Challenges of Recognition of the Psychiatric Aspects of Intimate Partner Violence

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Abstract

Background: Even though intimate partner violence represents a major public health problem in Nigeria, much of its associated burden of psychiatric morbidity presenting in the clinical setting goes unrecognized and untreated. **Objectives:** The purpose of this paper is to clarify the psychiatric perspectives on intimate partner violence and highlight the barriers that militate against the detection of these problems in clinical contexts. **Method:** This paper utilized the framework of relevant case series and a focused review of the relevant literature to describe and annotate the psychiatric problems of the victims and perpetrators of intimate partner violence in southeast Nigeria. **Results:** The major barriers to detection of the psychiatric disorders occurring in the context of intimate partner violence include patients' feelings of shame, reticence about the abuse experiences in the clinical encounter, and cloaking of their emotional distress in somatic complaints. Also, the poor interviewing skills of many doctors and their difficulty in processing psychosocial matters contributes to the non-detection of psychiatric problems occurring in the context of partner violence. **Conclusion:** Concerted efforts directed towards the improved detection, treatment and/or referral of patients presenting with these difficulties will enhance their wellbeing and quality of life.

Keywords: Africa, Domestic violence, Mental health problems, Partner violence, Psychiatric perspectives, South-East Nigeria

Introduction

Intimate partner violence represents a major public health problem with significant general and mental health impacts in virtually all regions of the world.[1-5] The prevalence of intimate partner violence is thought to be very high in Nigeria and other West African countries, with rates ranging from 20.2% to 78.8%.[3,5-7] This high prevalence is thought to be related to the patriarchy and associated rarefaction of partner abuse within the cultures of most West African societies.

The burden of intimate partner violence that presents in the clinical setting is high, although, much of this goes undetected in routine practice.[1,8,9] Detection of clinical cases that are related to intimate partner violence requires diligent evaluation and diagnostic astuteness applied in the setting of an empathic relationship between a clinician and a patient.[10,11] Doctors are uniquely positioned to identify and treat the physical and psychosocial problems related to intimate partner violence because many abused women seek medical care after victimization.[12,13] It has been estimated that about one-third of all women presenting to the emergency department of hospitals are victims of domestic violence.[14]

Use of mental health services is very low among victims of domestic violence[15] and even when they present to doctors their mental health problems and abuse remain undetected and untreated.[16-18] General practitioners and other clinicians who serve as gate-keepers to psychiatric referral are often unable to recognize the features of depression, anxiety, and other psychiatric sequelae of partner violence in the majority of the patients presenting to them.[19] Only about 10% of doctors working in primary care settings routinely screen patients for

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intimate partner violence.[20] The majority of doctors neither inquire about intimate partner violence nor explore clues that arise in the course of a medical evaluation.[21] Many doctors in developed countries usually cite lack of time, feeling uncomfortable with the subject of partner violence and training deficits as the main reasons for their failure to screen for the condition.[22] The reasons for the lack of detection of violence in a poor country where patriarchal beliefs rarefy the issue of violence against women are far from being clear and yet to be explored through empirical studies. This knowledge gap is worse with the psychiatric aspects of partner violence, whose burden and impact are yet to be appreciated in many developing countries whose healthcare resources are expended on combating the huge burden of infectious diseases. In such contexts, much of the psychiatric morbidity associated with intimate partner violence remains hidden, neglected, or trivialized in the course of searching for and treating the physical problems associated with partner abuse.

Incidentally, addressing the mental health consequences of intimate partner violence results in improved wellbeing, greater confidence and higher quality of life.[23] Though the physical symptoms that accompany partner violence (trauma, chronic headaches, pelvic pains, and sexual dysfunction) are usually salient,[24] these problems usually coexist with psychiatric symptoms such as anxiety, depression, and multiple somatic symptoms.[25]

The purpose of this paper is to clarify issues related to the presentation of psychiatric aspects of intimate partner violence in South-East Nigeria and highlight the barriers that militate against the detection of these problems in clinical contexts. The issues are explored and annotated through the discussion of a case series that came to the attention of the authors.

