Review Article

Mental Health and Loneliness: A Comparative Study of Glocalizing View of Gender Based Violence in Awka Town

Abstract

The study considers the comparativeness of mental health and loneliness on gender based violence. 149 married persons serve as participants. Convenient sampling technique was used for participant selection. They comprise of 71 (52.3%) male and 78 (47.7%) female. Their age ranged from 23-53 years with mean age of 39.66 and standard deviation of 8.76. Conflict Tactics Scales by Straus et al. (1979), Short Warwick–Edinburgh Mental Well-Being Scale and UCLA Loneliness Scale by (Russell, 1996) were employed for data generation. 2×2 Factorial Design and Two-way Analysis of Variance (ANOVA) statistic were used to analyze the data. The first hypothesis which stated that there will be no significant difference between those with positive mental health and those with negative mental health on gender based violence among married persons and second hypothesis which stated that there will be no significant difference between those with positive loneliness and those with negative loneliness on gender based violence among married persons were confirmed at p>.05. The third hypothesis which stated that there will be no significant interaction between mental health, loneliness and gender based violence among married persons was confirmed at p>.05. The study established suggestions.

Keywords: Mental Health, Loneliness, Gender based Violence, Glocalization.

Introduction

In Africa everyday life is 'glocal' in the sense that there is dialectic relationships between global influences and local life whiles the representations of 'glocal' lives are highly class-based, racialised and gendered. As such, status, intelligence and success are strongly associated with being a global citizen, while poverty, misery and narrow-mindedness are features used to characterise 'the locals' this fosters gender based violence which is pervasive across all glocalised cultures, regions and diverse social categories around the globe (United Nation, 2006; Ley, 2004). And its manifestations differ and vary in levels and intensity according to the socio-cultural and institutional factors that triggers it.

In Nigeria, the context of gender based violence is such that intertwined direct, structural and cultural typologies of violence, with factors responsible for the violence closely knitted together in a way that explains complex conflict dynamics among those in intimate relationship. While frustrations occasioned by factors relating to human insecurity and obnoxious policies, among others, largely define gender based violence, that results in, or is likely to, result in physical, sexual, or psychological harm to women or men including threats of such acts, coercion or arbitrary deprivation of liberty whether occurring in public or private life. McCloskey's (2016) that assert gender based violence as: "abuse of groups targeted because of their gender or gender roles and is relegated to a lower position of social status or power". Among the various forms of violence against women are battering by spouse, rape, verbal assault, female genital mutilation, incest, child marriage, forced marriage, denial of women work opportunity, denial of women's right to own property, denial of girl child right to choose her husband, denial of girl child access to education, child labour, girl child trafficking and using girl child for commercial sex purposes, among others.

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Although, women can also be involved in violent behaviour, and abuse also exists in some same-sex relationships, the vast majority of partner abuse is perpetrated by men against their female partners.

According to Velásquez (2003), every kind of abuse is frequently perpetrated, which turns gender based violence into a social problem. It generates physical (bruising, injuries, traumas, etc.), psychological (humiliation, low self-esteem, feelings of inferiority, among others), economic and social consequences for the victims. For instance, in Nigerian societies appeared to largely condone wife beating, where they believe that a husband's chastisement of his wife by beating her is embedded in the culture (IIika, Okonkwo and Adogu, 2002; Okemgbo, Omideyi and Odimegwu, 2002). At times, the perpetrators of such direct violence attempt to justify their actions on deconstructed religious sentiments, customs, traditions and cultural beliefs, while others anchor their justifications on conditions of human insecurity such as joblessness, hunger, environmental problems and so on (Irene, 2016). Moreover, the scourge of gender based violence is no doubt increasingly alarming (Jekayinka, 2010),

Forms of Gender Based Violence

Sexual coercion: Emerges as a defining feature of the female experience for many women and girls. Forced sexual contact can take place at any time in a woman's life and it includes a range of behaviours from forcible rape to non-physical forms of pressure that compel the girls or women to engage in sex against their will. The touchstone of coercion is that the woman lacks choices and faces severe physical or social consequences if she resists sexual advances. Studies indicate that the majority of non-consensual sex takes place amongst individuals known to each other, spouses, family, members, courtship, partners or acquaintance.

