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Women's Experiences with Intimate Partner Violence and Their Mental Health Status in India: A Qualitative Study of Sambalpur City

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Abstract: The intimate partner violence (IPV) against women has been identified as a violation of human rights and a serious public health concern. There is not only the immediate consequence of partner violence, such as injury or death but also the other long-term health consequences. IPV can be associated with psychological effects such as depressive disorder, posttraumatic stress disorder, and substance abuse. The study aims to explore the nature and causes of IPV on women's life and their personal experiences to deal with. This is an NGO-based study. For better understanding of the issues, Purposive sampling was used in selecting women with clinically diagnosed mental illness who experienced IPV. The qualitative research methodology was employed to explore the experiences and impact of IPV on the mental health status of women. For analysis, we used a phenomenological approach and conducted in-depth interviews. Findings show the participating women were suffering from IPV in physical, psychological, and sexual forms. Majority of respondents felt that wife-beating and abusing was fairly common. Most of the women had to face violence on a frequent and occasional basis. IPV experienced women were facing a mental illness like anxiety, depression and sleeping-disorder. The women, who were facing mental illness due to IPV, have been and continue to be exposed to such violence. Despite being employed and suffering from IPV deeply, women choose to stay with their abusive partner because of their children future, lack of support, and social security. The mental health of victims' was clinically diagnosed, including self-assessed symptoms. It means participants were aware that they are mentally ill because of IPV. The healthy and quick recovery treatment should be given according to the need of women, rather than providing comprehensive standardised treatment for all.

Keywords: Anxiety; intimate partner violence; mental health; sleeping disorder; qualitative study

1 Introduction

Intimate partner violence (IPV) against women has been identified as a violation of human rights and a serious public health concern [1]. It has severe consequences for the physical, mental, sexual, and

reproductive health of women [2]. There is not only the immediate consequence of partner violence, such as injury or death but also the other long-term health consequences, such as chronic pain, neurologic and gastrointestinal disorders, migraine headaches, and other disabilities [3]. Health problems widely experienced by battered women include gynecological issues such as pelvic inflammatory diseases, decreased sexual desire, urinary tract infections, AIDS, genital irritation, unexplained vaginal bleeding, pelvic pain, fibroids, sexually transmitted infections, the inability to use contraceptives, and unwanted pregnancy [4,5]. Partner violence during pregnancy is associated with many physical health complications. It includes spontaneous abortion, abruption placenta, premature rupture of membranes (PROM), low birth weight (LBW), preterm labor, neonatal and perinatal death; it also results in higher use of health services. Depression, suicide, posttraumatic stress disorder, drug abuse, low self-esteem, and eating and sleep disorders are mental sequelae of intimate partner violence [6–8].

IPV is overwhelmingly prevalent and contributing to ill health among women [9]. It can lead to not only adverse physical consequences but also severe psychological consequences, which can negatively affect the ability of the victims to carry out their daily activities efficiently [10]. IPV can be associated with psychological effects such as depressive disorder, posttraumatic stress disorder, and substance abuse [11,12]. Physical consequences of IPV include chronic pains, migraines, speech disorders, arthritis, ulcers, intestinal problems, sexually transmitted infections and pelvic pain [13]. IPV is considered mostly as "not a public affair" between intimate partners [14]. Therefore, victims usually do not report it to the concerned authorities [15,16]. As a result, most victimized women choose to keep violence as a secret. Moreover, they decided not to reveal it because they believed that disclosing such violence is not a sign of loyalty towards the partner. In Addition to that, they also felt of the danger of retaliation by the abusive partner. According to the findings of the investigations into the causes of IPV, socio-demographic and socioeconomic factors of societies have a significant effect on the occurrence of IPV [17]. Despite the high prevalence of IPV that negatively affects the quality of women's lives, most of them still choose to stay with their partners because of so many reasons including economic reliance, for the sake of the future concerns of their children and fear of more violence [18].