Psychiatric Aspects of Intimate Partner Violence

A number of psychiatric disorders accompany partner violence of various shades of severity and typology.[18,26,27] It has been variously estimated that the prevalence of psychiatric morbidity in the context of partner violence is 34%–75%.[25,27,28] The range of diagnosable conditions that are encountered frequently include depression, anxiety, post-traumatic stress disorder, eating disorders, substance use disorders, insomnia, and deliberate self harm.[27,29-31] Many of these conditions often coexist.[32] It has been estimated that about one-third of all suicide attempts are observed among women experiencing partner abuse.[33] The occurrence of suicidal behaviour among abused women is associated with intense psychological distress, helplessness and abuse of psychoactive substances.[34] Furthermore, there is increased risk of recurrence of suicide attempts among women who are abused.[33]

The impact of abuse on women's mental health increases with the severity and chronicity of the violence.[35-37] Similarly, more than one-third of the male perpetrators of partner violence met diagnostic criteria for some types of mental disorder, including anxiety, depression, substance use disorder, and personality disorder, especially, antisocial and borderline types.[29,38,39] Many of these psychiatric disorders are acknowledged by the batterers themselves as possible contributors to the partner violence.[40]

It is apparent from the thrust of the published studies that individuals suffering these psychiatric disorders do not clearly describe the psychological symptoms that could enable clinicians recognize the relevant syndromes. Instead, many of these patients report and elaborate on the somatic symptoms that accompany the experience. The somatic symptoms frequently complained of include headache, abdominal pain, gastrointestinal complaints, sleep difficulties and chronic pain.[41-43]

A number of social contextual factors may make certain individuals differentially vulnerable to developing negative mental health consequences after exposure to partner violence.[44,45] Among these factors are poverty,[46] living in poor urban neighborhoods and social isolation[45] and inadequate access to health services.[47]

Alcohol use by men may increase the risk that they attack their spouses, as well as increase the severity of the ensuing violence.[48] Intermittent employment or unemployment can act additively with alcohol or alone to heighten the risk of perpetrating domestic violence. Psychopathology in the perpetrators[39] and lower levels of education and poverty, whether absolute or relative, might be associated with an increased risk of inflicting injuries in the course of domestic violence.[31,48]

Barriers to Recognition and Treatment of Psychiatric Aspects of Partner Violence

A number of patient, clinician, and system related barriers may contribute to the poor detection of the psychiatric aspects of intimate partner violence. Help-seeking for a given problem is embedded within a cultural matrix in which various social and family factors influence the characterization of severity, help-seeking and appropriate coping resources to utilize.[49] Also, help-seeking is preceded by identification and labeling of illness experiences, both of which are culturally determined and involve the imputation of causal attributions.[50,51] For instance, certain sources of personal distress might not be construed to require mental health help-seeking so long as they are not associated with flagrant disruptive or dangerous behaviours that can affect the integrity or function of the larger social group.[52] Similarly, the communication and rapport between clinician and patient and quality of the clinical interview influence the outcome of the therapeutic encounter.[53] All these influence the ability to detect the clinical syndromes that require therapeutic intervention.

Patient Barriers

Many patients that are experiencing the psychiatric problems related to intimate partner violence often manifest unexplained physical complaints, multiple symptomatology, emotion-laden symptoms, and helplessness which doctors have difficulty processing in the clinical encounter.[54-57] Many of the patients also are unable to elaborate on the symptoms when requested to do so by their doctors, while some feel ashamed of presenting the problems before doctors.[24,58,59] Many research studies on the cross-cultural aspects of mental health help-seeking suggest that the cultural value attached to the avoidance of shame and stigmatization is a major deterrent to help-seeking for a range of mental health conditions.[60-62] Case 1 illustrates some of these features.

Case 1

This was a 36-year-old woman attorney who had come to the psychiatrist to seek treatment for her husband who was increasingly drinking too much alcohol, and threatening to kill her. The threats had compelled her to seek refuge in the home of a family friend. She described having been experiencing recurrent verbal and physical abuses in the course of their marriage of over 10 years. She was distressed, fearful, unable to sleep, and had a reduced appetite. The couple had two children, a boy and a girl, but was desirous of having more. Despite seeking treatment for secondary infertility from different hospitals, she had not been able to achieve another conception since her last childbirth, seven years ago. Although she had come for her husband's treatment, her emotional health became the focus of intervention in the course of pursuing the former aim, when she realized that the clinicians treating her husband could be of help to her.