Socio-economic violence: This is the Discrimination and/or denial of opportunities, denial of access to education, health assistance or remunerated employment; denial of property rights. It may be by Family members, society, institutions and organizations, government actors.

Physical violence: This refers to beating, biting, kicking, restraining, pulling hair, choking, throwing objects and using weapons among genders. Although same-sex physical violence (even including stabbing) can be common among adolescents, the unequal power relationship results in most physical violence being directed at girls by boys.

Harmful Traditional Practices: These include practices such as Female genital mutilation (FGM)which involves the Cutting of genital organs for non-medical reasons, usually done at a young age; ranges from partial to total cutting, removal of genitals, stitching whether for cultural or other non-therapeutic reasons; often undergone several times during life-time, like after delivery or if a girl/woman has been victim of sexual assault and early marriage practices that demeans the female gender (United Nations, 2009). This is carried out by Traditional practitioners and supported, condoned, and assisted by families, religious groups, entire communities and some States (Zinn, H. 2006).

Emotional and Psychological Violence: This is the Abuse/Humiliation which is Non-sexual verbal abuse that is insulting, degrading, demeaning; compelling the victim/survivor to engage in humiliating acts, whether in public or private; denying basic expenses for family survival. This may be carried out by anyone in a position of power and control; mostly by spouses, intimate partners or family members in a position of authority.

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Glocalization and Gender Based Violence

The concept of globalisation helps with the act of rethinking macro–macro relationships, glocalisation helped 'to alleviate the conceptual difficulties of macro–micro relationships' to illuminate that 'many of the social categories and practices assume a local flavour or character despite the fact that these products were invented elsewhere'(Khondker 2004). Glocalisation illustrates a twin process of macro-localisation and micro-globalisation, where macro-glocalisation involves expanding the boundaries of locality as well as making some local ideas, practices and institutions global (for example, religious or ethnic revivalist movements). Micro-globalisation involves incorporating certain global processes into the local setting (for example, feminist and ecological movements, as well as new production techniques) (Khondker 2004). In a more dystopian tone, Bauman (1998) denotes glocalisation as the reallocation of poverty and stigma from above, and as a product of globalisation, where the privileged are mobile but the poor are trapped in local poverty.

Glocalization can also destabilize local gender orders. Disruption of male authority within the culture may generate a backlash of masculine fundamentalism that tries to re-establish traditional gender hierarchies (Connell 2000). These processes play a role in the gender based violence. Gender based violence has never been limited to the poor or underprivileged. Well-publicized media coverage of celebrity violence to partners highlights what the anti violence movement has known for some time, that rich, famous or powerful men can be just as abusive and prone to violence as people who are poor. Individuals from all socio-economic groups, religions and cultures suffer gender based violence although the experience of abuse is often prolonged if the vulnerable to abuser entrapment and with fewer options to support themselves outside an abusive relationship (Dominy & Radford, 1996; Mooney, 2000).

Mental Health

Mental health is defined by the World Health Organization (WHO, 2002) as: a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. More so, the Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realize one's intellectual and emotional potential. It has also been defined as a state of well-being whereby individuals recognize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities. Mental health is about enhancing competencies of individuals and communities and enabling them to achieve their self-determined goals (WHO, 2002).

Evidence has shown that at least 60% of women globally are exposed to mental health problems related to GBV than their male counter parts (UNFPA, 2006; UNAIDS, 2010). Such exposure to mental health problems is contrary to the definition of human rights which stipulates, what universal respect for, and observance of human rights and the fundamental freedoms for all without discrimination as to race, sex, language, or religion (UN General Assembly, 2013; Human Rights Bulletin Number 68, 2013). Research has noted that GBV which involves repeated abuse during a period of time often leads to adverse health effects (Campbell, 2002; Ellsberg, Jansen, Heise, Watts & Garcia-Moreno, 2008; Krantz & Ostergren, 2000). These health effects may be physical (injury, gastro-intestinal disorders, common symptoms etc.) and psychological (depression, PTSD, anxiety, suicidality etc.). However, it has been shown that such adverse consequences may have long-lasting effects and persist long time after the abuse has stopped, resulting in chronic poor health and poor quality of life (Campbell, 2002).

