rights, particularly infringing on women's rights to life, freedom from torture and other forms of cruel, inhuman, or degrading treatment, and their ability to achieve the highest possible standards of physical and mental health.[1,2]

The United Nations defines violence against women as "any act of gender–based violence that results in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".[3] WHO Estimates that globally, 1 in 3 (30%) of women worldwide have been subjected to either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime.[4] National statistics using a modified Conflict Tactics Scale estimate that 40% of women face lifetime domestic violence in India. The most common forms of violence against women are domestic abuse and sexual violence, and victimization is associated with an increased risk of mental disorders.[5]

Approximately 35% of women globally have encountered intimate partner violence or non-partner sexual violence. Around 7% of women worldwide have experienced sexual assault by someone other than an intimate partner. Additionally, up to 38% of homicides of women globally are perpetrated by an intimate partner. Furthermore, an estimated 200 million women have undergone female genital mutilation/cutting.[6] In 2022, a staggering 445,256 cases of violence against women were registered in India, averaging nearly 51 cases per hour, revealing a stark rise compared to the figures from 2021 and 2020.[7]

The conditions brought about by the pandemic, such as COVID-19, including lockdowns, restricted movement, increased isolation, heightened stress, and economic instability, have caused a significant increase in domestic violence.[7] Additionally, they have exacerbated women and girls' exposure to other forms of violence, ranging from child marriage to online sexual harassment.[8]

Violence can negatively affect women's physical, mental, sexual, and reproductive health.3 The mental health impacts of violence against women may manifest as behavioral issues, sleep and eating disturbances, depression, anxiety, post-traumatic stress disorder (PTSD), self-harm, suicide attempts, low self-esteem, and problematic alcohol or substance use.[9,10] Research increasingly shows the global[11,12] and national significance[13-15] of these mental health consequences stemming from violence against women. Previous research indicates that women who have experienced domestic violence and abuse are three times more likely to develop depressive disorders, four times more likely to suffer from anxiety disorders, and seven times more likely to be diagnosed with post-traumatic stress disorder (PTSD).[16]

There is a noticeable absence of a comprehensive strategy to enhance healthcare systems' reactions to violence against women and children, as well as to ensure suitable mental health research and services.[17] Research should prioritize longitudinal studies that encompass all types of violence against women, examining their impacts to identify specific mechanisms that could be targeted through customized interventions.[18] If patients are interviewed and counselled at early stages these problems can be prevented. If any mental health problem is detected, early treatment and counseling will reduce the morbidity of this major health problem. This study aims at assessing the severity of violence among women and its effect on mental health in patients presenting to the psychiatry department at a tertiary care center.

Materials And Methods

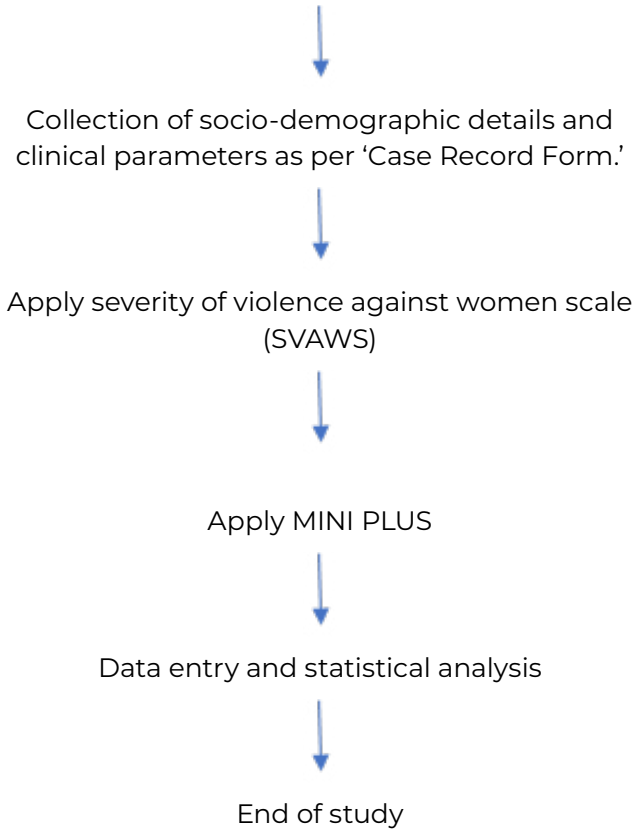
Following approval from the Institutional ethics committee, this cross-sectional study was carried out among women aged more than 18 years who were victims of violence according to the definition given by WHO, which is any act of gender–based violence that results in physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. Data were collected in semi structured proforma after getting an informed consent. Convenience sampling was done with subjects who presented to Psychiatry

OPD at a tertiary care hospital. The previous study by Susan Rees, *et al*. 52.5%[19] of women who were victims of violence had a mood disorders, based on this, our sample size calculation is $n = \frac{z \times p \times q}{d^2}$ where n=required sample size Z=standard normal distribution for a 95% confidence interval =1.96, P = expected prevalence = 52.5%, Q = 100-p = 100-52.5 = 47.5 D = precision=15% of P = 7.8 Based on this sample is 154.