The patient reported that most of the abuses she suffered usually came up after her husband had drunk alcohol in excess. Incidentally, his in-take of alcohol had increased progressively in the past few years, alongside a downward slide in his career and earnings. She believed the abuses resulted from his continued social decline and virtual underemployment, which contrasted with her increasing prosperity, higher earnings, and rising social status. For her, these factors made him to feel threatened by her growing success and increasing financial independence. On account of these forces, she considered him envious of her progress and achievements, which were in sharp contrast to his deteriorating financial situation.

In the recent months, she had been forced by the recurrent physical abuses of her husband to flee from her matrimonial home, especially after he began trumping up accusations of extra-marital affairs against her, as well as periodically searching her personal effects and phones for evidence to support his claims. In addition, he also had attempted setting the house ablaze while she was lying in the bedroom, after a particularly serious drinking bout. A few days after this incident, her husband chased her around the compound with a cutlass when one of her cousins had visited them at home, in the mistaken belief that the cousin in question was "one of her lovers." These serious threats of harm prompted her to flee their home. To worsen matters, since she left the house, her husband has been stalking her and threatening to kill her if she does not come back to the house. Even though many friends and health professionals had been advising her to seek treatment from the psychiatric hospital for her husband's drinking problem and its consequences, the shame of being associated with the hospital prevented her from doing so. Instead, during these intervening months, she preferred to seek help from various churches and spiritual healers for these problems. On assessment, she was found to have depressive disorder of moderate severity and secondary infertility in the setting of severe marital dysfunction and violence.

Many patients expressing psychosocial distress on account of intimate partner violence focus on the somatic symptoms which are often compounded by self-medication and partial treatment for different infectious conditions carried out by quacks and different health care providers. This causes difficulty in the assessment and diagnosis of such cases and makes detection of the underlying emotional condition difficult. Also, lack of understanding of mental health matters (low mental health literacy) makes many people unaware that many of the difficulties that are related to partner violence which they are striving hard to cope with can indeed be ameliorated by proper psychiatric assessment and treatment.[63] Again, gender differences exist in attitudes towards seeking help for emotional distress.[64,65] Some of these features are illustrated by the presentation of Case 2.

Case 2

This was a 46-year old man that was brought to a psychiatric hospital on account of excessive drinking of alcohol, repeated beating of his wife, destruction of household property, attempted burning of their house and threatening his wife with a cutlass, culminating in her running away from the house with their children. This patient is the husband to the patient described as Case 1. The man had started drinking in secondary school and came from a family where virtually all adult males drank heavily. His father had drunk heavily until he became very old, whereas his uncle had died from problems that resulted from severe alcohol intoxication.

On account of his drinking, his work performance had deteriorated progressively because he was spending increasingly more time drinking and recovering from the effects of intoxication. He was doing very poorly in his legal career and his income was very low. Consequently, his family had had to rely on his wife's earnings for their support, and overall up-keep. The patient had suffered several episodes of road traffic accidents on account of driving while drunk. He was a known hypertensive patient and was taking antihypertensive medications regularly. He vigorously denied having any health or social problems from his drinking and resented being brought to the hospital for evaluation and treatment. While in the hospital, he attempted to run away a number of times. He blamed his wife for the recurrent physical

abuses she had suffered from him, because according to him, she was engaging in extra-marital affairs, a charge the lady had vigorously denied.

At the time of presentation, the patient was withdrawn and aloof most times, and always talked to himself whilst alone. He denied having auditory hallucinations but accused his wife and "her male friends" of trying to harm him. He further stated that he still loved his wife and wanted her to come back to the house. The patient was considered to have met criteria for the diagnosis of alcohol dependence syndrome with hallucinosis, pathological jealousy, and erectile dysfunction.

Doctor-related barriers

The poor interviewing skills of some doctors and their lack of interest in exploring the emotional content of patients' symptomatology contributes to the difficulty in detection of psychosocial problems.[66] Also, many doctors do more talking than listening during the interview and cannot easily identify the clues of emotional distress provided by patients.[66-68] All these contribute to the difficulty of detecting psychiatric problems in general practice. These factors are relevant because unlike in other fields of medicine, the recognition of various psychiatric syndromes is directly related to the verbal exchange between the doctor and the patient regarding the nature, severity and impact of the symptoms. Some of these features were evident in the presentation of Case 3.