Studies from India consistently indicate a relatively high prevalence of IPV. A study found that about two-fifths of the 9938 Indian women, who were studied, reported IPV in their marriage [6]. A study explored that about 14% of studied women reported having experience of physical violence even during their pregnancy in the past year, psychological abuse by 15%, and sexual coercion by 9%. One-half of these women also reported ongoing abuse during pregnancy [19]. IPV, however, is often under-reported and variations across countries are likely to be influenced by culture and attitudes towards violence against women.

The present study is a phenomenological qualitative investigation that was carried out to analyze the lived experiences of women suffering from IPV to gain a deeper understanding of their feelings, thoughts, and perceptions. The result of the present study will add to the knowledge about the response of women to IPV, which will help the policymakers to build a strategy to help them reduce the adverse effects of living in an abusive and violent relationship.

2 Data and Methodology

2.1 Study Area

The present study conducted in Sambalpur city (Metropolitan Area) that is located in the western part of Odisha in India. The city is one of the largest and oldest urban centres in the state. As of 2011 census of India, Sambalpur city and it is Metropolitan Area (Amsadha Katapali Area, Burla Town, Dhankauda & Mathapali, Hirakud Town, and Sambalpur) has a population of 183,383, and 269,575, respectively. The sex ratio of Sambalpur city is 946 with a child sex ratio of 899. As per the 2011 Census of India report, the literacy rate of the city was 85.15% with 90.51% and 79.51% of male and female literacy respectively. Trade is

the major source for the economy of the city. Most of the residents are either self-employed or salaried workers. Forest products also play a significant role in the economy in terms of contribution to revenue and domestic merchandise.

2.2 Sampling Procedures

Respondents were reached through contact at the "Stop Violence Centre" an NGO working on violence against women located in the Sambalpur city. We selected all those married women (18–45 years of age), who were currently experiencing intimate partner violence or had any history of the experience of the same within the last five years. Including to that, they were clinically diagnosed as a patient of mental illness, and either they were a permanent resident of Sambalpur city or living there for the last two years. Besides, their participation was based on the participation willingness, and being agreed to sign out a consent form. Before data collection, women were briefed about the study and were asked to sign consent forms. Out of the 57 eligible respondents, who were currently seeking the counseling and other healing help in the NGO "Stop Violence Centre" in the city, 27 were selected through a purposive sampling for the study.

After participants signed the consent forms, they completed questionnaire that covered demographic information, a mental health checklist, and their previous experiences with mental health providers. The checklist was designed for this study and included a range of issues such as assertiveness, stress, depression, anxiety, and parenting. Participant women were asked to check any of the items that were causing them any difficulty. The questions were not rated or ranked by the participants. Participants were also asked if there were anything else, they would like to add to the checklist. Completing the questionnaires took approximately 10 minutes. The checklist aimed to include a wide range of possible issues that might be experienced by the participants. The checklist was based on a local mental health clinic's experience on the common issues reported by their clinical population.

2.3 Qualitative Personal In-Depth Interviews

In Qualitative research, the in-depth interviews are now widely opted method across many disciplines like Geography, Sociology, and Social work and even in Medical Sciences [20,21]. From the range of qualitative research methods available, keeping in mind the time and resource constraints, as well as the sensitive nature of the research problem, the in-depth interview method was thought to be the best-suited option and was selected for the study. Out of 27 selected respondents, we successfully conducted in-depth interviews only with 12 women who have completed the procedures of the consent form and given their complete information in questionnaires and checklist. This number was enough for interviewing such sensitive issues that help us to explore their IPV experiences to achieve maximum saturation point. A phenomenological approach has been used to understand and explore the experiences of women who faced intimate partner violence and resultant to that suffering from mental illness. Previous studies have shown this number considered adequate for a phenomenological approach [21,22].

