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The Adverse Impact of Domestic Violence on Mental Health

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ABSTRACT

Domestic violence has been reported in practically every group and civilization throughout recorded history. Every patriarchal society accepts discrimination and injustice that leads to physical, mental, or emotional violence. Domestic violence has been socially and legally tolerated for a long time unless there is a recent reference. Some significant events, laws, and ordinances give historical background within which domestic violence is clearly defined. Male dominance and portraying women as "property" or "objects" belonging to males, as well as expectations from women as an ideal "role model," combine to make women vulnerable to discrimination, oppression, and other forms of victimhood, and so impose their subordination. Psychological wellbeing is a phrase that can refer to a state of intellectual or emotional affluence, as well as the absence of a psychological problem. An automatic mental or standard of conduct that occurs in an individual and is regarded to produce trouble or inability that isn't typical as a component of ordinary turn of events or culture is known as a psychological issue or dysfunctional behaviour. The patterns of psychiatric disorder and psychological discomfort seen in women differ from those seen in men, according to an analysis of mental health indices and statistics. Women are 2-3 times more likely than men to experience symptoms of depression, anxiety, and nonspecific psychological distress. The impact of domestic abuse on mental health is critically examined in this research.

I. INTRODUCTION

Women and men differ not just in their physical characteristics but also in their mental composition. There are actual differences in the structure and "wiring" of men's and women's brains, as well as how they process information and react to events and stimuli. Women and men communicate, deal with relationships, express their thoughts, and react to stress in different ways. As a result, the distinctions between men and women are based on physical, physiological, and psychological characteristics.[2] There are psychological theories that present

[1] Author is a student, India.

[2] Hare-Mustin RT, Marecek J. The meaning of difference. Gender theory, postmodernism and psychology. Am Psychol 1988;43:455-64

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a gender-sensitive perspective, known as alpha bias, and others that present a gender-neutral perspective, known as beta bias. The concept of alpha bias claims that men and women have different levels of intelligence. Men and women are said to be different and opposed to alpha bias, but differences between men and women are ignored in beta bias. [3]Male anatomy and masculinity are the most wanted and valued goals, according to the Freudian viewpoint, whereas feminine anatomy and femininity are considered as a deviation in psychodynamic theories and therapies. The cognitive, behavioural, and humanistic-existential theories, on the other hand, all contain beta bias. Alpha bias may have more to do with society's social conditioning and power structure.

Psychological wellbeing is a phrase that can refer to a state of intellectual or emotional affluence, as well as the absence of a psychological problem. From the perspective of positive brain research or overall quality, emotional wellbeing may include a person's ability to appreciate life and maintain a balance between living activities and efforts to achieve mental variety. A psychological problem or dysfunctional behaviour, on the other hand, is an automatic mental or behavioural pattern that occurs in an individual and is regarded to produce difficulties or inability that isn't typical as part of everyday life or culture. Gender has an important role in mental health and mental illness. The gender-specific variables and mechanisms that promote and protect mental health and encourage resilience to stress and adversity have garnered far more attention than the morbidity associated with mental disease.[4]

The patterns of psychiatric disorder and psychological discomfort seen in women differ from those seen in men, according to an analysis of mental health indices and statistics. Women are 2-3 times more likely than men to experience symptoms of depression, anxiety, and nonspecific psychological distress, but men are more likely to experience addictions, substance use disorders, and psychopathic personality disorders. These facts are adequately laid out in the World Health Organization study. It has also been proposed that observed gender differences in prevalence rates are the result of women and men having different average standings on latent internalizing and externalizing liability dimensions, with women having a higher mean level of internalizing and men having a higher mean level of externalizing.[5]

Domestic violence depression manifests itself in a variety of physical and psychological

[3] Ibid.
[4] World Health Organization. Gender and women's mental health. Gender disparities and mental health: The Facts. Geneva: World Health Organization; 2001.
[5] Eaton NR, Keyes KM, Krueger RF, Balsis S, Skodol AE, Markon KE, et al. An invariant dimensional liability model of gender differences in mental disorder prevalence: Evidence from a national sample. J Abnorm Psychol 2012;121:282-8

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symptoms. Women often lose access to numerous social networks and familial support systems when they marry, which could have kept them afloat and enabled them to respond effectively when confronted with domestic violence.

