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Mental Health Related Consequences of Domestic Violence in Dubai, UAE

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Abstract

Background: violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. The term gender based violence has been defined as ‘‘acts or threats of acts intended to hurt or make women suffer physically, sexually or psychologically, and which affect women because they are women or affect women disproportionally. *Objectives:* To study mental health related consequences of domestic violence among Dubai women population and the extent to which intimate partner violence is associated with a range of health outcomes. *Methodology:* A cross sectional study on 700 Emirati women selected randomly from Primary health care centers by systematic random sampling using Epi-info epidemiological software. All ever-married women aged 15-49 years and seeking medical care in PHC at Dubai. A structured standardized interview questionnaire was utilized as data collection tool. *Results:* 19% of women not exposed to violence reported current symptoms of emotional distress compared to approximately 72%, 68.9%, and 70% in those exposed to sever physical, combination of physical and sexual, and combination of three types of violence respectively. Similarly percentage of women who are not exposed to violence and reported suicidal thoughts in their lifetime 7.2% are low compare to those exposed to sever physical violence 44.1%, physical and sexual violence 31.9%, and those exposed to the all three types of violence 32.3%. Moreover percentage of women reported exposure to sever physical violence and had suicidal attempts were high (27%) compare to women not exposed to violence and had suicidal attempts (2.9%). Another high percentage of women with suicidal attempts seen in those exposed to combination of physical and sexual violence (23%) and those exposed to the three types of violence 22.3%. *Conclusion:* A high percentage of women exposed to different types of violence had mental health effects. There are Significant associations between lifetime experiences of physical or sexual violence, or psychological, or a combination of any types by a male intimate partner, and a wide range of self-reported mental health problems in women. The vast majority of violence occurs in lifetime, thus the health effect of violence might last long after the actual violence has ended and become chronic.

Keywords

Mental Health Consequences, Domestic Violence, Dubai

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1. Introduction

The manifestations and forms of violence vary in different settings. “Domestic violence” has been used to describe acts of violence between family members, including adult partners, a parent against a child, caretakers or partners against elders and between siblings. [1] Family/partner violence describes violence between family members (often taking place in the home), while community violence

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describes violence between people who are unrelated and who may or may not know each other, and it generally takes place outside the home. Family/partner violence is usually the focus of researches concerned with violence among women as it is the kind of violence that usually strikes women most and especially at reproductive age, while community violence is more common among men. [2] defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." [3, 4] The term gender based violence has been defined as ‘‘acts or threats of acts intended to hurt or make women suffer physically, sexually or psychologically, and which affect women because they are women or affect women disproportionally’’. This inequality can be described as discrimination in pportunities and responsibilities and in access to and control of resources that is rooted in the socio-culturally ascribed notion of masculinity as superior to femininity. [2] Domestic violence can cause significant short- and long-term health consequences for victims, including a broad array of adverse aphy. [5-9] Mental health outcomes includes Depression, Fear, Anxiety, Low self-esteem, Sexual dysfunction, Eating problems, Obsessive-compulsive disorder, Post traumatic stress disorder, Suicide. [9-12] World Health Organization (WHO) released a report documenting levels of intimate partner violence Domestic Violence as a major contributor to the ill-health of women exploring outcomes of violence in terms of mental, sexual, and reproductive health in ten countries.[1, 13,14]

Evidence also shows that while women who experience domestic Violence rarely seek help from the police or support agencies, they will seek health care services at some point in their lives whether it is for routine health maintenance, pregnancy, childbirth, illness, injury or by bringing her child for health care services. This is especially the case in developing countries. In fact, women’s utilization of reproductive health services has been increasing globally, particularly in developing countries. For example, in 2008, 80% of pregnant women in the developing world received at least one antenatal visit by a skilled healthcare provider, up from 64% in 1990 [8]. Virtually every emirates woman interacts with the health care system at some point in her life. Although domestic violence directly or indirectly brings thousands of women to the health care system every year, health care providers often treat these women without inquiring about abuse, therefore never recognizing or addressing the underlying cause of their health problems. Taken together, this evidence on the widespread prevalence of (Intimate partner violence) IPV, resulting adverse health outcomes and costs, and increasing health care utilization among women, not only underscores the need for health care programs and systems to respond to IPV but also suggests that they represent an important opportunity to engage in IPV prevention and management. There is a need to understand better the magnitude and nature of the different forms of violence against women in UAE specially Dubai, some of the risk factors and its health consequence in Dubai by mean of standardized questionnaires on women attending health care system. In order to plan for actions that may serve to prevent it and respond to its consequences.