Apart from demographic data, data regarding awareness about violence, signs and symptoms, relationship with abusive individual, treatment given and referral to other department were collected. To assess severity of violence, severity of violence against women scale (SVAWS) was used, which is reliable and valid developed by Marshall. The frequency is measured on a 4-point Likert scale (1-never to 5-many times), and severity is measured based on the questions answered by the subjects. This scale also measures types of violence exposed by women like physical, emotional, verbal, and sexual violence. This scale measures lifetime exposure to violence. To assess the psychiatry morbidity, The Mini-International Neuropsychiatric Interview (M.I.N.I) was used, which is a short structured diagnostic interview developed jointly by psychiatrists and clinicians in the United States and Europe. The MINI Plus derived from MINI is more inclusive. It has 23 diagnoses. It features questions on rule-outs, disorder sub-typing, and chronology.

The data were statistically analysed using SPSS and Kolmogorov-Smirnov test was used to determine the normality of the data. Continuous variables are expressed in terms of mean, standard deviation (SD), median, and interquartile range (IQR). Ordinal or categorical variables are expressed in terms of frequency(n) and percentage (%). Chi-square was used to assess the significance between the severity of violence and the severity of suicidal intensity. All statistical correlations were considered significant if the value of $p < 0.05$.

Women who are aged more than 18 years and are willing to give informed consent and who are victims of violence?



Results

A total of 154 participants who took part in the study were included in the statistical analyses. Most of the subjects were aged between 25 and 40 (63.6%), had completed schooling up to high school (31.8%), identified as Hindu (89.6%), lived in urban areas (76.6%), and belonged to a low socio-economic status. 51.9% were unemployed. 78.6% of the women were married. (Table 1). 8.4% were not willing to disclose experiences of violence. 41.6% of the women were referred from other health facilities.

According to MINI plus, among the subjects, 64 had suicidality (41.6%), 22 had dysthymia (14.3%), 19 had Other specified depressive disorder (12.3%), 12 had Major Depressive Disorder (7.8%), 10 had Recurrent Depressive Disorder (6.5%), 7 had Panic disorder (4.5%), 6 had Bipolar disorder (3.9%), 3 had Generalised Anxiety disorder (1.9%), and 2 had PTSD (1.3%). A total of 42.9% of subjects experienced frequent violence. According to the SVAWS scale, the majority experienced mild violence (37.7%), which means they had answered questions like "held you down, pinning in a place" and "pushed or roughly

Table 1: Demographic details

Parameter	*Number (%)*
Age	
18-24	25(16.2%)
25 - 40	98(63.6%)
41-60	31(20.1%)
Education	
Illiterate	21(13.6%)
Literate	133(86.36%)
Occupation	
Unemployed	80(51.9%)
Employed	74(48.5%)
Religion	
Hindu	138(89.6%)
Christian	4(2.6%)
Muslim	12(7.8%)
Domicile	
Urban	142(92.2%)
Rural	12(7.8%)
Marital status	
Married	121(78.6%)
Unmarried	26(16.9%)
Socio-economic status	
Low	108(70.1%)
Middle	45(29.2%)
Upper	1(0.6%)

Table 2: Psychiatry morbidity and severity of violence

Psychiatry morbidity	
• Dysthymia	22(14.3%)
• Major depression - Recurrent	10(6.5%)
• Major depressive disorder	12(7.8%)
• Other Specified Depressive disorder	19(12.3%)
• Suicidality	64(41.6%)
• Others	27(17.5%)
Severity of Violence	
• Mild violence	58(37.7%)
• Minor violence	30(19.5%)
• Moderate violence	54(35.1%)
• Serious violence + sexual aggression	12(7.8%)

Table 3: Treatment and support

Crisis intervention counselling	67(43.5%)
Family psychoeducation	85(55.2%)
First-line support and Internal referral To another department	61(39.6%)

handled" followed by moderate violence (35.1%), which means they had answered questions like "slapping". Sexual aggression and serious violence were reported in 7.85% of cases which means they answered questions like "choking" "kicking" "forceful sexual activity" (Table 2). The prevalence of physical violence was high, followed by verbal and emotional violence. 42.9% of subjects experienced frequent violence.

First-line treatment and referrals to other departments like medicine, surgery was done for 61 subjects (39.6%). Patients who had suicidal ideations, crisis intervention was done. Patient who had current exposure to violence, family psychoeducation was done, and was referred to psychosocial worker for further management. (Table 3). The majority of abusive individuals were husbands (83.76%).

There is no statistically significant association between the severity of violence and age group (p–0.189), occupation (p–0.685), marital status (p–0.198), socio-economic status (p – 0.646), religion (p–0.393), or domicile (p – 0.663) (Table 4).

There is no statistical significant association was found between psychiatry morbidity and the severity of violence (Table 5).

