

The severity of Domestic Violence and its links to coping skills and Medication Compliance in Women with Mental Illnesses in Telangana

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Abstract

Domestic violence is widespread and has been linked to a number of mental health issues in all social classes. However, little research has been done on the severity of abuse among women who are mentally ill. The level of domestic violence frequently determines how much distress is felt. Abuse may be lessened by one's capacity for distress; this affects how severe the abuse is regarded to be. For women with mental illnesses, adherence behaviour to treatment may be influenced by the severity of maltreatment as well as distress tolerance. There is a dearth of research looking at these factors. In order to better understand the intensity of abuse, distress tolerance, and their relationship to medication adherence in women with mental illness, this study was conducted. This study was conducted in an outpatient setting at the psychiatry department of a tertiary care facility in Telangana. Following informed permission, 100 women with a mental illness who have been in remission for at least two months and are living in the community with family members following an episode of mental illness were purposively sampled in turn. Patients having a diagnoses of mental retardation, dementia, or psychotic symptoms were excluded due to dependability concerns. The initial evaluation of each participant involved the use of clinical and socio-demographic forms. Both the Composite Abuse Scale (CAS) and the Distress Tolerance Scale were used to gauge the intensity of the abuse and the amount of distress tolerance (DTS). Using the widely recognised Morisky Medication Adherence Scale, medication adherence status was evaluated (MMAS). Contrasting this sample with the general population, there was a high degree of abuse (mean 20.33, SD=20.55), as well as a high level of distress tolerance (mean 26.80, SD=12.07). The Tolerance ($p=0.001$) and Absorption ($p=0.014$) subscales of distress tolerance significantly positively correlated with scores in domestic abuse. There was no statistically significant correlation between domestic abuse scores and medication adherence. The results of this study allow us to draw the conclusion that women

with mental illness experience a high amount of domestic abuse and have a higher threshold for discomfort. The perceived ability of the victim to bear emotional suffering is inversely correlated with the severity of domestic violence, while the amount of attention that is given to negative emotions is positively correlated. Due to the cross-sectional design and short sample size of the study, more data replication with a larger sample size and control group is required.

Keywords: Domestic violence; Distress tolerance; Medication compliance; Mental illness.

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INTRODUCTION

A variety of sexual, psychological, and physical coercive acts against women are considered domestic abuse.¹ The size of the issue in India is not known with certainty, however it is thought to be enormous. Two-fifths of married women reported experiencing physical or sexual abuse at some or the other time² according to the National Family Health Survey (2005–2006). Women's mental illness is etiologically related to domestic abuse. Domestic abuse and the prevalence of mood and psychotic illnesses in women are positively correlated.^{3,4} Research on the effects of domestic abuse on women who have mental illnesses is scarce. There aren't many research that show how common domestic violence is among Indians.^{5–7} Although the tolerance for distress is unknown, domestic abuse is generally connected with severe psychological distress.^{8,9}

Distress tolerance (DT) is the capacity to withstand unpleasant emotional and physical experiences.¹⁰ The propensity to lessen or flee unpleasant emotional experiences is known as DT, which is an individual's assessment of and expectations around experiencing distress.¹¹ DT is seen as a cross-diagnostic risk, sustaining, or preventing factor of psychological illnesses.¹⁰ Distress tolerance is favourably related to domestic violence¹² and adversely related to health seeking abilities, according to some data.¹³ Distress tolerance and physical and psychological abuse are negatively correlated with substance use disorder¹⁴, according to Shorey et al. Indirect data points to a significant degree of stress in the general population related to medication non-adherence.¹⁵ On the other hand, distress tolerance may interact with the environment and a person's drive to improve adherence to drug abuse therapy.¹⁶ However, this association has to be investigated because it has not yet been found in other mental diseases. In addition to commonly experiencing mental illnesses, women who experience abuse also take psychotropic medications more frequently than the general population.¹⁷

Although abuse has been linked to poor medicine adherence in cases of physical illness, there hasn't been any research on this connection in cases of mental illness, therefore it has to be investigated.

Keeping in mind the above background, this study was conducted to access the levels and relationships of abuse, distress tolerance and medication adherence. There is a knowledge gap as to how abuse and distress tolerance are interrelated, and

what is their association with medication adherence. We hypothesised that adherence has a negative association with abuse and a positive association with distress tolerance, while the interrelationship of abuse and distress tolerance is positive.

MATERIALS AND METHODS

This investigation was carried out in a tertiary care facility in Telangana at the outpatient psychiatry department. Following informed consent, one hundred women with mental illness who have been in remission for at least two months and are residing in the community with family members following an episode of mental illness were purposefully sampled in turn.