2. Objectives

To study mental health related consequences of domestic violence among Dubai women population and the extent to which intimate partner violence is associated with a range of health outcomes

3. Methodology

A cross sectional study on 700 Emirati women selected randomly from Primary health care centers by systematic random sampling using Epi-info epidemiological software. All ever-married women aged 15-49 years (as in WHO multi-country study) [6], and seeking medical care in PHC at Dubai. Exclusion criteria was set and operational definition of variables adopted. a well-structured standardized interview questionnaire was utilized as data collection tool . Violence was divided into (physical violence, sexual violence and psychological violence: Emotional and controlling abusive behavior): The questionnaire included the following: The data about socio-demographic characteristics (age, original nationality, educational level of partners, financially dependent women, the drugs and alcohol intake of the husband) that might cause or protect women from IPV. Subjective measure "self-reported health, used by The WHO Study" the women were asked about their general health using a five-point scale (excellent, good, fair, poor or very poor). Women were considered to be in poor health, if they reported one of the two lowest categories. The data about exposure to different types of violence using "the Women’s Health and Life Experiences standardized Questionnaire" developed by the WHO for violence research [6] asking direct, clearly worded questions about the respondent’s experience of specific violence acts from current or former partner Ethical issues were addressed

4. Results

Table 1 illustrates stepwise logistic regression to determine

the effect of lifetime exposure to IPV on current physical health symptoms reported by ever-partnered women. The table shows that women exposed to any types of violence were associated with increased risk of reporting symptoms of current ill physical health compare to those who were not exposed. However a dose-response effect was noted in this study with women who reported experiencing a combination of three types of violence by an intimate partner, having stronger risk of current ill health than women who experienced one type of violence; including OR of; Self-reported poor or very poor health 7.41 [95% CI 2.4-23.o4]), Some/many problems, or unable to perform usual activities (5.7 [2.9-11.2]), Many problems walking/unable to walk (7.3 [2.6-20.7]), Moderate/severe/extreme pain or discomfort(3.6 [2.0-6.5]), Some/many or extreme memory or concentration problems (5.2 [3.3-8.2]), Dizziness (2.7 [1.7-4.4]), and Vaginal discharge (3.1 [2.1-4.6]). Furthermore it was noted that another high risk of symptoms of ill physical health were reported by women exposed to physical violence alone with OR of (6.4 [1.9-21.2]), (4.3 [2.1-8.7]), (3.7 [1.2-1104]), (3.3 [1.9-5.9]), (2.0 [1.1-3.6]), (3.1 [2.1-4.5]), (2.3 [1.6-3.2]) respectively to previous ill physical health effects. As well as in women exposed to a combination of physical and sexual violence with OR of (7.1 [2.3-21.9]), (5.4 [2.8-10.5]), (7.0 [2.5-19.7]), (3.5 [1.9-6.2]), (4.9 [3.1-7.6]), (2.4 [1.5-4.0]), (3.0 [2.0-4.3]) respectively to previous ill physical health effects. On the other hand women who were exposed to sexual or psychological violence reported current symptoms of Many problems walking/unable to walk with OR of (14.7 [5.6-38.5]), (12.5 [3.8-41.1]) respectively. In addition to that women exposed to sexual violence alone had OR of (1.6 [1.1-2.4]) of complaining of vaginal discharge and this risk increase when sexual violence is combined with physical OR of (3.0 [2.0-4.3]) or with physical and psychological violence (3.1 [2.1-4.6]).