Because intimate partner violence is a sensitive issue and many women prefer to maintain silence about it, the in-depth interviews were initiated by more straightforward topics and questions. That includes common health problems faced by them, decision making in the family, and place of women in the society. After establishing rapport, the question of intimate partner violence was initiated. An interview guide was developed, covering the key topics to be explored with the respondents. The interviews followed a semi-structured format, using open-ended questions in a face-to-face conversation rather than a formal question-answer format. To collect the required data on the participants lived experiences of intimate partner violence, and the associated mental health problems, in-depth semi-structured interviews were conducted. The discussion with respondent started with general descriptive queries, e.g., "*tell me about your marriage*" followed by questions or request, e.g., "*Please tell me about your feelings*," "*Tell*

me about your relationship with husband," "*Do you have children?*" and so on. Subsequently, the participant was asked questions regarding symptomology: "*What are the difficulties you are experiencing?*" The interviewer followed up on each difficulty by asking questions such as: "*How long have you had this difficulty?*," "*Is there any event that is precipitating this difficulty?*" "*How are you coping with this?*" and "*Do you have a support system?*" As a tactic to elicit more information about the subject, the interviewer kept silent after each question so that the respondents get more time to express their feelings and thoughts about their experiences of partner violence and related mental health problems. Each interview lasted 50–60 minutes. The interviews were conducted in the participant's language and for the study; it was carefully translated into English.

3 Results

3.1 Characteristics of Interviewed Participants

Tab. 1 illustrated the socioeconomic characteristics of interviewed respondent women and their mental health issues that were clinically diagnosed, along with the self-accessed feelings of illness. In the table, we could see that the age, educational status and occupation do not have any specific role to be or not to be the victim of IPV in the study region. It shows that women across all socioeconomic and demographic profile suffer from IPV. The analysis in the present study led the researcher to understand the lived experiences, feelings, thoughts, psychological and emotional state of women who were abused by their intimate partners.

Table 1: Characteristics of interviewed participants

Participant code	Age	Education	Occupation	Clinically diagnosed mental illness	Self-assessed feelings
A	29	Post Graduation	Housewife	Depression	Hopeless, sad, social withdrawal
B	42	High School	Housewife	Sleeping disorder	Restless, cannot sit still
C	32	Graduation	Lab attendant	Anxiety and panic	Fear, worry, irritability, confusion, inferiority complex
D	28	Graduation	Primary school Teacher	Eating problems	Worthless, hopeless, no desire to eat, lack of self-esteem
E	31	Primary	Sweeper	Depression	Sad, tired out, hopeless, worthless
F	39	Graduation	House keeper in a girls chamber	Bipolar mood disorder	Excessive fear, worry, anxiety, social withdrawal, irritability, mood swings
G	21	High school	Sweeper	Anxiety and panic attack	Excessive fear, social withdrawal, worry, dramatic changes in eating and sleeping habits
H	36	Primary	Craft making for a shop	Depression	Hopeless, nervous, sad
I	33	Graduation	Housewife	Acute stress disorder	Stress for no reason
J	44	High school	Domestic helper	Sleeping disorder	Confused thinking, sadness, worry, anxiety
L	23	Graduation	Lab assistant	Sleeping disorder	Worthless, inferiority complex, restless
M	30	High school	Domestic helper	Acute stress disorder	Excessive worry, stress

3.2 The Magnitude of the Problem

A total of 12 women have participated in personal in-depth interviewed in the study. Out of this, about half of women were the graduate and above level of educational qualifications. Most of them were either housewives or low paid workers. In poor economic households, intimate partner violence was perceived as a significant problem. Majority of respondents felt that wife beating and abusing was common and that there were very few couples untouched by this squalor. Majority of the women had witnessed violence in their families in their childhood. However, they agreed that the problem is of lesser magnitude now. Most of the women had to face violence on a frequent and occasional basis. A respondent woman, who was housewife, stated:

"*Hardly a few men are there who don't beat their wives, rest all do. Wife beating occurs every other day.*"

Another woman (32 years of age), who was lab attendant, said,

"*It is the way of society. I have seen my mother being beaten up by my father during my childhood*."

Along with physical violence, verbal abuse was a common phenomenon. She further added,

"*Getting abused verbally is an everyday matter"* (Gaali Galauj to roz ki baat hai).

