The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 12, Issue 2, April- June, 2024
DIP: 18.01.341.20241202, DOI: 10.25215/1202.341
https://www.ijip.in

Research Paper

Examining Violence Against Women Among Individuals with a History of Deliberate Self-Harm: A Cross-Sectional Study

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ABSTRACT

Background: Violence against women, particularly intimate partner violence and sexual violence is a major public health problem and a violation of women's human rights. Estimates published by WHO indicate that globally about 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[1]. Violence can negatively affect women's physical, mental, sexual, and reproductive health, and may increase the risk of acquiring HIV in some settings. Violence can lead to depression, post-traumatic stress and other anxiety disorders, sleep difficulties, eating disorders and suicide attempts[2]. **Materials and method:** Using the criterion sampling, participants were selected in a tertiary care hospital. Assessments tools include COLUMBIA- SUICIDE SEVERITY RATING SCALE(C-SSRS), SEVERITY OF VIOLENCE AGAINST WOMEN SCALE. The objectives were to evaluate the proportion of women who are exposed to violence among those who attempted deliberate self-harm. SPSSv20.0 was used to analyse the data. **Results:** Out of 68 participants,24 used OP poisoning as a method of self-harm.27.9% had moderate-severe suicidal intensity. 29.4 % had no suicidal intensity. 52.9% had lethality score of 2 which signifies moderate physical damage. 33.8% had mild violence. 7.4% had serious violence plus sexual aggression. There was significant correlation between severity of suicidal intensity and severity of violence. (p =0.002). **Conclusion:** The results point to a significant correlation between severity of suicidal ideation intensity and violence. This highlights that violence being one of the risk factors for deliberate self-harm. This warrants us for public education against domestic violence and timely psychosocial management of the vulnerable cases through a protracted community based mental health program, which will help to reduce the frequency of DSH and domestic violence.

Keywords: *Violence, Deliberate Self-harm, Suicidal Intensity*

Violence against women is a prominent public health problem and a violation of human rights, which impairs, in particular, women's rights to life, to freedom from torture and other cruel, inhuman, or degrading treatments or punishments, and to the highest attainable standards of physical and mental health[1,3].

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Received: June 13, 2024; Revision Received: June 22, 2024; Accepted: June 26, 2024

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"[2]. 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. 35% of women worldwide have experienced intimate partner violence or non-partner sexual violence. Globally, 7% of women have been sexually assaulted by someone other than a partner. Globally, as many as 38% of murders of women are committed by an intimate partner[4]. The National Crime Records Bureau's (NCRB) annual report reveals a harrowing surge in crimes against women in India. With a staggering 4,45,256 cases registered in 2022 alone, equivalent to nearly 51 FIRs every hour, the data exposes a grim escalation from 2021 and 2020.

Violence can negatively affect women's physical, mental, sexual, and reproductive health. Mental health effects of violence against women can include behavioral problems, sleeping and eating disorders, depression, anxiety, posttraumatic stress disorder (PTSD), self-harm and suicide attempts, poor self-esteem, harmful alcohol, and substance use[5,6]. There is growing evidence on mental health consequences of DV globally, and also at national level[7,8].

The DSM 5 TR defines suicide attempt as 'a self-initiated sequence of behaviors by an individual who, at the time of initiation, expected that the set of actions would lead to his or own death'[9]. The lifetime prevalence of deliberate self-harm is about 3% to 5% of the population in Europe and the US, and has been increasing. This condition could be repetitive in up to 23% of people over 4 years, and could lead to death by suicide in up to 8% of the people over 9 years[10]. A total of 1,64,033 suicides were reported in India in 2021 which is an increase of 7.2% in comparison to the previous year in terms of total numbers. In terms of rate of suicide, India reported a rate of 12 (per lakh population) and this rate reflects a 6.2% increase during 2021 over 2020. Among the females who committed suicide, the highest number involved "Marriage Related Issues" (specifically "Dowry Related Issues") and in terms of profession, homemakers constituted the highest number[11].

Studies employing community samples, mostly from high-income countries, have found mental illness as a major factor associated with suicide, though anecdotal reports suggest that they may be a less common cause of suicide in developing countries[12]. Family conflicts, social maladjustments, breakdown of intimate relationships and exam failure are some of the social factors associated with suicide in developing countries. Adversities including physical violence, emotional and sexual abuse can lead to substantially higher risk for suicide.

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 could be addressed by tailored interventions. Public education against domestic violence and timely psychosocial management of the vulnerable cases through a protracted community based mental health program may help to reduce the frequency of DSH and domestic violence. Considering that violence could be probable risk factor for deliberate self-harm, our study aims to find the cause effect relationship between violence and deliberate self-harm. Since there are less studies in this field especially from India our study was undertaken.

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 meeting criteria for deliberate self-harm according to DSM 5 TR. Data were collected in semi structured proforma after getting an informed consent. Criterion sampling was done with subjects who presented to Psychiatry OPD at a tertiary care hospital.

Apart from demographic data and data regarding suicidal ideation, intensity and violence questionnaires were included. To assess suicidal ideation, intensity and lethality, COLUMBIA- SUICIDE SEVERITY RATING SCALE(C-SSRS) scale was used which is reliable and valid scale developed by multiple institutions, including Columbia University, with NIMH support. It comprises "yes/no" questions to assess the suicidal ideation, intensity of ideation is measured on a 6-point Likert scale with scores ranging from 2 to 25 and lethality of attempt is measured on 5-pont Likert scale (0- no physical damage to 5-death).

To assess severity of violence, SEVERITY OF VIOLENCE AGAINST WOMEN SCALE was used which is reliable and valid developed by Marshall. The frequency is measured on 4-ponit Likert scale (1-never to 5-many times) and severity is measured based on the questions answered by the subjects.