Table 1. Distribution of ever-partnered women experienced lifetime IPV according to prevalence of current mental health symptoms reported by them, Dubai 2013.

Type of violence	Suicidal thoughts ever		Suicidal attempts ever		SRQ score greater than 7	
	No. (%)	X^2 (P)	No. (%)	X^2 (P)	No. (%)	X^2 (P)
No intimate partner violence	37(7.2)		15(2.9)		101(19.7)	
Mild to moderate physical violence	27(21.1	73.7(0.001)	23(18)	66.9(0.001)	75(58.6)	123.9(0.001)
Sever physical violence	26(44.1)		16(27.1)		43(72.9)	
2- Sexual violence	58(25.4)	47.8(0.001)	37(16.2)	34.3(0.001)	126(55.3)	90.4(0.001)
3- Psychological violence	74(21.4)	45.2(0.001)	44(12.8)	24.5(0.001)	181(52.6)	143.2(0.001)
4- physical IPV& Sexual IPV	43(31.9)	53.9(0.001)	31(23)	54.6(0.001)	93(68.9)	123.9(0.001)
5- physical IPV& Psychological IPV	50(29.6)	55.6(0.001)	37(21.9)	62.9(0.001)	113(66.9)	110.01(0.001)
6- Sexual IPV& Psychological IPV	54(29.2)	59.8(0.001)	3317.8)	36.2(0.001)	120(64.9)	131.1(0.001)
7- physical & Sexual & Psychological IPV	42(32.3)	53.9(0.001)	29(22.3)	47.7(0.001)	91(70)	111.3(0.001)

Table 2 demonstrates a high percentage of women exposed to different types of IPV and had mental health effects. 19% of women not exposed to violence reported current symptoms of emotional distress (SRQ>7) compared to approximately 72%, 68.9%, and 70% in those exposed to sever physical, combination of physical and sexual, and combination of three types of violence respectively. Similarly percentage of women who are not exposed to violence and reported suicidal thoughts in their lifetime 7.2% are low compare to those exposed to sever physical violence 44.1%, physical and sexual violence 31.9%, and those exposed to the all three types of violence 32.3%. Moreover percentage of women reported exposure to sever physical violence and had suicidal attempts were high (27%) compare to women not exposed to violence and had suicidal attempts (2.9%). Another high percentage of women with

Table 2. Distribution of ever-partnered women experienced lifetime IPV according to prevalence of current mental health symptoms reported by them, Dubai 2013.

SRQ score greater than 7		Suicidal attempts ever		Suicidal thoughts ever		Type of violence
X^2 (P)	No. (%)	X^2 (P)	No.(%)	X^2 (P)	No. (%)	
	101(19.7)		15(2.9)		37(7.2)	No intimate partner violence
123.9(0.001)	75(58.6)	66.9(0.001)	23(18)	73.7(0.001)	27(21.1	Mild to moderate physical violence
	43(72.9)		16(27.1)		26(44.1)	Sever physical violence
90.4(0.001)	126(55.3)	34.3(0.001)	37(16.2)	47.8(0.001)	58(25.4)	2- Sexual violence
143.2(0.001)	181(52.6)	24.5(0.001)	44(12.8)	45.2(0.001)	74(21.4)	3- Psychological violence
123.9(0.001)	93(68.9)	54.6(0.001)	31(23)	53.9(0.001)	43(31.9)	4- physical IPV& Sexual IPV
110.01(0.001)	113(66.9)	62.9(0.001)	37(21.9)	55.6(0.001)	50(29.6)	5- physical IPV& Psychological IPV
131.1(0.001)	120(64.9)	36.2(0.001)	3317.8)	59.8(0.001)	54(29.2)	6- Sexual IPV& Psychological IPV
111.3(0.001)	91(70)	47.7(0.001)	29(22.3)	53.9(0.001)	42(32.3)	7- physical & Sexual & Psychological IPV

Table 3 illustrates stepwise logistic regression to determine the most disturbance type of lifetime IPV on women mental health. Women who had experienced psychological violence alone were over 9 times more likely to report current symptoms of emotional distress (SRQ>7), and 5 times more likely to report suicidal thoughts in comparison to women who had experienced a combination of physical and psychological violence were more likely to report symptoms of emotional distress, and suicidal attempts by approximately 8 times. However women who experience any type of violence or in a combination were over 5 times more likely to report suicidal thoughts.