Case 3

This was a 33-year-old primary school teacher, who was referred to one of the authors by a colleague in general practice for specialist evaluation following repeated visits to his clinic and several others, with complaints of burning and peppery sensation in the head and body, insomnia, persistent feeling of apprehension, impaired concentration, irritability and fatigue. She also had pain in different parts of the body, anorexia, menstrual irregularities and loss of interest in sex. The burning and peppery sensation had predated all the other complaints and was described by the patient as the most troublesome of all the symptoms. Further questioning indicated that she had been experiencing recurrent episodes of verbal and physical abuse from her boyfriend, with whom she had been engaged for the past five years. The bouts of abuse emanated during periods of intense quarrelling, which, were usually provoked by her inquiries into the nature of her boyfriend's liaison with certain other ladies she frequently encountered around him. Each time she asked about these persons, the patient's boyfriend became angry, an argument ensued, and this would culminate in the boyfriend's anger escalating, and ultimately lead to his physically abusing her. Usually, the physical abuses were preceded by intense verbal insults during which he called her names, shoved, pushed around, and hit her. After the beating, the man would apologize to her and promise he would make up for the "mistake" he had made and that it would not happen again. Unfortunately, such suave assurances never deterred any subsequent episodes. Besides, the patient noted that the man had not been giving her financial support, which was expected since she earned a very low wage from which she also provided assistance to her mother and three younger siblings in higher institutions.

Asked why she had maintained the relationship in spite of the abuses, she stated that ordinarily, she loved the man, and that when he was not angry, he also showed love to her and understood her. Also, he accepted her as she was, and was well liked by her mother and other family members. Besides, the man had assured her that he would marry her "very soon." Above all, since no other serious suitors had yet turned up, the patient felt that she had to make do with the person she had at the moment.

The doctor had referred the patient after he and several others had been treating her for malaria, typhoid fever and other infectious diseases on several occasions along with prescriptions of various multivitamin and haematinic medications. However, despite the fact that none of these treatments ameliorated the patient's persistent distress, the pattern of treatment was repeated several times that it was the patient herself that requested that she be referred out, to a facility where a diligent search could be made for the cause of her continued problems. It was this request that prompted the patient's referral. Our assessments showed that the patient had depressive disorder in the setting of recurrent intimate partner abuse.

Systemic barriers

A number of barriers may prevent individuals from accessing the mental health services in times of distress. Factors that are unrelated to culture like not being aware of available services, geographical access barriers, and limitations in the organization of the mental health services may prevent emotionally distressed individuals from seeking needed help.[69] The use of health services may be low because individuals in the culture may prefer to receive help from informal sources like family, friends and clergy.[70] This may be related to the insufficiency of health care access or to the explanatory models espoused in relation to a given health problem.[71] Delays in making referrals and economic barriers may also contribute to delays in obtaining needed psychiatric evaluation and treatment for the psychosocial complications of intimate partner violence.[72,73] Thus, poverty and its consequences may contribute to delayed help-seeking for distressing experiences.[74] The presentation of Case 4 illustrates some of these perspectives.

Case 4

This was a 41-year-old woman who presented after she was severely beaten by her husband and had associated severe chest pain, headache, haemoptysis and intense unhappiness. The couple had been married for 13 years and did not have any children. However, in the earliest years of their marriage, the woman had had three miscarriages. This patient had

been referred to a gynaecologist by a general practitioner in the hope that the former could help her find solutions to her relational difficulties with her spouse. After several months of not making progress in this direction, the gynaecologist in turn, advised the patient to find out if she could derive any benefit from consulting the psychiatrist for these problems. Rather very reluctantly, the patient eventually turned up in the psychiatrist's office.

