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CASE REPORT

CHALLENGES IN THE MULTI-DISCIPLINARY MANAGEMENT OF INTIMATE PARTNER VIOLENCE CASES IN SRI LANKA: A CASE REPORT

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ABSTRACT

Introduction: Intimate partner violence (IPV) is a major public health issue associated with significant physical and psychological morbidity. In Sri Lanka, social stigma and delayed legal intervention may further worsen mental health outcomes among victims.

Case Presentation: A 42-year-old mother of three presented to the National Hospital of Sri Lanka with severe depression, dissociative symptoms, and suicidal ideation following approximately two decades of IPV. Her husband reportedly exhibited morbid jealousy, alcohol dependence, and polysubstance abuse. Past medical history included assault-related head injury, post-traumatic seizures, and a previous suicide attempt by drug overdose. Following psychiatric evaluation and family intervention, the patient was referred for medicolegal examination and legal protection under the Prevention of Domestic Violence Act, No. 34 of 2005. Limited physical examination revealed no fresh injuries, while full examination was declined by the patient. Despite multidisciplinary management involving psychiatric, medicolegal, and social support services, the patient remained vulnerable due to persistent psychological distress, financial dependency, and limited social support.

Conclusion: This case highlights the cumulative psychiatric impact of chronic IPV and emphasizes the importance of coordinated medicolegal intervention, sustained psychiatric care, and strengthened social support systems for vulnerable victims.

Keywords: *Depression; intimate partner violence; medicolegal*

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INTRODUCTION

Intimate partner violence (IPV) affects an estimated one in three women worldwide, according to the World Health Organization (WHO)[1]. Local statistics from the women and child protection bureau show a declining trend in violence from 2022 to 2024, and the same period also shows an increase in the number of protection orders issued. Such abuse frequently results in long-term psychiatric complications, including depression, anxiety, post-traumatic stress disorder (PTSD), and dissociation[2].

The Prevention of Domestic Violence Act No. 34 of 2005[3] is a great tool that provides a mechanism for protection orders and

emergency intervention; however, enforcement remains inconsistent[3]. This may be due to a lack of knowledge and awareness among the public. Social media and local media can play a vital role by educating and creating awareness among the public. Victims often delay reporting due to fear, social stigma, and economic dependency. This situation follows the pattern of Stockholm Syndrome, which is a recognized psychological phenomenon in which a person who is being abused, threatened, or held under the control of another develops emotional attachment, sympathy, or loyalty towards the perpetrator.

CASE PRESENTATION

A 42-year-old married woman, mother of three, was admitted to the psychiatric unit of the National Hospital Sri Lanka on January 25, 2025, following a dissociative episode and suicidal ideation. During my medicolegal examination, it was very difficult to get a history from her as she was clinically depressed and did not even make eye contact. The bed head ticket (BHT) records were useful to understand her background story. During the second session, she was talking more freely, and her daughter was also present. According to her, she was the only victim in the family; her husband had never assaulted the children (the eldest daughter had finished her education, while the other two were still schooling). She has endured 20 years of recurrent IPV, including physical assaults and emotional breakdowns, from her husband, who displayed morbid jealousy, alcohol dependence, and poly-substance abuse. These are strong predisposing factors for the ongoing physical abuse, along with financial burden and lack of education. The psychiatric team had a family intervention with the husband and the eldest daughter. During this intervention, the husband acknowledged most of the allegations and agreed to undergo rehabilitation and treatment.

Her medical history included multiple admissions; a head injury 15 years ago due to assault, with subsequent post-traumatic seizures, and a suicide attempt by amitriptyline and metformin overdose (Table 1 and Figure 1).

Table 1: Summary of hospital admissions and outcomes

Year	Presentation	Cause	Outcome
2010	Head injury	Physical assault	Healed
2022	Seizures	Post-traumatic	Controlled with medication
2024	Drug overdose (amitriptyline and metformin)	Suicide attempt	Recovered
2025	Dissociative episode	Chronic IPV	Psychiatric admission

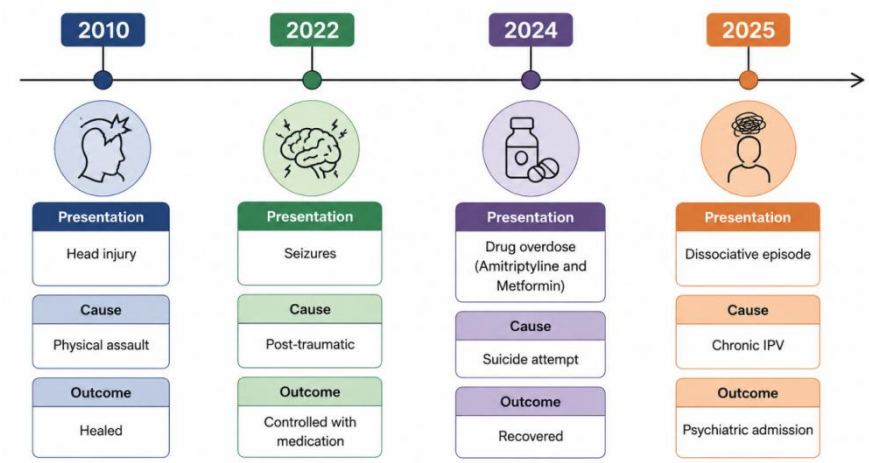

Figure 1: Timeline of hospital admissions and outcomes.