Table 3. Stepwise logistic regression to determine the effect of lifetime exposure to IPV on mental health symptoms reported by ever-partnered women, Dubai 2013.

SRQ score greater than 7			Suicidal attempts ever			Suicidal thoughts ever			Type of violence
95% CI	OR	P	95% CI	OR	P	95% CI	OR	P	
(4.8,10.1)	6.434	0.001	(4.7,16.3)	8.75	0.001	(3.2,8.1)	5.088	0.001	1-physical violence
(3.6,7.1)	5.034	0.001	(2.8,9.4)	5.185	0.001	(2.9,7.5)	4.691	0.001	2- Sexual violence
(6.2,13.8)	9.293	0.001	(2.5,10.3)	5.075	0.001	(3.3,10.2)	5.824	0.001	3- Psychological violence
(5.1,11.7)	7.715	0.001	(3.9,12.5)	7.024	0.001	(3.2,8.2)	5.151	0.001	4- physical IPV& Sexual IPV
(5.5,11.9)	8.090	0.001	(4.6,15.5)	8.475	0.001	(3.3,8.2)	5.158	0.001	5- physical IPV& Psychological IPV
(5.3,11.3)	7.758	0.001	(2.9,9.1)	5.107	0.001	(3.5,8.7)	5.485	0.001	6- Sexual IPV& Psychological IPV
(5.3,12.3)	8.057	0.001	(3.5,11.1)	6.259	0.001	(3.2,8.3)	5.190	0.001	7- physical & Sexual & Psychological IPV

5. Discussion

Psychological violence most frequently reported by approximately half of the respondents the corresponding figures were 41% and 7.5% respectively. A total of 277 women (39.6%) reported experiencing at least one form of control, giving the same results when restricted to WHO questionnaire items. The most frequency reported form of control was the husband insists on knowing where the respondent are at all times. For emotional violence 40.9% of the respondents reported experiencing at least one form. When restricted to only the items included in WHO questionnaire this dropped to 36%, the most prevalent experiences of psychological violence included being blamed for things that happened to her husband or to the household followed by being insulted or made her feel bad about herself which was WHO questionnaire. The results of our study were consistent with the range found in most sites by WHO study. Across all countries, the proportion of women reporting one or more of controlling behaviors by their partner varied from 20% and 75%. And for emotional abuse from a low of 21% in Japan to almost 90% in urban United Republic of Tanzania. [6] This suggests a great variation in the degree to which such behavior is acceptable (normative) in different cultures.

Moreover in our study it was found women those who were exposed to either sexual or psychological violence alone, had un-expectedly more than 14 times and more than 12 times risk of reporting symptoms of many problems walking /un-able to walk respectively compare to non violated women. This is very high risk even when compared to women exposed to other types of violence. In addition to that women exposed to psychological violence had more than five times risk of reporting pain or discomfort. One explanation is that both of these violence's (sexual and psychological) affect women psychological status. Thus it can be manifested as psychosomatic symptoms of problem to walk or pain and discomfort, Rather than real physical problem. the results of this study show that current abuse was strongly associated with poor mental health and, more interestingly, that women who experienced abuse in the past were also more likely to present current psychological distress than never-abused women. Studies from the different countries support our findings, in that women who experienced IPV were more likely to attempt suicide than those with no history of IPV. [15-17] From our study it can be concluded that psychological violence had the biggest effect on women mental health. As it makes women over 9 times more likely to had current emotional distress symptoms and 5 times more likely to have suicidal thoughts. Moreover psychological violence had higher impact on women mental health when it is combined with physical violence. As women who are exposed to these two types of violence are 8 times more likely to have current symptoms of emotional distress and suicidal attempts in their lifetime, 5 times more likely to had suicidal thoughts, furthermore exposure to three types of violence give same results. Similar to our results, linking self-reported mental-health problems and suicidality with partner violence are consistent with findings from many studies in developing and developed countries. [11, 17-20]

