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Psychological distress and domestic violence among urban women in Chennai

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Abstract:

Domestic violence (DV) is a widespread global issue with severe mental health impacts on women. Therefore, it is of interest to examine the prevalence, socio-demographic factors and psychological distress among women facing DV in Choolai, Chennai. Data from 60 women aged 21 and above revealed high levels of emotional/verbal abuse and psychological distress. Significant correlations were found between DV, conflict tactics and distress. Thus, data shows the critical need for mental health screening, educational support and trauma-informed care for women experiencing DV.

Keywords: Domestic violence (DV); psychological distress; conflict tactics; Kessler psychological distress scale; women; urban India

Background:

Domestic violence (DV) remains one of the most pervasive but under-acknowledged public health crises facing women globally. The World Health Organization estimates that nearly one in three women worldwide, approximately 27% of ever-partnered women aged 15–49 years, experience physical and sexual violence by an intimate partner during their lifetime [1]. Beyond physical injury, the psychological outcome of such abuse manifests as anxiety, depression, post-traumatic stress disorder (PTSD) and suicidal ideation, all of which substantially erode quality of life [2]. The COVID-19 pandemic, often termed the "shadow pandemic," further intensified DV worldwide, magnifying women's psychological vulnerability under prolonged confinement [3]. In India, DV continues to thrive within deeply rooted patriarchal structures. Analyses of the National Family Health Survey-5 (2019–2021) indicate that approximately 31.2% of ever-married women experienced lifetime DV, with Karnataka, Bihar and Manipur reporting the highest prevalence rates [4]. Even among empowered women, intimate partner violence affects 26.21%, with physical aggression comprising the predominant subtype (60%) [5]. Cross-sectional Indian studies have repeatedly identified emotional/verbal abuse as the most common form, followed by physical and sexual aggression [6, 7]. Mental-health sequelae are pronounced; abused Indian women are several times more likely to develop depressive and anxiety disorders compared with their non-abused counterparts [8]. Psychological distress, defined as the collection of unpleasant emotional and somatic responses to internal and external stressors, is now recognised as a critical mental-health indicator among DV survivors. Spousal violence is a well-documented determinant of psychological distress [9, 10]. Research among adolescents and young adults in low- and middle-income contexts also shows that intimate partner violence is an independent predictor of depressive symptoms and psychological distress, even after accounting for sociodemographic and protective influences [11, 12]. The COVID-19 era brought renewed urgency to this issue. Lund and Thomas reported that 44% of American adults exposed to

physical and psychological domestic violence during the pandemic developed elevated depressive and post-traumatic stress symptoms, with psychological violence proving more prevalent than physical aggression [13]. Therefore, it is of interest to report the prevalence of DV, behavioural patterns among women in an urban Chennai community.

Materials and Methods:

A descriptive cross-sectional design was adopted in Choolai, a densely populated urban locality within the Chennai Metropolitan Region of Tamil Nadu, India. Sixty participants were recruited via non-probability convenience sampling for a period of one month. Sample size was calculated using $N = Z^2(1-p)/(p \times e^2)$, based on a previous prevalence of 42.04% psychological distress among women experiencing DV, with 95% confidence and 30% relative precision, yielding a required minimum of 60. Women aged above 21 years currently experiencing DV (as identified through the Domestic Violence Worksheet), residing in Choolai, fluent in Tamil or English and providing informed consent were included. Women with cognitive impairment, on active psychiatric treatment, or critically ill at assessment were excluded. Data collection was done using socio-demographic data, the Domestic Violence Worksheet, the Conflict Tactics Scale (CTS) and the Kessler Psychological Distress Scale (K10). Content validity was established through expert review by nurses, psychiatrists and statisticians. A pilot study with 10% of the target sample confirmed feasibility; pilot participants were excluded from the final analysis. Ethics approval was granted by IEC, Madras Medical College and Chennai. Participants gave written informed consent. Data were analysed using SPSS 25; descriptive statistics, Pearson correlations and chi-square tests were applied, with $p \leq 0.05$ significant.