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Even though both men and women are exposed to GBV, findings show that women display a wide range of adverse health effects compared to men, these are highly associated with GBV for women (Afifi, MacMillan, Cox, Asmundson, Stein *et al.*, 2009; Ansara & Hindin, 2011). For example, GBV may have quite severe consequences for women's physical, sexual, reproductive and mental health (Campbell, 2002; Garcia-Moreno, Jansen, Ellsberg, Heise *et al,* 2006; Umubyeyi, Mogren, Ntaganira and Krantz, 2014). GBV is also associated with HIV infection and other sexually transmitted infections for women (Li, Marshall, Rees, Nunez, Ezeanolue, *et al.*, 2014; World Health Organization, 2013). A review study has presented a difference in GBV prevalence across nations. Regardless of the difference in its magnitude, GBV is associated with a variety of mental disorders for women including depression, PTSD, anxiety, self-harm, and sleep-disorders as women experience more chronic and severe exposure to GBV compared to men (Dillon, Hussain, Loxton & Rahman, 2013; Romito & Grassi, 2007).

While the impact of GBV on health has been investigated mostly in women and in high income countries, there are relatively few studies on GBV and health effects which have included both sexes, interestingly the studies finding shows that both men and women suffer from increased risk of depression, suicide attempts, HIV, PTSD and chronic diseases such as stroke and asthma (Breiding, Black & Ryan, 2008; Campbell, 2002; Coker, Smith, Bethea, King *et al*., 2000; Devries, Mak, Bacchus, Child, Falder *et al.*, 2013; Dillon, Hussain, Loxton & Rahman, 2013; Dunkle, Jewkes, Brown, Gray, *et al.*, 2004; Foshee, Benefield, Ennett, Bauman *et al.*, 2004; Jonsson, Bohman, Hjern, von Knorring *et al.* 2011; Mahenge, Likindikoki, Stockl & Mbwambo, 2013; Peltzer, Pengpid, McFarlane & Banyini, 2013; Resnick, Acierno & Kilpatrick, 1997; Sipsma, Ofori-Atta, Canavan, Osei-Akoto *et al.,* 2013; Vizcarra, Hassan, Hunter, Munoz *et al.*, 2004). Further, studies including men and women report that men exposed to IPV are more likely to experience more disruptive behaviours and substance abuse disorders while women are more likely to experience mood disorders and anxiety (Afifi, MacMillan, Cox, Asmundson, Stein *et al.*, 2009). In another study including men only, GBV was shown to be associated with depressive symptoms (Reid, Bonomi, Rivara, Anderson *et al.*, 2008).Therefore, more studies on men are needed to develop understanding about men's exposure to GBV, its risk factors and health effects, and theories should be developed to improve understanding of partner violence directed at men (Devries, Mak, Bacchus, Child, Falder *et al.*, 2013).

Loneliness

Loneliness is defined as an emotional distress experience that goes along with the perception of unsatisfying social relationships. Perceived unsatisfying relationships, thus, are independent of the quantity of social interactions, but are caused by the felt sense of social isolation and unsatisfied need for affection in current relationships and a low quantity and diminished meaning of social contacts has also been related to loneliness (Cacioppo, Capitanio & Cacioppo, 2014; Hawkley & Cacioppo, 2010). Furthermore, loneliness involves a person's perception, their experiences, and their evaluation of their isolation. Loneliness is known to cause multiple health problems such as an increase in depression, sleeping problems, and a decrease or increase in appetite (Gierveld, 1998). Loneliness leads to many negative consequences such as "depression, suicide, hostility, alcoholism, poor self-concept, and psychosomatic illnesses" (Rokach & Neto, 2000).