This finding suggests that the effects of IPV on mental health may not only be immediate and acute but could be long term or even became chronic. This has also been demonstrated by many studies. [17, 21] However this study does not seems to support the hypothesis of an accumulative effect of the diverse kinds of IPV on women's mental health unlike other

studies [17, 22] which indicates that women experiencing the 3 types of abuse were the most likely to present negative mental health indicators. A dose-response effect was noted in this study with women who reported experiencing more types of violence by an intimate partner, having stronger risk of current ill physical health than women who experienced one type of violence. Which is in consistent with other studies. [23] Where other studies have shown that the severity and duration of violence is more predictive of health problems than when it occurred. [17]

In this study the association between women's experience of IPV and increased use of medications may be understandable, given that women who experienced intimate partner violence were also more likely to experience pain, depression, and sleep problems. Thus, there may be circumstances in which medications assist in the appropriate clinical management of symptoms associated with these problems. These results concur with results reported by other studies. [24-26] Women may also self-manage their health problems using over-the-counter (OTC) medications. However, there are documented instances where medications such as mild tranquilisers or pain medications are prescribed for victims of IPV, yet have the potential to make her more vulnerable to further assault. [27] Reviewed studies that dealt specially with pain medication. Yoshihama et al. [28] found no association between IPV and the use of pain medication, but this study also reported no significant increase in the level of pain reported by the abused women in their Japanese population-based sample that was part of the WHO multi-country study. Wuest et al. [29] in an allied study on medication use reported that even though this sample of abused women reported high levels of back pain, headaches, and swollen painful joints, they were less likely to be taking over-the-counter non-steroidal anti-inflammatory drugs (NSAIDs) and analgesics.

6. Conclusion

There are Significant associations between lifetime experiences of physical or sexual violence, or psychological, or a combination of any types by a male intimate partner, and a wide range of self-reported mental health problems in women. The vast majority of violence occurs in lifetime, thus the health effect of violence might last long after the actual violence has ended and become chronic.

References

[1] Heise, L.; Pitanguy, J.; Germaine, A. Violence against women: The hidden health burden. Washington, D.C: The World Bank; Discussion paper 1994; 225: 46.

[2] Krantz G, Garcia-Moreno C. Violence against women. GLOSSARY J Epidemiol Community Health 2005; 59: 818–821.

[3] Frieze, I.H., Browne, A. (1989) Violence in Marriage. In L.E. Ohlin & M. H. Tonry (eds.) Family Violence. Chicago, IL: University of Chicago Press.

[4] The United Nations Declaration on the Elimination of Violence against Women, General Assembly Resolution, December 1993.

[5] Groves B, Augustyn M, Lee D, Sawires P, Identifying and responding to domestic violence consensus recommendations for child and adolescent health. Family Violence Prevention Fund, US department of health and human services, administration for children and families and the Conrad N. Hilton foundation, December 7, 2001.

[6] Garcia-Moreno C, Jansen H, Ellsberg M, Heise L, and Watts C. WHO multi-country Study on women's health and domestic violence against women: Initial results on prevalence, health outcomes and women's responses. World Health Organization, Geneva, Switzerland. 2005.

[7] Garcia-Moreno, C., Jansen H.A, Ellsberg M, Heise L, Watts C.H. Prevalence of intimate partner violence: Findings from the WHO multi-country study on women's health and domestic violence. The Lancet.2006; 368(9543): 1260-9.

[8] Chibber KS, Krishnan S. Mt Sinai J Med. 2011 May-Jun;78(3):449-57. Review.

[9] Dillon G, Hussain R, Loxton D, Rahman S. Mental and Physical Health and Intimate Partner Violenceagainst Women: A Review of the Literature. Int J Family Med. 2013; 2013: 313909. Epub 2013 Jan 23.