The data were statistically analysed using SPSS and Shapiro-Wilk test was used to determine the normality of the data. Chi-square was used to assess the significance between severity of violence and severity of suicidal intensity. All statistical correlations were considered significant if the value of $p<0.05$.

RESULTS

A total of 68 participants who participated in the study were included in the statistical analyses. The mean age of distribution was 28.09. Most were married (69.1%). Majority were from lower socio-economic class (76.5%). Around 73.5% were hailing from urban background. OP poisoning was the most common mode of suicidal attempt (35.3%) followed by tablet consumption (33.8%)(Table 1). 29.4% of participants didn't have suicidal intent severity and 27.9% had moderate-severe suicidal intensity. 52.9 had lethality score of 2 which indicates moderate physical damage. 33.8% had mild violence followed by 30.9% had moderate violence.

On Chi square test significant association was found between severity of suicidal intensity and severity of violence. (p -0.02) (Table 2)

Table 1 - Demographic details

Mean age of distribution – 28.09

Marital status	
• Married	47(69.1)
• Separated	1(1.5)
• Unmarried	20(29.4)
Socioeconomic status	
• Lower	52(76.5)
• Lower middle	12(17.6)

• Upper middle	4(5.9)
Address	
• Rural	13(19.1)
• Semi urban	4(5.9)
• Urban	51(73.5)
Mode of suicide	
• Bed bug poisoning	1(1.5)
• Corrosive poisoning	3(4.4)
• Hanging	5(7.4)
• Mosquito repellent	1(1.5)
• OP poisoning	24(35.3)
• Paraquet consumption	1(1.5)
• Partial hanging	3(4.4)
• Rat poisoning	7 (10.3)
• Tablet consumption	23 (33.8)

Table 2 - Association between severity of suicidal intensity and severity of violence

Parameter	Chi – square value	P value
Severity of suicidal intensity and severity of violence	33.71	0.02

DISCUSSION

Our study aimed at assessing the association between violence against women and deliberate self-harm. We found that females are more commonly the victims of domestic violence, and across all studies, suicidal behaviours such as suicidal thoughts and ideation were the most common findings. Suicide is one of the leading causes of morbidity in women worldwide.

The study by Chowdhary titled "The effect of spousal violence on women's health: findings from the Stree Arogya Shodh in Goa, India" showed the following characteristics of the recruited sample. Of the 1750 married women, majority were Hindu (73%), homemakers (76%) and literate (83%); the mean age was 35.37 years which is similar to our study where the mean age of distribution was 28.09, majority were homemakers and were Hindu[13].

In a multi centric study conducted by WHO found that the percentage of women who had ever been in an intimate partnership ranged from 68.5% in Thailand city to 93.9% in Japan city. The most common form of violence reported in most sites was intimate partner violence. The prevalence of lifetime suicidal thoughts ranged from 7.2% in Tanzania city to 29.0% in Peru province. The percentage of women who reported having suicidal thoughts in the past 4 weeks ranged from 2.1% in Japan city to 13.6% in Peru province. Among those who had ever thought about suicide, the percentage of those who had ever attempted suicide ranged from 9.4% in Tanzania province to 41.6% in Peru city[14]. In our study it was found that that 82.4% women who attempted deliberate self-harm were victims of violence among which 33.8% had moderate violence.

A cross-sectional study by Sally at al showed that the odds ratio of a past-year suicide attempt were 2·82 (95% CI 1·54–5·17) times higher in those who have ever experienced IPV, compared with those who had not. Fully adjusted odds ratios for past-year self-harm

(2·20, 95% CI 1·37–3·53) and suicidal thoughts (1·85, 1·39–2·46) were also raised in those who had ever experienced IPV[15]. This is similar to the results found in our study where there was significant association between suicidal intensity severity and violence severity.

In our study we found that 29.4% of participants didn't have suicidal intent severity and 27.9% had moderate-severe suicidal intensity, which explains that not all suicidal attempt has suicidal intensity. 52.9 had lethality score of 2 which indicates moderate physical damage, which warrants us about the severity of suicidal attempt.33.8% had mild violence followed by 30.9% had moderate violence which are indicative of physical violence. In our study majority were married (69.1%) and were victims of intimate partner violence.

There was significant association was found between severity of suicidal intensity and severity of violence (p -0.02). This tells us the correlation between severity of suicidal intensity and severity of violence which further explains that violence as one of the potent risk factors of deliberate self-harm. It also said that higher the suicidal intensity there is increased chance of future attempt on life.

The limitations of our study are that we haven't taken consideration of temporality of violence and deliberate self-harm. We have not mentioned the different types of violence seen in women. Not including children less than 18 years excludes childhood abuse since adults have problem in recalling childhood adverse events. This could lead to recall bias. Not considering other psychiatric morbidity.

CONCLUSION

The results point to a significant correlation between severity of suicidal ideation intensity and violence. This highlights that violence being one of the risk factors for deliberate self-harm. This warrants us for public education against domestic violence and timely psychosocial management of the vulnerable cases through a protracted community based mental health program, which will help to reduce the frequency of DSH and domestic violence.

Future directions

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[16]. 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 could be addressed by tailored interventions[17]. 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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Acknowledgment
The author(s) appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest
The author(s) declared no conflict of interest.

How to cite this article: Gowdar, T.M., Madhusudan, S. & Guruprasad, C. (2024). Examining Violence Against Women Among Individuals with a History of Deliberate Self-Harm: A Cross-Sectional Study. *International Journal of Indian Psychology, 12*(2), 3840-3845. DIP:18.01.341.20241202, DOI:10.25215/1202.341