Discussion

Our study was planned to assess the relationship between the severity of violence among women and its relationship with different mental health conditions. In our study, the prevalence of physical violence is high, followed by verbal and emotional violence. In our study, we observed that women experienced more than one type of violence, with physical, verbal, and emotional violence seen in 40.9% of women. Sexual violence was observed in 7.8% of subjects. The prevalence of psychological, physical, and sexual violence was 43.4%,27.2%, and 26.4%, respectively, in a study conducted by Kamlesh Kumari Sharma *et al.*[20] The difference in results are due to different assessment tools used in both the studies.

Table 4: Association between severity of violence and demographic data

Parameter	*Chi-square value*	*p-value*
Severity of violence and age	8.733	0.189
Severity of violence and occupation	9.212	0.685
Severity of violence and marital life	8.597	0.198
Severity of violence and religion	6.276	0.393
Severity of violence and socio-economic status	6.915	0.646
Severity of violence and domicile	4.101	0.663

p-value < 0.05 is considered statistically significant

Table 5: Association between psychiatry morbidity and severity of violence

Parameter	*Chi-square value*	*p-value*
Psychiatry morbidity and severity of violence	52.891	0.121

p-value < 0.05 is considered statistically significant

In our study, mild violence was observed in 58 subjects (37.7%), moderate violence in 54 subjects (35.1%), and sexual aggression and serious violence in 12 subjects (7.8%). These findings are consistent with those of Mysore Narasimha Vranda *et al*.,[21] where the mean danger assessment score was 2.39 with a standard deviation of 2.06, indicating a moderate level of danger from perpetrators. In a study by Giulia Ferrari *et al*,[22] it was found that 70% of women had severe abuse.

In our study majority had dysthymia and suicidality. This finding is in contrast with the study by Susan Rees *et al*.,[19] where the lifetime prevalence rates were reported as 37.8% for any mental disorder, 24.6% for anxiety disorder, 18.3% for mood disorder, 13.9% for substance use disorder, and 9.8% for PTSD. The differences observed can be attributed to variations in sampling techniques. In the study by S. Jonas *et al*.,[23] the prevalence rates of Depressive episode, Generalised anxiety disorder, Panic disorder, Obsessive-Compulsive disorder, PTSD, and Alcohol dependence were 3.5%, 5.3%, 1.3%, 1.3%, 3.2%, and 3.3% respectively. There are similarities in the prevalence of anxiety and PTSD between our study and theirs.

There is no association between psychiatry morbidity and severity of violence after adjusting variables (P value – 0.112). This is different from the study by Susan Rees *et al,*[19] where Gender-based violence was associated with more severe current mental disorders (OR, 4.60; 95% CI, 2.93-7.22). The difference in the result is seen because of the different assessment tools used and the correlation of incremental exposure to violence with psychiatry morbidity. In a study conducted by Alka S Vachher *et al*[24] in Delhi, it was found that domestic violence was significantly associated with adverse mental health status (OR =2.9,95% CI, 1.4-6.0). This difference is seen because of the different sampling methods and assessment tools used. There might be other factors that mediate between violence and psychiatry morbidity. These are resilience, social support, coping skills, premorbid personality, and access to legal help.

The limitations of our study include its cross-sectional design, which prevents us from establishing temporal relationships between violence exposure and psychiatric morbidity. Given that suicidality and dysthymia were predominant diagnoses in our study population, our findings may not extend to other psychiatric conditions. Our study did not explore the correlation between various types of violence and psychiatric morbidity, which is a limitation considering previous research indicating that sexual violence is associated with higher psychiatric morbidity. Furthermore, our study did not account for comorbid psychiatric disorders despite their high prevalence in clinical settings. For example, while many participants were diagnosed with suicidality, we did not consider co-occurring conditions such as depression or anxiety. Addressing these limitations could enhance the comprehensiveness and applicability of future research in this area. The assessment tool, which was used to assess the severity of violence, its validation is limited in Indian setting, using a scale which is validated in Indian setting in future studies will yield more valuable insights.

In India, very few studies have conducted research in this area where the severity of violence

and its association with psychiatric morbidity is looked at. In our study, we have also mentioned intervention for women who are currently exposed to violence and a referral to other departments whenever necessary.

Our initial hypothesis, derived from previous research, suggested a relationship between the severity of violence and psychiatric morbidity; however, our study did not find a significant correlation between the two. This is because there is a need to explore other factors which mediate the link between exposure to violence and psychiatric morbidity among women.

Conclusion

Most women in our study had a lifetime history of exposure to mild to moderate violence. There was no association between the severity of violence and the presence of psychiatry morbidity. There is a need to explore other factors that mediate the link between exposure to violence and psychiatric morbidity among women.

Future Direction

Further research needs to explore other factors that mediate the link between exposure to violence and psychiatric morbidity among women, like social support, self-concept, and personality disposition. A Global plan of action to strengthen health-system responses to violence against women and children, appropriate mental health research, and service provision is necessary. Research needs to be informed by more longitudinal studies into all forms of violence against women, including measures of impact of violence, which could identify potential mechanisms that tailored interventions could address. Law and Policies needs to be enforced to protect women from violence and necessary actions should be taken in situations where it is breached.

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