Since loneliness is based on one's perception, certain individuals might view others as being lonely even though this may not be the case. For example, extroverts and introverts have

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different social needs and therefore different perceptions of loneliness. Extraverts are social, easy going, and are very people-oriented (Saklofske & Yackulic, 1989). They are known to be active and deliberate in seeking social contacts and situations as they feel they need to have people to talk to and therefore dislike being alone and even reading or studying alone (Saklofske, Yackulic, & Kelly, 1986). Extraverts have lower levels of cortical arousal and therefore have a great need for simulation and therefore are more social and increase their interpersonal contact which reduces the likelihood of an extravert to experience loneliness. An extravert may experience loneliness when they are given limitations on their opportunity to interact with others on a regular basis. In general, if limitations are not placed, extraverts have been found to experience less feelings of loneliness than introverts (Saklofske & Yackulic, 1989). Loneliness has also been linked to gender based violence. People who act violently towards others tend be rejected by partners because they often have distorted and deficient social information-processing mechanisms. For example, violent partner tend to become angry in situations where non-violent partner perceive the situation differently and don't become angry. This can also be due to having hostile attributional biases and cue-detection deficits (Kassinove, 1995).

Theoretically, everything we do has been learned. Much learning in humans, results from observing the behaviour of others and from imagining the consequences of our own actions. Often children copy the behaviour they have observed from others. Hence, Social learning theory by Bandura (1986) served as an anchor theory for the study, because it explains violence as a coping mechanism learned through observation or experience. Interestingly, modelling is a contributory factor to learning violent behaviour as well (Gentlewarrier, 2010). However, this theory maintains that the likelihood of repeated abusive behaviour is contingent upon reinforcement. Intergenerational transmission of violence is one component of social learning theory (Coleman, 2004). This aspect maintains that children who witness or experience violence in their family of origin are more likely to integrate violence into their behavioural repertoire. Research has been done linking exposure to violence during childhood and the experience of violence as an adult in an intimate relationship. More so, Lie and Gentlewarrier (2011) noted that if people witnessed violent between members of their family of origin they are more likely to have been a victim of violent with a current intimate partner. Hence, this current study wishes the achieve the purpose whether mental health and loneliness will have comparative significant on gender based violence in glocalizing context in Awka metropolis. In order to get answer to the aforementioned purpose the following hypotheses will guide the study.

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Hypotheses

1. There will be no significant difference between those with positive mental health and those with negative mental health on gender based violence among married persons in Awka Town.
2. There will be no significant difference between those with positive loneliness and those with negative loneliness on gender based violence among married persons in Awka Town.
3. There will be no significant interaction between mental health, loneliness and gender based violence among married persons in Awka Town.

Method

Participants

A total number of one hundred and forty-nine (149) married persons in Awka Town; served as participant for the study. They comprise of 71 (52.3%) male and 78 (47.7%) female. Their

age ranged from 23 to 53 years and their mean age was 39.66 with standard deviation of 8.76. Systematic sampling technique was used in the study to select the participants. This is based on the premises that the sample is chosen randomly by using a fixed interval. This interval is calculated by dividing population size by the targeted sample size.