A respondent, who was working as a sweeper, said,

"My husband uses very foul language, usually calls such bad names that I've never heard before. Many times, he uses to abuse and kicks me with his legs to listen."

The severity in terms of physical, psychological and sexual harm and the need for treatment varied from mild, moderate, to severe. Sometimes the women had to visit a health facility. One woman narrated:

"My husband hits me with anything that comes in his hand, be it an axe. Once he hit me with a hard object and fractured my arm. I have to go to the health centre sometimes. He also hurts me physically and sexual when he wants sex, and I don't have a desire for the same."

Even pregnant women were not spared. One of the women said,

"I was beaten up during my eighth month of pregnancy because I denied having the sex. He did not care at all and forcefully did it after beating. I was not even taken to the hospital afterwards."

A feeling of fear was there among many of the respondent women. One of the women said,

"I am afraid of my husband. He has a terrible temper. He is in a foul mood all the time. As soon as you speak a word to him, the things get worse to beat me. At times, I go to the neighbors' house and hide myself to escape the beating."

3.3 Living in a Physical Threatening Environment

Physical violence is the most common form of violence, as the results revealed. Women, who live in homes where there is partner violence, actually live in an unpredictable condition, filled with a lot of mental tension and anxiety and dominated by fear. Instead of growing up in a physically and emotionally safe, secure, and predictable environment, these women were forced to live in a mentally pathetic environment and worry about the future; they try to predict when it might happen next and strive to protect them. Almost all the respondents experienced the wish of running away from that life or die and resultant to that they trapped in mental ill-health conditions like depression, sleeping disorder and anxiety. Participants stated their pain in this regard:

"My husband beats me for even small arguments with him. If leaving the husband was not taboo, I wish I would surely leave him. I am always living in a household that is dominated by tension and fear. He discourages me from going to work. He always blames me for his violent behavior and tells me that I deserve it."

Few husbands use to beat their wives because of the doubt of extra-marital affairs. Most in such cases if a woman was working, then the suspicious maybe her male colleagues and husband abide to talk with them, and in case, if she would be housewife, then her husband blamed for anyone who talked her fairly. One respondent stated:

"My husband falsely accuses me of having an affair with my colleague. He beats me if I get late after work even though I am hungry and tired. I feel hopeless and worthless at that time. I don't know whether I will be free from this hell or not, and it made me depressive."

Physical violence by partner also caused because he did not care about his partner's need instead that every households chore at his own time. One of our respondents said:

"I work in a craft shop. I return home tired and exhausted. Despite knowing this, even one minute late in preparing dinner, my husband threw all the prepared dinner on me and beat me until I run away from the house. I am always scared about what would happen next. This episodic behavior of my husband made me mentally ill."

3.4 Living in a Psychologically Threatening Environment

Psychological violence included acts that threatened the participant's self-esteem, personality and dignity. Almost all the participants experienced insults, belittling, threats of harm, constant humiliation, intimidation (e.g., destroying things), threats to take away children and controlling behavior (isolating from family and friends; monitoring their movements). Many women reported that their husband used to humiliate them mentally by spying on them and keeping an eye on their working place. They used to spy through different channels like snipping in their mobiles contacts, chats and messages and being in touch with any male person who may be her office colleague. One of respondent stated in this regard:

"I am a primary school teacher. My husband has stolen all the contact number of my colleagues from my phone. He calls them frequently and embarrasses me by enquiring about me whether I have an affair with my male colleagues or not. One day he was hiding behind the main door of our house, and I returned home, he started shouting at me that he has seen me with a male person in the park. But he lied as always and accused me falsely."

Most of the interviewed women mentioned that their husband and in-laws family members were not happy with their working status, especially when she had to go outside the home for work. Although they love her earnings to share in their manner, they do not like to provide space and freedom to work outside the home. It may be a cause of psychological stress all the time. They never miss a single chance to taunting and humiliating in front of friends and colleagues. That made them mentally ill and has a lack of confidence to perform better at their workplaces.