She described a recurrent pattern of verbal abuse, assaults, and being hit with objects following minor disagreements in the course of their marriage. Occasionally, she got beaten without her being sure of the reason for the attack. In fact, she described herself as living in terror, and needed to maintain vigilance over what she said or did in the house to avoid provoking an assault. Many times, she felt freer and happier when she was outside the home. She described her husband as having a fiery temper that made him go into fits of rage at intervals, during which he could do things he could regret later. For instance, he had on occasions damaged a number of household property, furniture, and crockery during the bouts of rage. She attributed the recurrent attacks of violent behaviour against her to their not having children. She had suggested to her husband that they adopt one or two children, but he had always refused, stating that such a practice was not part of their culture, and consequently, if he did, he could be subjected to ridicule by his peers and family members. This re-echoed stance had stalled their going through with adoption.

In the course of their stormy relationship, the patient had always solicited the mediation of her in-laws and the support of her own family members. In fact, she had stated that it was the continued support she enjoyed from her in-laws over the years that made it possible for them to manage to keep the relationship together so far. She described experiencing complaints of insomnia, anhedonia, and persistently low energy. She had crawling sensations all over the body as well as feeling as if she had a heavy load placed on her head. Several times in the week, she suffered bouts of throbbing headache that were not relieved by paracetamol. She described having fear of facing each new day and inability to go for her business on account of fatigue and feeling of being unwell. On assessment, she was found to have both severe hypertension and moderately severe depressive disorder with suicidal ideation.

Discussion

Psychiatric disorder can be found in both victims and the perpetrators of intimate partner violence. Often, this could remain hidden and undetected for a long time, despite frequent visits to the doctor. For many victims, mental health problems develop after years of recurrent abuses, both verbal and physical. The psychosocial environment for abused persons is often characterized by feelings of fear and insecurity, emotional rejection, and feeling helpless and powerless over the prevailing circumstances. Also, for many victims, the psychological impact of domestic violence can be more debilitating than the physical injuries.[26]

These cases raise issues regarding the difficulties in the recognition of the psychiatric complications of intimate partner violence in a culture that accepts and normalizes the intimidation and abuse of women owing to its patriarchal beliefs. The range of mental health sequelae of domestic violence in the victims, is broad, and may include depression, anxiety disorder and phobias, low self-esteem, post-traumatic stress disorder, and somatoform disorders, as shown by the cases described in the report. Self-harm can result from any of these conditions.[28,75] Golding (1999) estimated that 17.9% of domestic violence victims develop suicidal ideation, whereas 47.6% and 63.8% develop depression and PTSD, respectively.[28] Also, a link has been described between chronic domestic violence experience, suffering PTSD and suicidal ideation and homicidal attacks by the victimized women against their abusive partners.[76] It has also been argued that the distress associated with intimate partner violence may be involved in the enactment of a somatoform disorder like pseudocyesis in susceptible persons.[77]

Although the presentation of emotional distress as somatic complaints is common across cultures, there is a high prevalence of somatic symptoms among abused women in different cultures.[42,78,79] This may reflect the varying individual response to emotionally distressing experiences or the somatic presentation of psychiatric disorders such as depression, anxiety disorders or PTSD which are commonly encountered among abused women. It has been shown that in many countries, depression is frequently experienced as physical complaints like aches and pains, headache, fatigue, weakness and related bodily symptoms.[49] However, the presentation of mostly somatic complaints in the clinical encounter tends to mislead doctors.[80,81] Somatic presentation of emotional distress often leads to unnecessary diagnostic investigations and wrong treatment which add to the patients' difficulties, frustration, and resource wastages and also, further delay recognition of the cases.[80,81]

Apparently, the shame and stigma associated with intimate partner violence contributes to the reluctance of many patients to disclose their problems related to spousal abuses to their clinicians.[24,58,59] This reticence of many patients in the clinical encounter reduces the likelihood of partner violence case detection. Also, case detection is hampered by the clinicians' knowledge gap, negative attitudes and lack of interest in the evaluation of the sources of emotional distress.[82,83] All these contribute to delayed recognition, treatment or/and referral of partner violence cases.