Results:

Of the 60 women, 41.67% were aged 21–30 years, 28.33% were 31–40 years, 25% were 41–50 years and 5% were 51 years or older. Educationally, 38.33% had completed higher secondary

schooling and 35% held an undergraduate or higher degree. Business was the leading occupation (46.67%), followed by homemakers (40%). Most participants (61.67%) earned Rs. 17,756–23,673 monthly. Nuclear families predominated (55%), with 48.33% in rented accommodation. Hindus formed the largest religious group (58.33%). Most women had one (46.67%) or two (45%) children and 43.33% had been married for fewer than five years. Emotional/verbal abuse was the most prevalent form (70%), with constant criticism and humiliation reported most frequently. Physical abuse affected 53.33% (mainly verbal threats and pushing), financial abuse 41.67% (controlling access to money), sexual abuse 21.67% (typically withholding sex as punishment) and isolation tactics 28.33%. Overall, 80% of women scored within the low DV range (mean = 4.62 ± 2.43 ; 23.10% of maximum), 20% in the moderate range and none in the high range. The mean CTS score was 24.02 ± 3.84 (48.04% of maximum). Constructive behaviours such as apologising (65%), problem-solving (61.6%) and compromise (56%) were frequently reported, but emotional manipulation (60%), verbal threats (47%) and physical aggressions (43%) were also evident. Two-thirds of participants (66.67%) demonstrated moderate-level

conflict tactics, while 33.33% had low-level scores; none scored high. The mean K10 score was 37.78 ± 2.98 (75.56% of maximum), placing the cohort in the severe distress category. The most pronounced symptoms were restlessness (96%), depression (95.6%) and hopelessness (94.4%). High distress was reported by 73.33% of women and moderate distress by 26.67%; none reported low distress (**Figure 1**). Pearson’s correlation revealed significant positive associations among all three measures: DV vs CTS ($r = 0.36$, $p = 0.01$), DV vs K10 ($r = 0.38$, $p = 0.01$) and CTS vs K10 ($r = 0.39$, $p = 0.01$), indicating that increases in DV exposure and conflict-related behaviours were accompanied by greater psychological distress. Chi-square analysis (**Table 1**) showed that conflict tactics scores were significantly associated with age ($\chi^2 = 7.61$, $p = 0.05$) and family type ($\chi^2 = 7.79$, $p = 0.05$); DV scores with age ($\chi^2 = 10.83$, $p = 0.05$) and educational qualification ($\chi^2 = 9.99$, $p = 0.05$); and psychological distress with educational qualification ($\chi^2 = 9.52$, $p = 0.05$) and occupation ($\chi^2 = 8.62$, $p = 0.05$). Notably, all women with no formal or primary education reported high distress, while 95.24% of women with undergraduate education had low DV scores, suggesting education’s protective influence.

Table 1: Mean scores, level distribution and significant socio-demographic associations of domestic violence (DV), conflict tactics (CTS) and psychological distress (K10) among women experiencing domestic violence (n = 60)

Outcome variable	Mean SD	±	% of maximum	Level distribution n (%)	Significant socio-demographic associations (χ^2 , p)
Domestic Violence Worksheet	4.62 2.43	±	23.10%	Low: 48 (80.00%); Moderate: 12 (20.00%); High: 0 (0.00%)	Age ($\chi^2 = 10.83$, $p = 0.05^*$); Education ($\chi^2 = 9.99$, $p = 0.05^*$)
Conflict Tactics Scale	24.02 3.84	±	48.04%	Low: 20 (33.33%); Moderate: 40 (66.67%); High: 0 (0.00%)	Age ($\chi^2 = 7.61$, $p = 0.05^*$); Family type ($\chi^2 = 7.79$, $p = 0.05^*$)
Kessler Psychological Distress Scale, K10	37.78 2.98	±	75.56%	Low: 0 (0.00%); Moderate: 16 (26.67%); High: 44 (73.33%)	Education ($\chi^2 = 9.52$, $p = 0.05^*$); Occupation ($\chi^2 = 8.62$, $p = 0.05^*$)

* $p \leq 0.05$ (statistically significant)