"My husband forces me to stay at home instead of going to work and earn money. For fulfilling his desire, he broke my phone and burnt my new clothes and documents. He humiliates me in fronts of my friends and family. None of my friends and family members wants to come to my home. I have become isolated, depressed and hopeless."

The above-mentioned narratives illustrated that the petty behaviors of the male partner created a threatening psychological environment for the women. It drastically influences the life of such women into a painful experience that is with less productive and ill mental health status.

3.5 Living in a Sexually Threatening Environment

Sexual violence has posed a threat to participant's personality, dignity and quality of life. It prevented them from enjoying their intercourse with their husbands. Moreover, the anger and cruelty of her male partner made their sexual life much painful, and it turned into a threatening environment. Participants stated in this regard:

"My husband is an astringent kind of man. Whenever he wants sex, I have to agree; otherwise, he will beat me up. I am scared that he may go to other women for his satisfaction. What to do? We will have to do what they say. That is our fate. Sometimes I cry for so long and cannot even eat and sleep properly."

Woman's narratives stated that she has to suffer from force-sex that may call as marital rape. This undesired sexual cohabitation leads them to such an environment where, for them, sex would not be a pleasure rather than a kind of sexual violence. Consequences that they used to suffer from several physical illnesses, including many mental health problems like anxiety and depression. Some researches show that sexual violence has the most significant effect on self-esteem, and victims experience lower self-esteem, lower assertiveness, and higher social anxiety. Many porn-addict male partners forced to act with their female what they watch through videos, and it somehow humiliated the dignity of such victim women. The expression of women illustrated as,

"I am a domestic helper. I feel completely tired out and want to take rest after dinner when I use to return home. However, usually, my husband forces me to have anal sex that he use to enjoy a lot. If I deny, he started to humiliate me and compare my body with another woman."

"My husband is a porn edict. He forces me to watch with him and act like them, which is very disturbing because I cannot do like those porn stars."

4 Discussions

Analyzing the narratives of the participants who suffered from IPV revealed that they are living with violence and poor mental health. The whole lives of such women were under threat because of their intimate partners' acts of violence that included physical, psychological, and sexual violence. Despite being employed, they are exposed to violence. The probable reason might lie with the urban husband's elevated attitude of physically hurting his wife due to his superiority complex [23,24]. Historically, according to societal norms in India, the husband was the breadwinner of the family, and women worked only in the household [25–27]. Women now work for economic benefit, and this might go against the long-nurtured societal beliefs of the husband and the notion of a husband's empowerment in the family, thereby inducing violence against women. As the wives who earn more than their husband are more likely to be abused, the actual reasons for IPV victimization of women in India might be explained through complex phenomena including socioeconomic inequality in power and rights, familial hierarchy, and marriage related norms [23,28–30].

As we explored from the participants of the present study, they were suffering from physical violence by their intimate partners. This type of violence ranged from beating to throwing things at them and hitting them for false accuse. Such acts of physical violence can lead to numerous physical pains, problems and creation of an environment full of fear and tension. Experiencing such physical abuse in an intimate relationship significantly affects the mental health status of female victims, and further, it increases the probability of depression, anxiety, posttraumatic stress disorder (PTSD) and a bipolar mood disorder [13,31]. Previous research has established relationships between physical violence victimization and a wide variety of adverse mental health outcomes [32–36].

Psychological violence was the most frequent type of IPV in the present study. This type of violence usually happened orally by shouting and yelling, insulting, belittling, constant humiliating, intimidation (e.g., destroying things), threats of harm, threats to take away children and controlling behavior which hurt the participants' personality, dignity and self-esteem. Psychological violence was also reported in other studies [37–40]. Consequences of this type of IPV can affect the victim mentally, leading to a post-traumatic stress disorder, sleeping-disorders, bipolar mood disorder, nervousness, and eating problems [12,41]. Psychological violence can also lead to individuals being restricted from social support, which further diminishes identity and control [42]. Again, this is pertinent in the association between

psychological Intimate Partner Violence (IPV) and subsequent Post Traumatic Stress Disorder (PTSD). Addition to that social and mental support in the aftermath of traumatic experience is an established protective factor in the development of PTSD symptoms [43]. Qualitative research [44] found that IPV victims reported psychological violence as more harmful than other types of violence. It must be noted that psychological violence can no longer be considered a minor kind of violence and ignorable but rather a possible key predictor of specific mental health outcomes.