Due to dependability concerns, participants were disqualified if they had a diagnosis of mental retardation, dementia, or a psychotic condition. For this study, the presence of any psychiatric diagnosis according to ICD 10 (10th revision of the International Statistical Classification of Diseases and Related Health Problems) was considered as "Mental disorder". The diagnostic and remission states were evaluated by a psychiatrist using MINI Plus¹⁹ case record files, discussion with the treating psychiatrist, and interviews with patients and important informants (s).

The following instruments were used to further evaluate each qualified participant: Age, education, occupation, marital status, socioeconomic status, family structure, place of residence, diagnosis, age at sickness onset, period of illness, family history of mental illness, history of childhood abuse, family drug use, attitude of others, etc. are socio-demographic and clinical forms.

The Composite Abuse Scale (CAS) is the most popular measure for determining how frequently domestic abuse occurs.²⁰ All 30 items on the measure receive a five-point Likert rating. The total number of elements (CAS Score) represents the level of abuse. More severe and regular abuse is indicated by higher scores. Items on the CAS can be divided into 4 subscales: harassment, severe combined abuse, physical abuse, and emotional abuse. These subscales are helpful in determining how various types of abuse affect women's physical and mental health. CAS has a high level of internal coherence and a Cronbach's alpha of greater than 0.85. The scale was converted into Telugu for this investigation. This scale is used in the population of India.⁵

The DTS, or Distress Tolerance Scale - The goal of

this 15-item self-report scale is to assess a person's capacity to withstand psychological suffering, or distress tolerance.¹¹ Four subscales can be created from the overall scale: (1) Tolerance - perceived capacity to withstand emotional suffering, (2) Absorption-focus being taken over by unfavourable feelings, (3) Appraisal - subjective assessment of distress, and (4) Regulation - regulation efforts to lessen distress. The scale's scores, which range from 15 to 75, have strong test-retest reliability, discriminant validity, and internal consistency. The scale was converted into Telugu for this investigation. This instrument has been used in the Indian population.⁵

Morisky Medication Adherence Scale: The MMAS-8, is a self-reporting instrument that is frequently used in studies to assess medication adherence. Each question contains a 'yes' or 'no' response choice, and scores range from 0 to 1. Each question aims to gauge the respondent's particular adherence behaviour. Scores between 6 and 8 suggest high adherence, whereas scores between 6 and 8 indicate low adherence. With a Cronbach's alpha of 0.83, the sensitivity and specificity are 93 and 53 percent, respectively.²¹ This study made use of a Telugu translation. Version 16 of SPSS was used to conduct the data analysis. Descriptive statistics were used to express the demographic and clinical traits. Multiple linear regression analysis was performed to determine the link between the severity of abuse and the scores on the subscales of distress tolerance and various severity of burden. The Kruskal-Wallis H test was used to investigate the group difference between three or more variables. For all tests, the level of statistical significance was maintained at < 0.05.

RESULTS

The majority of participants were employed, from lower socioeconomic position, Hindus, married, with rural origin, and had mood disorders (Table 1). The majority of individuals omitted information about childhood abuse, substance use in the family,

and mental illness in the family.

Age and sickness duration were both on the average 37 years old in our group. Table 2 displays the results from the CAS, DTS, and MMAS tests.

A substantial negative connection of the CAS score with the Tolerance subscale ($p=0.001$) and a positive association with the Absorption subscale ($p=0.014$) were found in the linear regression analysis between the CAS score and the subscales of the DTS ($R^2 = 0.179$, $F=5.175$, $p=0.001$) (Table 3).

Table 1: Demographic and clinical characteristics

-	Variables	n=%
Occupation	Unemployed	35
SES	Low	62
	Middle	38
Religion	Hindu	91
	Muslim	9
Marital status	Single	10
Residence	Rural	68
Family type	Nuclear	85
	Joint	15
Diagnosis	F10	3
	F20	4
	F30	82
	F40	11
Substance use in family	Yes	21
Childhood abuse	Yes	5
Family history of mental illness	Yes	10

Table 2: Demographic and clinical characteristics

-	Minimum	Maximum	Mean(SD)
Age	14.00	61.00	37.02(9.37)
Education	1.00	5.00	2.02(1.00)
Age at onset	1.00	54.00	32.45(9.28)
Duration of illness	1.00	25.00	4.91(4.07)
CAS score	0.00	92.00	20.33(20.55)
DTS score	4.00	51.00	26.80(12.07)
MMAS score	1.00	8.00	5.84(1.66)

Table 3: Multiple regression analysis with scores on DTS subscales as independent variables