Women's Mental Health: The Facts (World Health Organization Report, 2001)

1. Depressive disorders are responsible for over 41.9 per cent of the disability caused by neuropsychiatric diseases in women, compared to 29.3 per cent in men.

2. Depression, organic brain disorders, and dementias are the most common mental health issues among the aged. Women make up the vast majority.

3. Women and children make up an estimated 80 per cent of the 50 million people affected by violent conflicts, civil wars, disasters, and displacement.

4. Violence against women is prevalent at any period in a woman's life, ranging from 16 per cent to 50 per cent.

5. At least one in every five women is subjected to rape or attempted rape at some point in their lives.

II. COMMON MENTAL DISORDERS (CMD'S)

Gender disparities are most noticeable in the incidence of common mental disorders (CMDs) such as depression, anxiety, and somatic complaints, where women outnumber men. Women are twice as likely as males to suffer from unipolar depression, which is expected to be the second major cause of worldwide disability burden by 2020. Furthermore, females have a 2-3 times higher lifetime risk of anxiety disorders (e.g., generalized anxiety disorder) than males.[6]

Furthermore, wretchedness is not only the most generally acknowledged female psychological health concern, but it may also be more persistent in women than in men. Although unpleasant side effects of men and women are often considered to be similar, women are more likely to experience unusual or unexpected vegetative side effects, such as increased hunger and weight gain. If an uneasy problem arises, females are more likely to have severe side effects, as well as more frequent depression.

As in the rest of the world, studies in India have found that CMDs like depression and anxiety are highly linked to the female gender, in addition to poverty. Women are 2-3 times more likely than men to be affected by CMD, according to community-based research and studies of treatment seekers. Given this compelling evidence that CMD is more prevalent in women, the next most intriguing topic is what makes women appear to be more vulnerable. Women's

[6] Pigott TA. Anxiety disorders. In: Kornstein SG, Clayton AH, editors. Women's Mental Health - A Comprehensive Textbook. New York: The Gulliford Press; 2002. p. 195-22.

heightened predisposition to depression may be due to hormonal variables associated with the reproductive cycle. Another possibility is that the characteristics that are independently linked to the risk of CMD are indicators of gender disadvantage.[7] Excessive partner alcohol usage, sexual and physical abuse by the husband, being widowed or separated, having little autonomy in decision-making, and having little support from one's family are examples of these variables. Furthermore, stressful life events are linked to the development of depression in people who are vulnerable. Although the female gender is linked to a better outcome, social implications such as marriage dissolution, homelessness, sexual abuse vulnerability, and HIV exposure, as well as other infections, complicate women's rehabilitation. Sexual and physical abuse is twice as common in women with serious mental problems as they are in the general population of women. The lack of clear legislation for the welfare of chronically ill women in India, as well as social shame, exacerbates the problem.[8]

III. IMPACTS OF MENTAL ILLNESS

(A) Suicide- Suicide and willful self-harm studies have indicated a uniform tendency of more female suicide attempters and more male suicide completers. In India, however, women outweigh males in completed suicides, despite the fact that the margin between them is narrow, in contrast to data from many other nations, with the exception of China, which has the highest female suicide rate. According to a study, girls from nuclear households and women married at a young age are more likely to try suicide and self-harm. The suicide rate by age in India shows that suicide rates peak for both men and women between the ages of 18 and 29, but the female rate exceeds the male rate in the age group 10-17.[9]

(B) Violence and abuse- According to a shocking UN report, almost two-thirds of married women in India are victims of domestic violence, with each occurrence resulting in a loss of seven working days in the country. Furthermore, 70 per cent of married women between the ages of 15 and 49 are beaten, raped, or subjected to compelled sex. Female feticide (selective abortion based on the gender of the fetus or child's sex selection), domestic violence, dowry killing or harassment, mental and physical torture, sexual trafficking, and public humiliation are all typical types of abuse against Indian women. Wife-battering and female suicides have been linked to women's reproductive duties, such as their expected role of having children, the