[10] Kirby AC, Beckham JC, Calhoun PS, Roberts ST, Taft CT, Elbogen EB, Dennis MF. An examination of general aggression and intimate partnerviolence in women with posttraumatic stress disorder. Violence Vict. 2012; 27(5): 777-92.

[11] JC, Falder G, Petzold M, Astbury J, Watts CH. Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies. Devries KM, Mak JY, Bacchus LJ, Child PLoS Med. 2013; 10(5): e1001439. Epub 2013 May 7.

[12] Devries K, Watts C, Yoshihama M, Kiss L, Schraiber LB, Deyessa N, Heise L, Durand J, Mbwambo J, Jansen H. Violence against women is strongly associated with suicide attempts: evidence from the WHO multi-country study on women's health and domestic violence against women. et al. Soc Sci Med. 2011 Jul; 73(1): 79-86. Epub 2011 May 27.

[13] World Health Organization, London School of Hygiene and Tropical Medicine: Preventing Intimate Partner and Sexual Violence Against Women: Taking Action and Generating Evidence. World Health Organization: Geneva; 2010.

[14] United Nations Children's Fund (UNICEF). Domestic violence against women and girls, Innocenti Digest. no. 6, June 2000.

[15] Bonomi AE, Anderson ML, Rivara FP, Thompson RS. Health outcomes in women with physical and/or sexual intimate partner violence exposure. J Women's Health 2007; 16: 987–97.

[16] A Pico-Alfonso MA, Garcia-Linares MI, Celda-Navarro N, Blasco-Ros C, et al. The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. J Women's Health 2006; 15: 599–611.

[17] Dillon, G., Hussain, R., Loxton, D., Rahman, S. Mental and Physical Health and Intimate Partner Violence against Women: A Review of the Literature. Int J Family Med. 2013; 2013: 313909. Published online 2013 January 23.

[18] Hien D, Ruglass L. Interpersonal partner violence and women in the United States: an overview of prevalence rates, psychiatric correlates and consequences and barriers to help seeking. Int J Law Psychiatry. 2009 Jan-Feb; 32(1):48-55. Epub 2008 Dec 19. Review.

[19] World Health Organization (WHO). 'Violence Against Women'. WHO Consultation, Geneva. 1996.

[20] Ludermir, A. B., Schraiber, L. B., D'Oliveira, A. F., França-Junior, I., & Jansen, H. A.Violence against women by their intimate partner and common mental disorders. A.B. Ludermir et al. Social science & medicine, 2008, 66.4: 1008-1018.

[21] Romito P, Molzan TJ, De Marchi M. The impact of current and past interpersonal violence on women's mental health. Soc Sci Med 2005; 60: 1717–27.

[22] Wingood GM, DiClemente RJ, Raj A. Adverse consequences of intimate partner abuse among women in non-urban domestic violence shelters. Am J Prev Med 2000; 19: 270–5.

[23] Fanslow J. L, Robinson E. M. Violence against women in New Zealand: prevalence and health consequences. 2004.

[24] Ali TS, Asad N, Mogren I, Krantz G. Intimate partner violence in urban Pakistan: prevalence, frequency, and risk factors. Int J Womens Health. 2011 Mar 16; 3: 105-15.

[25] Vung, N. D., Ostergren, P. O., Krantz, G. Intimate partner violence against women, health effects and health care seeking in rural Vietnam. The European Journal of Public Health, 2009, 19.2: 178-182.

[26] Fanslow, J. L., Robinson, E. M. Violence against women in New Zealand: prevalence and health consequences. 2004.

[27] Council on Ethical and Judicial Affairs, American Medical Association. Physicians and domestic violence: ethical considerations. JAMA. 1992; 267: 3190–3.

[28] Yoshihama M, Horrocks J, Kamano S, The role of emotional abuse in intimate partner violence and health among women in Yokohama. Japan. American Journal of Public Health, 2009, 99.4: 647-653.

[29] Wuest, J., Merritt-Gray, M., Lent, B., Varcoe, C., Connors, A. J., Ford-Gilboe, M. Patterns of medication use among women survivors of intimate partner violence. Canadian Journal of Public Health. 2007, 98. 6: 460–464.