Instruments

The first instrument was Conflict Tactics Scales (CTS) developed in 1979 (Straus et al. 1979). This measure consists of 19 items grouped into three scales: (1) Reasoning (3 items), (2) Verbal Aggression (7 items), and (3) Physical Assault (9 items), in which each item is asked twice, once about the respondent's behaviour toward a target, and then about the target's behaviour toward the respondent. The scale has seven point rating format: 0 = Never; 1 = Once; 2 = Twice; 3 = 3-5 times; 4 = 6-10 times; 5 = 11-20 times; 6 = More than. The internal consistency reliability of the CTS2 scales ranges from 0.79 to 0.95 (Straus et al. 1996). According to Straus (2007), alpha coefficients of reliability for the CTS2, reported in 41 articles, ranged from 0.34 to 0.94, with a mean of 0.77. Conflict Tactics Scales (CTS2) was validated for the Portuguese population by Paiva and Figueiredo (2006) using a sample of 551 university students. The five scales for perpetration and victimization had internal consistency rates ranging from 0.50 to 0.78 (Paiva and Figueiredo 2006). Psychometric findings have been reported for the version of the CTS2 (e.g., Paiva and Figueiredo 2006; Vega and O'Leary 2007); however, there is still insufficient data for examining the psychometric characteristics of the CTS2-SP beyond that performed by the authors. The second was Short Warwick–Edinburgh Mental Well-Being Scale: 7-item scale. The SWEMWBS was constructed to assess aspects of mental well-being as a unitary construct. With 5-point rating format: None of the time=1; Rarely=2; Some of the time=3; Often=4; All of the time=5.The seven items in the SWEMWBS Cronbach's alpha ranging from .64 to .78 (Norway), and from.67 to .82 (Sweden).The third was UCLA Loneliness Scale (Version 3) by (Russell, 1996)**.** The UCLA Loneliness Scale (Version 3) consists of 20 statements assess an individuals' unique experience of loneliness. The UCLA Loneliness Scale (Version 3) is a revised version of the initial version of the UCLA Loneliness Scale. One reason for the revision is that the original UCLA Loneliness scale only contained items that were worded with a negative connotation. Version 3 contains 10 negatively worded and 10 positively worded items. Participants are asked to rate the statements by rating them using 1 to 4 (1-Never, 2 – Rarely, 3- Sometimes, 4- Always). Higher scores indicate a greater degree of loneliness. The loneliness scale is said to be a reliable instrument and has a coefficient alpha that ranges from .89 to .94 and test-retest reliability of r=.73 over a 1 year period. Significant correlations with other measures of loneliness were used as a way to measure convergent validity. The UCLA Loneliness Scale (Version 3) is significantly correlated (.65) with the NYU Loneliness Scale and with the Differential Loneliness Scale (.72).

Procedure

The participants were drawn from workplaces that are within Awka Town. And the researchers briefed them about the objectives of the study and assured them of confidentiality of the information that they are going to provide in the research. To gather research data in this study, questionnaire was preferred due to its ability to collect data from respondents within a limited time frame. Informed consent, of all the participants was sought after which the questionnaires along with demographic sheets were distributed to the participants. The overall properly answered questionnaires were 149 copies which constituted the participants of this study.

Design and Statistics

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The study adopted Two by Two (2×2) Factorial Design was adopted (Because the study is geared towards comparison): Two-way Analysis of Variance (ANOVA) statistic was used to analyze the data.

Results

Based on the above tables, the corrected model accounted for .012% variance in gender based violence, with ($F_{3,145}$) = .59, p>.05; R = .012, R^2 adjusted = .008. The first hypothesis which stated there will be no significant difference between those with positive mental health and those with negative mental health on gender based violence among married persons in Awka town was confirmed at ($F_{1,145}$)=.41, p>.05. Also the mean differences and standard deviation within the mental health: M=74.45, SD= 7.02 (positive) and M=73.47, SD=6.45 (negative), N=149. This means that persons with positive mental health experience gender based violence less than persons with negative mental health experience at 62%. The second hypothesis which stated that there will be no significant difference between those with positive loneliness and those with negative loneliness on gender based violence among married persons in Awka town was confirmed at ($F_{1,145}$)=.66, p>.05. Also the mean differences and standard deviation within the loneliness: M=74.45, SD= 7.02 (positive) and M=73.47, SD=6.45 (negative), N=149. This means that persons with positive loneliness experience gender based violence less than those with negative loneliness experience at 62%. The third hypothesis which stated that there will be no significant interaction between mental health, loneliness and gender based violence among married persons in Awka town was confirmed at ($F_{1,145}$)=.40, p>.05.