[7] Thara R, Patel V. Women's mental health: A public health concern. In: Regional Health Forum-WHO South-East Asia Region. Vol. 5. World Health Organization; 2001. p. 24-34.
[8] Shidhaye R, Patel V. Association of socio-economic, gender and health factors with common mental disorders in women: A population-based study of 5703 married rural women in India. Int J Epidemiol 2010
[9] Chowdhary N, Patel V. The effect of spousal violence on women's health: Findings from the Stree Arogya Shodh in Goa, India. J Postgrad Med 2008

repercussions of infertility, and the failure to produce a male child.[10] Gender-based violence has far-reaching implications, including long-term emotional anguish, mental health difficulties such as posttraumatic stress disorder, and poor reproductive health. Depression, anxiety, posttraumatic stress, insomnia, and alcohol use disorders, as well as a variety of physical and psychological issues, are common mental health problems reported by abused women. Battered women are much more likely than non-battered women to require psychiatric treatment and attempt suicide.[11]

(C) Substance Use- Although there are differences between countries, global rates of substance misuse, particularly of alcohol, tranquillizers, and analgesics, are on the rise. Women who misuse alcohol or drugs are more likely than other women to blame their drinking on a traumatic incident or stressor, and women who abuse alcohol or drugs are more likely to have been sexually or physically assaulted. Females with alcoholism have significantly higher rates of serious depression and anxiety problems. As a result, the profile of female substance abusers differs from that of male addicts. Despite rising rates, however, services to aid women are inadequate.[12]

IV. LEGAL PROVISIONS AND POLICIES RELATED TO MENTAL HEALTH IN INDIA

The right to life in India has been broadened to include the right to health, beginning with Article 21 of the Constitution. It is critical that mentally ill people have access to high-quality mental healthcare and live in safe environments in their homes and communities. The National Mental Health Programme was established by the Indian government in 1982. (NMHP). It's still on paper after 38 years. The National Mental Health Program (NMHP) was created in response to the enormous burden of mental illness on society and the country's woefully inadequate mental health care infrastructure.[13]

Since its inception in 1987, the Mental Health Act has been a source of controversy. Mental health is addressed in the National Health Policy of 2002. However, there is no distinct mental health policy. The District Mental Health Program (DMHP) was established in 1996 and restructured in 2003 to incorporate two major schemes: modernization of state mental hospitals and upgrading of psychiatric wings of medical colleges and general hospitals. The Convention

[10] Press Trust of India. Two-Third Married Indian Women Victims of Domestic Violence: UN. Posted Online; Thursday, October 13, 2005. Available from: http://www.expressindia.com/fullstory.php?newsid=56501. [Last accessed on 2021 September 01].
[11] Ibid.
[12] Lex BW. Some gender differences in alcohol and polysubstance users. Health Psychol 1991.
[13] Manisha T karia, Urgent need for reforms in law and policy for Mental Health in India,Bar and Bench (retrieved on 5th September 2021), https://www.barandbench.com/columns/urgent-need-for-reforms-in-law-and-policy-for-mental-health-in-india .

on the Rights of Persons with Disabilities and its Optional Protocol were signed and ratified by India in 2007. The Manpower Development Scheme (Scheme-A and B) was added to the Program in 2009.

The Ministry of Health and Family Welfare (MoHFW) created a Mental Health Policy Group (MHPG) in 2012 to draught a DMHP for the Twelfth Five Year Plan (2012–2017). The main goal was to reduce mental illness-related distress, disability, and premature mortality, as well as to improve recovery from mental illness by ensuring that mental health care was available and accessible to all people during the plan period, especially the most vulnerable and underprivileged. In addition, a central mental health team has been established to oversee and administer the program. The development of a Mental Health Monitoring System (MHIS) is underway. A training document was used to suggest standardized training.[14]

Following the National Mental Health Survey in 2014–2016, the Indian government began working to improve mental health services by establishing policies such as the National Mental Health Policy (NMHP), 2014, and the Mental Healthcare Act, 2017, which was enacted and notified on May 29, 2018. The Mental Health Act of 1987 was repealed, and the new Act focused on the rights of mentally ill people.