Unstandardized coefficients	Unstandardized Coefficients		Standardised coefficients	Sig.	t
	B	Std.error	Beta		
(Constant)	15.605	4.870		3.204	0.002
Tolerance	-4.447	1.294	-0.557	-3.437	0.001
Absorption	4.522	1.808	0.591	2.501	0.014
Appraisal	0.231	0.785	0.057	0.294	0.770
Regulation	0.664	1.254	0.092	0.530	0.598

(a) Predictors: Regulation, Tolerance, Appraisal, Absorption (b) Dependent Variable: CAS Score (c) $R^2 = 0.179$, $F=5.175$, $p=0.001$

Using the Kruskal Wallis H Test, statistically no significant association was observed between CAS and MMAS score or between DTS and MMAS score (tables 4 and 5, respectively).

DISCUSSION

Demographic characteristics in this study were similar to other reports from the centre. Some variables such as low socioeconomic status, rural background and duration of illness more than 4 years are known to be associated with domestic abuse,⁵ while there were other clinical variables such as low substance use in family and nil child abuse which were associated with low domestic violence.²² However mean score of 20.33 (SD±20.55) on CAS indicates an overall high level of abuse in this study compared to those reported in general population (Mean=3.3, SD=3.3).²³

High levels of distress tolerance have been observed in India, where they have been linked to familial drug use history, a history of past treatment for ongoing psychiatric disease, and treatment knowledge. Higher distress tolerance has been attributed to Indian culture.¹⁷ Indian women employ a variety of coping mechanisms, including meditation, yoga, exercise, journaling, prayer, time spent with family and friends, reading, going on trips, and listening to music²⁴, among others.

In this investigation, we discovered a statistically significant correlation between the CAS score and the DTS Tolerance (negative) and Absorption (positive) subscales.

The degree of the abuse determines one's tolerance for it. In the Indian setting, psychological abuse of women is to some extent accepted. Tolerance may, however, decline dramatically if the threshold has been passed. So, while higher amounts of abuse are deemed inappropriate and result in low distress tolerance, smaller degrees of abuse may be more tolerable. This is in line with our finding that this study had a high level of distress tolerance. Another explanation is that abusers deplete their capacity for toleration, and severe abuse may be linked to reduced levels of distress tolerance.

In line with our prediction, we discovered a favourable correlation between the abuse and absorption subscales of DTS. Greater abuse results in more attention being used and alterations in cognition.²⁵ Individual differences in distress tolerance are influenced by how people approach or avoid potentially upsetting events, their coping mechanisms, their propensity to focus on or try to

avoid attending to upsetting aspects of situations, and how they interpret those situations differently. Behavioral, experiential, and physiological reactions to abuse must all be modulated, and each one can rise or decrease depending on how tolerable the distress is. One's ability to tolerate psychological discomfort may thus influence both types of strategies one uses to manage affect as well as moderating affective regulatory functions on behaviour.¹¹

Table 4: Relationship between abuse and medication adherence (Kruskal Wallis test).

-	MMAS score	n	Mean rank	Chi-square	df	p
CAS score	Poor	29	47.78	-	-	-
-	Moderate	69	51.38	0.514	2	0.773
	Good	2	59.50	-	-	-

Table 5: Relationship between distress tolerance and medication adherence (Kruskal Wallis test).

	MMAS score	n	Mean Rank	Chi-Square	df	p
DTS score	Poor	29	45.57	-	-	-
	Moderate	69	53.03	1.955	2	0.376
	Good	2	34.75	-	-	-

Our hypothesis suggested that adherence was negatively correlated with abuse and positively correlated with distress tolerance, however this was not supported by the data. This shows that having experienced abuse does not aid in the development of adaptive coping mechanisms and that the effects are lessened by having strong resilience. An earlier study found that abuse had a negative correlation with adherence, although HIV patients' resilience helped them do so.^{26,27} According to Freire de Medeiros et al., adherence and resilience are positively correlated in hemodialysis patients.²⁸ Possible explanations include the fact that prior studies' research demographics, disease severity, and quantity and type of abuse varied. Between wealthy and developing nations, a variation in adherence has been noted.²⁹ The majority of studies were carried out in Western nations,^{15,18} and socio-demographic characteristics may differently impact adherence behavior³⁰ due to the complexity of adherence.

Based on the study's findings, it can be said that women with mental illnesses experience a high level of domestic abuse and have a higher threshold for distress. Domestic abuse severity is positively correlated with levels of attention being taken up by unpleasant emotions and negatively correlated with perceived ability to withstand emotional

suffering. Due to the cross-sectional methodology and small sample size of our study, additional replication research involving studies with larger samples and control groups is required.

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