Sexual violence was another most frequent type of violence in the present study. It has been linked to poor health outcomes among women, such as acute morbidity [45], gynecological problems [46], sexually transmitted infections [47] and severe mental health issues like depression, sleeping disorder, bipolar and acute stress [21,48,49]. Several scholars have investigated and documented that in more than half of the cases of physical, psychological violence and sexual violence, the perpetrator was the spouse or intimate male partner and that cause serious health problems in women primarily mental disorder across the globe [50–52]. Another study examined a multi-country analysis of Demographic and Health Survey (DHS) data showed that approximately one-fifth to one-half of women experienced spousal or intimate-partner sexual abuse [51]. In Indian societies, the explanation for the higher intimate partner sexual violence may be either the cultural norms or nature of families where it is a conscious process of intimidation and assertion of the superiority of men over women [21,53–55]. Therefore, they get the right to force their wives for sexual coercion whenever they want.

Previous studies demonstrate that victims were often exposed to different forms of violence within a relationship, known as poly victimization [56]. For example, [57] in their longitudinal study found that women who had been victims of intimate partner sexual violence in a relationship were also victims of physical and psychological violence. The co-occurrence of multiple types of violence, including intimate sexual violence confers higher risk to victim women concerning a more significant number of adverse health outcomes [56]. This is particularly salient in relation to mental health outcomes associated with IPV victimization. Indeed, [58] report that poly victimization of IPV across the life course is associated with a higher degree of psychiatric morbidity.

5 Conclusion

The results of this paper revealed that the participating women are suffering from IPV in physical, psychological, and sexual forms. However, despite being employed and suffering from IPV deeply, they choose to stay with their abusive partner because of their children future, lack of support, and social security. Psychological violence and emotional torture by the partners were the most common type of violence among the participants. The study also revealed the occurrence of poly victimization. The co-occurrence of multiple kinds of violence was posing a higher risk to the victim's mental health and well-being. The mental health of victims' was not only clinically diagnosed but also self-assessed. It means participants were also aware that they are mentally ill because of IPV victimization. The study also revealed that different women have different mental health needs. Therefore, for the healthy and quick recovery, treatment should be given according to the need of women, rather than providing general standardized treatment for all.

6 Limitations of the Study

This is an exploratory study and did not use any statistical model to linkages and estimate the impact and prevalence of intimate partner violence and mental health problems among such violence-suffering women. The findings need to be interpreted mindful of the limitations of the study. These include the exclusion of women who were too mentally ill to participate. It is quite possible that the severity of IPV among these (excluded) women would have been even greater than it was among those we were able to include. Important issues that were not addressed in the study but that require investigation include the temporal

relationship between mental illness and IPV experiences and factors related to help seeking in the context of mental illness itself (e.g., stigma, not being taken seriously, the role of family reactions). We did not interview other stakeholders, like general physicians or other medical professionals. We did not do it for many reasons as our presence might raise undue attention, which might be harmful to the respondent.

7 The Ethical Concern

A consent form has been used to inform the respondents regarding their right, that is, at any time, they could withdraw from the interview even after participating. The participants have been informed that they could hide any personal facts or information that they do not want to reveal, and we assured them of their confidentiality. The verbal consent has been taken before interviewing an individual. Additionally, we recorded the consenting process for all discussions. We assured to maintain confidentiality in interviewing up to the end of the study. Furthermore, we recorded all interview files with a unique code that could be understandable only to the author. Besides, we replaced the actual name with a pseudonym in the manuscript and secured information with the investigators. We obtained formal ethical clearance from the NGO "Stop Violence Centre."

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