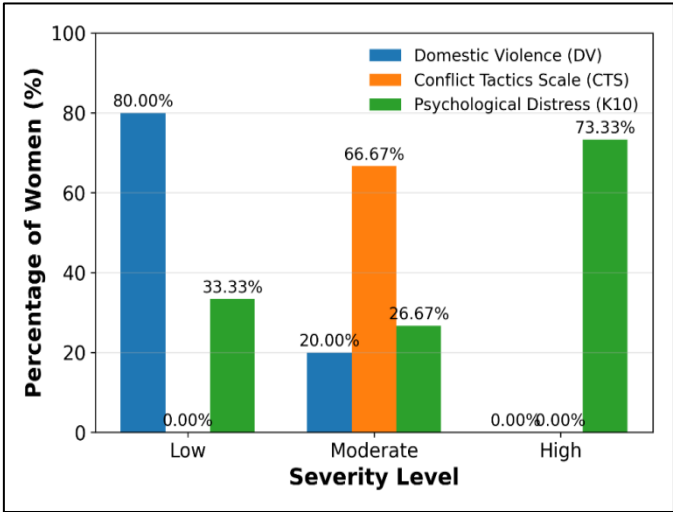


Figure 1: Distribution of Domestic Violence (DV), Conflict Tactics Scale (CTS) and Kessler Psychological Distress (K10) score levels among women experiencing domestic violence in urban Chennai (n = 60).

Discussion:

This study highlights an important paradox: although 80% of women in urban Chennai reported only low-level domestic violence on objective measures, three-quarters experienced clinically significant psychological distress on the K10. This decoupling of overt-violence severity from internal distress underscores that the psychological footprint of abuse extends well beyond observable physical aggression. Globally, similar patterns are documented; Sardinha *et al.* (2022) [14] estimated that 27% of ever-partnered women aged 15–49 worldwide had experienced lifetime physical or sexual partner violence, with low- and middle-income regions disproportionately affected. White *et al.* (2024) [15] meta-analysis of 201 studies (n = 250,599) confirmed strong associations between any form of intimate partner violence and adverse mental-health outcomes, even when subtypes appeared mild. The high prevalence of emotional/verbal abuse (70%) in this sample reflects Indian and South Asian patterns reported by Bhattacharya *et al.* (2020) [16] where psychological abuse consistently exceeded physical and sexual aggression. Tun and Ostergren’s (2020) [17] analysis of Myanmar Demographic and Health Survey data also identified controlling and emotional behaviours as predictors of psychological harm. The significant positive correlations between domestic violence, conflict tactics and psychological distress ($r = 0.36$ – 0.39 , $p = 0.01$) align with Amédée *et al.*, (2020)

[18] who reported that intimate partner violence independently predicted depressive symptoms and psychological distress among 3,586 Haitian adolescents and young adults. Cénat *et al.* (2024) [19] similarly showed that IPV exposure is a strong predictor of post-traumatic stress disorder, mediated partly by emotion dysregulation. Sediri *et al.* (2020) [20] documented an acute pandemic-related rise in DV-related psychiatric morbidity among Tunisian women [14]. Subhashchandra *et al.* (2022) [21] National NFHS-5 analysis identified low education and low socio-economic status as principal predictors of DV in India [4]; conversely, our analysis showed that 95.24% of undergraduate-educated women fell into the low DV-score category, while all women with no formal or primary education reported high distress. Iktilat *et al.* (2024) [22] similarly observed gender-specific psychological vulnerability among middle-aged women exposed to ongoing violence. Cochrane evidence suggests that psychological therapies tailored to women experiencing intimate partner violence yield meaningful reductions in depressive and post-traumatic symptoms. These findings affirm that empowering women through education, economic agency and accessible mental-health services serves as a key buffer against both DV exposure and its psychological aftermath. Limitations include the small convenience sample, single-site design, self-reported data and brief one-week data-collection window, which constrain generalisability. Multi-centric longitudinal research is recommended.

Conclusion:

Psychological distress was highly prevalent among women experiencing domestic violence, despite predominantly low-level overt abuse. These findings highlight the need to address psychological consequences alongside physical violence in domestic violence care. Multicentric longitudinal studies are needed to validate these findings and assess culturally sensitive interventions.

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