The unique characteristics of the psychiatric perspectives of intimate partner violence that is evident in this case series are the predominance of poor recognition and delayed referral, low

mental health literacy, seeking help from alternative healthcare and religious healers and the pervasive influence of poverty, inadequate health care accessibility and other systemic barriers. Studies of help-seeking for emotional problems among African Americans suggest that they are more likely to turn to family, friends, and the church for assistance rather than professional help providers.[51,84] There is reported to be stigma against admitting a need for mental health intervention in the African American community in general.[85] All these are also similar to the situation in the context of the individuals whose cases are explored in this report. Also, when Afro-American women are suffering, they are more likely to pray about the problem than ask for professional help. Indeed, seeking help from a professional may also be perceived as an admission of lack of faith in God to meet one's needs.[86] It is uncertain whether such views are entertained by emotionally distressed Nigerians in the context of partner violence. There is, therefore, a need to conduct qualitative studies to clearly understand their unique perspectives.

Many intimate partner violence cases have association with alcohol, either as a trigger, or as a relief for longstanding emotional difficulties.[87,88] When this becomes associated with loss of status or decline in career and/or income, its effects on mental health could be overwhelming.[31] The effects of alcohol on intimate partner violence may be accentuated by interaction with other social factors like unemployment, social isolation, and reduced income.[48] Marital relationships characterized by increasing episodes of physical violence, threats of harm, recurrent intimidation, harassment, and stalking are actually doomed unless appropriate interventions are instituted. There is evidence that extreme controlling behavior and stalking tend to precede most partner violence homicides.[89,90]

Abusive behavior by male perpetrators could be triggered when the individual feels threatened, insecure, or trapped in limiting circumstances.[91] It may also reflect the effect of personality disorders, such as borderline or antisocial personality disorders with environmental factors such as unemployment, diminished income, and alcohol abuse acting as precipitants of the episodes of domestic violence.

Deliberate self-harm can accompany many experiences of intimate partner violence, either alone or co-existing with other mental disorders like depression and anxiety disorders. It is more likely to develop in situations where the abuses have been severe, and have lasted for a long time.[34,92] Like most of the mental health consequences of intimate partner violence, the consequences could be disastrous unless appropriate interventions are instituted.[93,94]

Regarding the link between partner violence and mental disorders, the thrust of the burgeoning literature suggests that repeated exposure to both physical and psychological abuse may act as precipitating factors that lead to depression, anxiety, and related disorders.[95] The re-enactment of the abuse and its associated conflicts exerts a deleterious impact on the self-esteem and coping capacity of the affected women and this further increases vulnerability to the psychiatric disorders and their impacts. This interpretation is consistent with the empirical evidence that causally links exposure to adverse life experiences to the onset of depression, anxiety, and stress related psychiatric disorders.[96-98] The adverse impact of stressful life events on health and wellbeing is fairly well established.[96,99-101]

Unfortunately, the negative impact of the mental health consequences of intimate partner violence worsens with the passage of time. These may adversely affect the quality of life and social functioning of the affected persons. Incidentally, for many of these problems, appropriate interventions exist in contemporary psychiatric practice, even though many clinicians who are not psychiatrists may not be aware of them. It is rather unfortunate that many patients that could benefit from the available interventions do not get referred to psychiatrists for evaluation and treatment.

In sum, much of the burden of intimate partner violence presenting to clinicians goes on recognized and untreated. This is all the more so for the psychiatric effects and concomitants of intimate partner abuse. Incidentally, the impact of abuse on the mental health and wellbeing of the woman increases with the duration and severity of the violence. The range of mental health sequelae of domestic violence in the victims is broad and varied and may include depression, anxiety disorder and phobias, low self-esteem, post-traumatic stress disorder, somatoform disorders, and deliberate self-harm. Many patient related factors like feeling of shame, reticence and clouding of emotional distress in somatic verbiage many contribute to the inability of clinicians to recognize the psychiatric aspects of domestic violence. Also, the poor interviewing skills of many doctors and their lack of interest in exploring psychosocial themes despite the patients' clues during the clinical encounter contributes to the difficulty in their recognition of the psychiatric problems associated with intimate partner violence. Related to these, the poverty, preference of informal help-seeking and difficulties in accessing appropriate mental health services often compound the challenge of detection of the psychiatric aspects of intimate partner violence. Unknown to many clinicians, interventions exist in the therapeutic armamentarium of modern psychiatric practice that could provide relief to the sufferers of the psychiatric impacts of domestic violence and improve their quality of life. Increased attempts to detect, treat and refer cases of intimate partner violence that appear to present complex symptomatology may lead to greater recognition of patients that might benefit from these interventions.

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