V. MENTAL HEALTH CARE REFORMS

Despite the fact that the country's National Mental Health Programme has been in place since 1982 and was re-strategised in 1996, it is fair to say that mental health policy and programming have been reactive rather than proactive thus far. Tragedies like Erwadi, as well as a slew of public interest litigations (PILs), filed before India's Supreme Court, have been important catalysts for change. Some PILs have addressed not only institutional treatments but also the economic, social, and cultural rights of people with mental illnesses. A series of reports from the National Human Rights Commission highlights the serious flaws in institutional care for people with mental illnesses, as well as the positive changes that could be achieved with continued monitoring, collaboration, and proactive intervention – structural facilities and living conditions were improved, budgets were improved, and voluntary admissions were increased.

Meanwhile, the National Mental Health Policy has been guided by the need to provide the least restrictive care for people with mental illnesses and, as a result, to build suitable community care facilities for people with mental illnesses. However, recent research combining state and union territory statistics on the condition of mental health care found that primary mental health

[14] Ibid.

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care coverage in the country is severely low. The NDPS Act has so been revised three times, the most recent being in 2014. Several flaws in the Mental Health Care Act of 1987 were identified; state rules were not formulated for decades after it was enacted, and the requirement to comply with the UNCRPD prompted several arguments about whether to change the existing law or enact a new one. The Mental Health Care Bill 2016, which was passed by the Rajya Sabha, is currently awaiting confirmation by the Lok Sabha. Similarly, the Rights of Persons with Disabilities Bill, which aims to replace the 1995 Act, was introduced in 2014 and is currently awaiting ratification.

VI. IMPORTANCE OF DEVELOPMENT COUNSELING AND TRAINING PROGRAMS

(A) Developmental counseling- The only way out of repeated attacks of mental illness is to make women's material reality more secure, liberating and healthy. Developmental counseling seeks to remove chronic conflict situations in women's lives that are associated with high mental health mortality. It is based on the understanding that the doctor's or counselor's commitment is a necessary condition for counseling success. It improves problem-solving and decision-making abilities by increasing self-direction. This is the axis around which human rights therapy or counseling revolves. It emerged in the wake of the liberationist social movements as an alternative to the bio-medical approach. The most effective healer avoids victim-blaming and focuses on patient listening. Those with communication difficulties require extra assistance.[15] At the same time, reversing the process of alienation by consciously building community networks is a must. Mental health professionals should be seen in the community rather than in the secure institute or clinics.

(B) Training programs- There is an immediate need to educate and train general practitioners and other health care professionals about the mental health issues that can arise as a result of domestic violence. Social counselors must be available in health clinics and public hospitals, and they must be in contact with non-profit organizations that provide institutional support to women in need. Doctors should discuss domestic violence and mental health in the electronic and print media and remind the profession of its ethical duty to victims' needs.[16]

VII. CONCLUSION

In conclusion, it can be said that domestic violence is a complex issue with its roots in multiple facets of society, such as the status of women in society, illiteracy, poverty, substance abuse,

[15] Shetty H. Prevent suicide, save life. One India, One People. Special issue on prescriptions for healthcare. 2001; (4): 21-22.
[16] Seden J. Counselling skills in social work practice. Open University Press, Buckingham and Philadelphia, USA, 1999, p 142

and various other evil practices such as dowry and female feticides, especially in rural areas. Thus, any method which does not target all these problems concurrently is unlikely to yield any positive results. All the stakeholders such as various governmental departments, law enforcement, judiciary, women and children groups, non-governmental organizations, journalists, and licensed bodies need to work in a coordinated and planned method to make any appreciable impact and for advocacy of the rights of the women and children.

Domestic violence against women is inversely connected with their mental health. A multispectral plan is needed to address this problem. In India, most services currently available for victims of domestic violence are on the legal front, including "The Dowry Prohibition Act/s and Section 498A to the Indian Penal Code (1983)" and so on. The new "protection of women from domestic violence Act 2005" allows women to seek sanctions and protective orders and covers all women in abusive relationships, notwithstanding the relationship of the perpetrator. Healthcare providers, especially primary care physicians, have a special possibility to identify, mediate, and support survivors of violence, given that most women visit these settings at some point in their lifetime. They ought to be sensitized to the issues of domestic violence and be trained adequately to recognize them early. The need of the hour is to screen women for abuse, integrate a gender-sensitive plan in healthcare services and generate community awareness.

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