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# Case Series: Consequences of Domestic Violence: A Report Of Two Cases in Benin City, Nigeria.

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## I. Introduction

Various dimensions of violence exist in the home such as spousal abuse, child abuse and elderly abuse. A WHO study in 2005 revealed that domestic violence (DV) is the most common form of violence in women's lives (much more than assault or rape by strangers or acquaintances) and suggested it should be treated as a major public health issue.[1] Records show that between 50% and 75% of women are subjected to DV in Nigeria.[2] Nevertheless, it is a frequently neglected problem in most crisis centres, emergency wards and obstetrics and gynaecological emergency rooms.

## II. Case series

Presented are two cases of DV who were managed by the authors. They all had complications of DV; one had traumatic rupture of tympanic membrane and the other had splenic rupture. Their presentation and management is discussed below after obtaining approval from the ethics committee.

### Case 1

A 35 year old self-employed seamstress with tertiary level of education who developed ringing ear sensation, bleeding and pain in the left ear following an altercation with her spouse where he slapped her severally on the face. She had been hospitalized four times in last three years for complications from violence from her husband where wounds were sutured on two occasions. She was highly dependent on spouse financially (but been saving separately in last two previous years before presentation to help cushion effects if husband carried out threat of throwing her out of their matrimonial home), had a weak marital relationship and poor family function. She had never reported violence to the law enforcement agency.

On examination, she had healed scars over the face, back, thighs and both upper limbs. Left pinna was stained with crusted blood with dark coloured blood occluding the external auditory meatus. Tragus was tender. Otoscopy of the left ear revealed ecchymosis around the walls of external meatus, small slit perforation with irregular margins in the central part of the pars tensa and haemorrhagic effusion. Testing for conductive and sensorineural deafness using tuning fork (512Hz) revealed conductive deafness of the left ear. A diagnosis of perforated tympanic membrane (TM) was made.

### Case 2

A 27 year old unemployed female married to a 43year old commercial bus driver and had a three month old daughter. She had an eight hour history of abdominal pain and difficulty in breathing that worsened with standing erect. She offered that she was pushed down the stair case by her spouse following her attempt to escape from his punching and kicking as he returned home drunk. He had been verbally and physically abusive to her since their marriage of almost two years. She had suffered a miscarriage from one such episode but had never been hospitalised from any of the assaults. She had run away on several occasions but was appeased by the church elders and their relatives to return to her matrimonial home but had never reported the crime.

On examination, a bruise of 2cm by 3cm in widest diameter was noticed in the left flank and tenderness in the left upper quadrant with guarding. Bowel sounds were absent. Other systems were unremarkable. An abdominal ultrasonography revealed free peritoneal fluid. A diagnosis of splenic rupture was made.

### Treatment

Both patients were admitted into the wards. They were informed that their safety and respect were their rights, and permission to invite the social welfare department to review them was sought. The first patient was

managed conservatively for perforated TM and the second had splenectomy. Both sought assistance to commence legal actions against spouses and assistance from a Non-Governmental Organization for shelter was obtained for the second patient while the first was sheltered by her sister. They both enrolled in a support group for abused women managed by the Ministry of women affairs.

## III. Discussion

The morbidity of the above cases occurred as a result of domestic violence (DV) which is defined as the intentional and persistent abuse of anyone in the home in a way that causes pain, distress or injury in the form of physical abuse, neglect, sexual abuse, economic abuse, spiritual abuse or emotional abuse.[3] Consequences which may be physical or psychosocial are numerous; as experienced by the above clients: perforated TM, had several hospitalizations, temporary hearing loss, disfiguring scars from repeated violence, a prior miscarriage and surgery.[4] Other consequences may be seen in children from such homes where DV takes place such as sleep, eating and anxiety disorders, drugs and substance use/abuse or developmental problems especially poor academic achievements. In Nigeria, DV functions as a means of enforcing conformity with the role of a woman which is seen to be subordinate in a patriarchal society.[4] This means that the society regards wife beating as a consequence of a man's right to inflict punishment on his wife.[4]

A WHO study in 2005 revealed that DV is the most common form of violence in women's lives (much more than assault or rape by strangers or acquaintances) and suggested it should be treated as a major public health issue.[1] Records show that between 50% and 75% of women are subjected to DV in Nigeria.[2] Various studies also document that between 10% and 35% of women experience DV at some point in their lives.[5] It is sad to note that, some women do not know if they have been abused or not. This may be because the abuse has been taken to be normal and acceptable. In a survey by Afrolnews, cited by Aihie on the common forms of spousal abuse, 93% reported shouting, 77% reported slapping and 40% reported punching and kicking.[3] Failure of the index cases to report past episodes of violence is not surprising as has been documented by a study in Nigeria which suggest that 97.2% of abused women do not report the crime.[2]

Interventions usually entail treating the physical and emotional injuries, psychosocial support and counselling the client on the need for a safety plan or that violence may escalate. Referral to support services with the patients' consent such as; referral for legal services or interventions, shelter and counselling should be offerred.[6]The presented cases received all these interventions and were also enrolled into abused women society (support group); granted legal custody of their children. The first case however had a safety plan and was already saving for such prior to presentation.

Violence in any form is preventable as reports have suggested quite a strong relationship between the degree of violence and modifiable risk factors like gender inequality, low income, poverty, low academic achievement, marital conflict, poor family function, weak community sanctions against DV and weak traditional gender norms.[4] The following risk factors for DV identified in the above cases were; female gender, high dependency on spouse financially even though the first client had high academic achievement, weak marital relationship, poor family function and belonging to a largely patriarchal society. However, according to Bruckner et al as cited by Flurry M et al, experiences from shelters for battered women and counselling centres show that DV can happen to any woman, regardless of her level of education, nationality, income, religion, age or ethnicity.[5] Both victims and abusers are found amongst all social classes.[5]

In this era of plaguing violent crimes such as terrorism, kidnapping and armed robbery, domestic violence should be discouraged as it creates a violent society wherein the saying; 'charity begins at home' comes to play because a child that grows up in an abusive home will find it enjoyable and entertaining to maim or kill in the society. Frontline Physicians and primary care doctors are positioned to detect, manage and offer assistance to victims of DV as observed in the presented cases. However, existing evidence suggest that healthcare providers hardly enquire of women whether they are being abused or even check for obvious signs.[4] Physicians and healthcare practitioners, especially those that care for women should routinely screen for DV at consultations. The physical consequences such as old scars, fractures could be obvious but its psychosocial consequences like depression, anxiety and family disintegration could be missed with grave consequences. The Physician should advocate for legal reforms criminalizing DV and educate his community on the need to amend traditional gender norms. There should be promotion of gender equality by advocating female empowerment through education and economic empowerment. Health facilities should have protocols for active screening for DV in order to identify clients that need interventions. There should be concerted and collaborative effort by the Government and traditional institutions to promulgate laws that will protect women's rights, education of the girl child and women empowerment. Women rights groups should bring to the fore and sensitize the public about the negative impact of domestic violence.

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