Her only consistent emotional support was her adult daughter, who was planning to marry and leave home soon, leaving the patient at risk of isolation.

Following the psychiatric admission and the family intervention, the patient was referred for medicolegal examination. A limited physical examination (where only the exposed portions of her body, including face, neck, upper limbs, and feet) was done with her consent. There were no fresh injuries, and there was no recent history of assault. The need of the hour was for a full physical examination to rule out/confirm scars and other evidence of chronic physical abuse, but she did not give consent for this (her

refusal was documented in the MLEF). Referrals were made to "Women In Need", "Children and Women Bureau", and "Mithuru Piyasa" for social and legal support. A protection order was sought under the Prevention of Domestic Violence Act No. 34 of 2005[3]. The medicolegal team collaborated closely with psychiatric and social services to ensure continued follow-up.

Pharmacotherapy with Selective Serotonin Reuptake Inhibitors (SSRIs) and short-term anxiolytics was initiated. Cognitive Behavioural Therapy (CBT) was also started simultaneously for empowerment, safety planning, and relapse prevention. The patient and her daughter were informed of emergency contacts, including the 1938 national women helpline[5].

However, adherence to treatment was poor. The patient expressed fear of societal stigma and financial dependency on her husband. Despite protection orders, enforcement remained inadequate, and the lack of sustainable shelter options prevented her from living independently.

DISCUSSION

Intimate partner violence (IPV) is increasingly recognized not only as a social and legal issue but also as a major determinant of long-term physical and psychiatric morbidity. Global data indicate that IPV remains highly prevalent despite legal and public health interventions, with substantial regional variation and persistent underreporting, particularly in South Asia[4]. Victims of chronic IPV frequently develop depression, anxiety, dissociative symptoms, post-traumatic stress disorder, and suicidal behaviour, especially when exposure to abuse is prolonged and recurrent. The present case demonstrates the cumulative psychiatric impact of long-standing IPV complicated by social isolation, financial dependency, and inadequate psychosocial support.

A critical concern in IPV-related morbidity is the potential escalation from chronic abuse to severe injury or fatal violence. Domestic homicide reviews have shown that intimate partner homicides are often preceded by repeated assaults, coercive control, and multiple prior contacts with healthcare or legal services[5]. Early recognition of high-risk indicators within psychiatric, emergency, and forensic settings is therefore essential, even when physical findings are minimal or absent at the time of examination. In this case, although no fresh injuries were identified during the limited physical examination, the absence of demonstrable injuries did not exclude prior or ongoing abuse. Delayed presentation, repetitive low-force assaults, and healing of previous injuries may reduce objective physical findings despite a significant history of violence. From a psychosocial perspective, prolonged exposure to abuse may result in trauma bonding and maladaptive attachment patterns that impair a victim's ability to disengage from the abusive environment[6]. Such psychological dependence may contribute to delayed reporting, reluctance to pursue legal remedies, poor adherence to treatment, and recurrent psychiatric crises. These features were evident in the present case, where the patient remained emotionally vulnerable despite multidisciplinary intervention and continued to depend financially and socially on the perpetrator.

Management of IPV-related psychiatric crises in many high-income countries involves coordinated multidisciplinary systems integrating law enforcement, mental health services, social support agencies, legal advocates, emergency shelters, and structured risk assessment pathways. Such approaches facilitate rapid implementation and enforcement of protection measures with continued follow-up. Although India shares several sociocultural barriers similar to Sri Lanka, initiatives such as one-stop crisis centres and fast-track legal mechanisms have improved coordination of medicolegal and psychosocial care despite ongoing resource limitations. In contrast, Sri Lanka continues to face challenges, including inconsistent enforcement of protection orders, limited shelter availability, and fragmented interagency collaboration, all of which may hinder long-term safety and recovery in IPV victims.

Overall, current literature suggests that effective IPV management requires more than episodic medical or legal intervention. Sustained recovery depends on continuous risk

reassessment, integration of psychiatric and medicolegal services, effective legal protection mechanisms, and long-term social support systems for vulnerable victims[4-6].

CONCLUSION

Chronic IPV may present primarily with psychiatric morbidity (depression, anxiety, suicidal ideation) even in the absence of fresh injuries or visible scars at examination. Lack of recent physical findings does not exclude ongoing abuse, particularly in repetitive, low-force, or temporally spaced violence. Scar dating is of limited medicolegal utility beyond approximately 6–8 weeks, as progressive maturation leads to loss of objective features required for reliable age estimation; thus, older scars cannot be accurately timed, although they may still corroborate prior trauma when interpreted alongside history and psychiatric assessment.

This case underscores the persistent vulnerability of IPV survivors in Sri Lanka despite multidisciplinary intervention, largely due to gaps in enforcement and limited social support. Strengthening protection order implementation, expanding shelter services, and integrating IPV screening into routine healthcare are essential for improving long-term safety and outcomes.

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CONFLICTS OF INTEREST

The authors declared no conflicts of interest.

ETHICAL ISSUES

The presented case was conducted for medicolegal purposes, and the findings were used for academic purposes, according to the institutional guidelines, without divulging the identity of the individual.

SOURCES OF SUPPORT

None.

AUTHOR CONTRIBUTIONS

AMH: Conception and design of the work; the acquisition, analysis, and interpretation of data for the work; drafting the work and revising it critically for important intellectual content; final approval of the version to be published; and agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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