Editorial

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Domestic violence: Does it concern the psychiatrist?

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It is an unfortunate truth that in our day-to-day work as clinicians, we see women who are facing, or have faced domestic violence, most often from an intimate partner. This is not a phenomenon limited to Sri Lanka – one third of women, all over the world, are reported to have faced domestic violence by an intimate partner (1). Reported rates from Sri Lanka vary, ranging from 20 to 72% (2). A study from Colombo has reported that 34% of women in the Western province have been exposed to domestic violence by an intimate partner during their lifetime (3). The Sri Lanka Demographic and Health Survey (SLDHS) conducted by the Department of Census and Statistics in 2016 reported that 17% of ever-married women aged 15-49 years have experienced domestic violence from an intimate partner (4). High rates of domestic violence have been reported from tea plantations in the Central Province, from socio-economically deprived urban areas, as well as in the Districts of Killinochchi and Batticaloa (2, 4).

Domestic violence in Sri Lanka appears to be highest in the lower socio-economic groups (4). More indepth analysis indicates that the risk of domestic violence is significantly associated with early age of marriage for women, and low educational attainment (3, 4). Abuser characteristics, such as alcohol or drug abuse, depression or childhood experiences of violence, and relationship factors, such as suspicions of infidelity have also been linked with increased risk of violence to women (2).

Understandably, existing research has focused on the experiences of women who are victims of domestic violence; but the perceptions and attitudes of men, may be worth exploring further in the Sri Lankan context. For example, Sri Lanka is traditionally considered a patriarchal society, and women are expected to confirm to conservative norms and obey their husbands (2). At the same time, in recent years the role of women has expanded, with women having increasing access to education and employment – while the male role seems to have remained rather static. Could this be contributing to gender conflict, and could the males be reacting maladaptively with violence? These are aspects worth exploring further.

On the other hand, international studies report that men too are victims of domestic violence, but this is a little explored area in Sri Lanka, with little research data available.

Does it matter?

Exposure to domestic violence by an intimate partner obviously places the woman at risk of physical harm. The degree of risk will vary according to the situation, and may range from minor injury to the risk of death due to violence.

But what of the psychological consequences? Women exposed to domestic violence are at increased risk of developing psychiatric sequalae such as depression, suicide and self-harm, and post-traumatic stress disorder (2). The hidden tragedy is that domestic violence may cause more psychological harm than stranger violence, because of the relationship between the perpetrator and the victim (1). On the other hand, women who have been exposed to childhood domestic violence, or who are already suffering from a psychiatric illness, are more vulnerable to get into situations where they will be victims of domestic violence (1). Thus the association between domestic violence and psychiatric illness works both ways.

The often overlooked consequence of domestic violence is the adverse impact on children, growing up in an home with violence. So much so that the Royal Australian and New Zealand College of Psychiatrists describes exposure of children to domestic violence to be a form of child abuse in it's own right (5). According to a study done among school children in the Northern Province in Sri Lanka, upto 41% of children had witnessed violence by their father, against their mother (6). We know very little of the potential impact of this exposure on children in Sri Lanka, both in the short and longer term.

Why not seek help?

Many of us, as clinicians, have faced the dilemma where, despite facing ongoing domestic violence, the woman

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concerned chooses to stay in the abusive relationship, rather than seek help or leave.

According to the 2016 SLDHS survey, of all the women facing domestic violence – only 28% ever sought help (4). Of these women who did seek help, 75% asked for help from a family member or friend, 18% went to the police, and only a *small minority* sought help from health services (4). This was despite the presence of services such as the Sri Lanka Women Bureau and the 'Mithuru Piyasa' first contact centres established in hospital outpatient settings by the Family Health Bureau (FHB).

But for a woman, particularly in Sri Lanka, even seeking help is a complex dilemma; often the woman simply does not have the socioeconomic means to support herself and her children independently. Or she may be afraid of increased violence if she seeks help or tries to leave, may be unaware of any services available for support, or may even be disheartened by responses received when approaching institutions such as the police. Another key factor is the stigma associated around separation and divorce, for the woman, and her children (2). The irony is that the woman may choose to stay in the abusive relationship for the 'sake of the children' – although growing up in an environment of violence is likely to have significant adverse psychological effects on the children. And in certain situations or backgrounds, the experience of violence may also be 'normalized' and endured – for instance, from the female perspective *"He only hits me occasionally"*, and from the male perspective *"I don't hit her, it's only when she does something wrong"*.

The role of the psychiatrist, and the way forward

Some may argue that domestic violence itself is not a psychiatric problem, and thus not the responsibility of the psychiatrist. A sense of 'nothing can be done' and a lack of awareness regarding any services available, may also enhance this professional reluctance to be involved.

Nevertheless, in our clinical work, we inevitably see women who are facing domestic violence. Evidence also shows that while most women don't directly complain of domestic violence, many will often present to hospital clinics and outpatient departments, with non-specific complaints and somatic pains (3). Thus the first step of support is detection of women facing domestic violence – by increased awareness of this phenomenon among health care professionals, and inquiring about it. However, detection alone is not enough – and may even be dangerous, for example, if it places the woman at increased risk of violence when she returns to her home environment. Thus routine screening for women facing violence, without subsequent support measures, is not recommended (7).

Having said that, supporting women who are facing domestic violence is both complex and challenging. Assessment of risk, encouraging and ensuring safety behaviours and treatment of any psychiatric illness are some of the first issues to be addressed. But overall support for women facing violence cannot be provided by one person alone – it would inevitably need both multi disciplinary and multi-sectorial service involvement. While not overwhelming, there are currently services available for women facing domestic violence in Sri Lanka – such as the Mithuru Piyasa centres established by the FHB, the Sri Lanka Women Bureau, the Legal Aid Commission and services offered by the Social Services Department. However, coordination between services, accessibility and the quality of service provided vary. An important role for us as psychiatrists, would be to spearhead coordination between these different sectors. The passing of the Prevention of Domestic Violence Act in 2005, is also a very encouraging development in Sri Lanka. However, there are almost no places in Sri Lanka for women facing violence to seek refuge and stay – a significant omission to be addressed.

As psychiatrists we also have the opportunity to educate and facilitate attitudinal change about domestic violence – among the different sectors involved, such as the police, social services, doctors and other health professionals, and even medical students. A study of undergraduate male medical students in Sri Lanka found that upto 33% were in agreement that at least on some occasions wife beating is justified – reflecting the importance of provision of information to change attitudes, for professionals who will be working with women facing violence (8).

Last but not least, although challenging, the way forward should also include exploration and research about what kind of support women facing domestic violence in Sri Lanka would find acceptable and useful, and about strategies for minimisation of domestic violence in this country.

Conflicts of interest

None declared

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