The results were presented in the order in which the research hypotheses were tested

Table 1: Summary of Descriptive Statistics and Two-Way Analysis of Variance of the Study Variables

Loneliness	**Mean**	**Std. D**	N
Positive	74.45	7.02	62
Negative	73.47	6.45	87
Total	73.88	6.69	149
Loneliness	**Mean**	**Std. D**	**N**
Positive	74.45	7.02	62
Negative	73.47	6.45	87
Total	73.88	6.69	149

Table 2:

Source	**Type III Sum of Squares**	***df***	**Mean Square**	***F***	**Sig.**
Corrected Model	79.70	3	26.57	.59	.623
Mental Health	18.46	1	18.46	.41	.523
Loneliness	29.86	1	29.86	.66	.417
Mental Health * Loneliness	17.91	1	17.91	.40	.530
Error	6542.13	145	45.12		
Total	819884.00	149			

Dependent Variable: Gender Based Violence. a. R Squared = .012 (Adjusted R Squared = -.008).

Discussion

Based on the results, the first hypothesis which stated there will be no significant difference between those with positive mental health and those with negative mental health on gender based violence among married persons in Awka town was confirmed. This implies that those with negative mental health experience more gender based violence than persons with positive mental health. This perhaps may be because the thought patterns and there behavioural disposition is usually fault in their relationship. The thought could be inappropriate reasoning about sexual and physical behaviour which now make them perceive their partner as either inferior or overbearing this thereby prompted unwholesome reaction from their partner and engender them into major psychological problems faced by the victims of violence such as poor self-concept, low self-esteem, feelings of powerlessness, helplessness, worthlessness, hopelessness, sleep problems, anhedonia, post-traumatic stress disorder and depression.

Also, the second hypothesis which stated that there will be no significant difference between those with positive loneliness and those with negative loneliness on gender based violence among married persons in Awka town was confirmed. This implies that persons with negative loneliness experience are involved in gender based violence than persons with positive loneliness experience. This may because those that experience gender based violence involves in negative perception and interpretation of their life experiences which usually push them into isolating lifestyle and thereby resurrect multiple health problems such as an increase in depression, sleeping problems, decrease or increase in appetite, suicide, hostility, alcoholism, poor self-concept, and psychosomatic illnesses" (Gierveld, 1998; Rokach *et al.,*, 2000). More so, the third hypothesis which stated that there will be no significant interaction between mental health, loneliness and gender based violence among married persons in Awka town was confirmed. This is in support of Social learning theory that explains violence as a coping mechanism learned through observation or experience (Bandura, 1986). This theory maintains that the likelihood of repeated abusive behaviour is contingent upon reinforcement.

Suggestions

Based on the findings the following suggestions were made:

Mental Service Centre Establishment: availability and accessibility of mental service centres for victims and perpetrators of partner violence is urgently needed. This will aid in counselling the partners on the danger of violence against their partner and need for them to understand that they are two individuals with different personality, orientation and aspirations.

Workshop and Seminars: Psychologists/behavioural scientists should as a matter of urgency engage in enlightenment strategy like seminar and workshop in order to make the married persons to know the causes, consequences and strategies of overcoming gender based violence in their marriages.

Public Campaign: use of publicity in tackling social problem in our society cannot be overemphasised, hence social scientists are expected to engage in public campaign via use of social media, radio, television, market/community publicity and so on in getting the married persons and others informed about gender based violence menace. This however, will aid in reducing this menace among partners.

Religious Leaders Involvement: The religious leaders should get involved in educating married partners about gender based violence, since they are first people that some of this partners run to when this problem erupt for counsel, thus they needed also to inculcate this education to their sermons this invariably will help bring solution to gender based violence in our society today.

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Further Research: the study recommends for further studies in this area in order to know whether different interplay will emerge between mental health, loneliness and gender based violence in the future studies.

Conclusion

Poverty, misery and narrow-mindedness are features used to characterise 'the locals' this fosters gender based violence which is pervasive across all glocalised cultures, regions and diverse social categories around the globe. And this violence usually come in various forms ranging from physical, verbal and sexual assault and this however causes a lot harms which at times result hospitalisation or death of the victims. Hence, the study considered the comparativeness of mental health and loneliness on gender based violence in glocalized society and the result indicated that mental health and loneliness have no comparativeness with gender based violence. Based on the result, the study make needed recommendations.

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