

INTIMATE PARTNER VIOLENCE AND POST-TRAUMATIC STRESS DISORDER

Intimate partner violence is a common problem, some studies showing a prevalence of 55%.



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Intimate partner violence (IPV) is a term used to describe physical or sexual assault, or both, of a spouse or sexual intimate. Psychological abuse frequently accompanies the assault. It is a common health care problem, with some studies showing prevalence rates of 55%.¹ IPV is increased in settings where there is a culture of violence (i.e. the use of violence is normal) and where the social and economic power and value of women is low. In addition, childhood experiences of violence, alcohol abuse, and poverty are key contributors to IPV.

IPV is associated with numerous physical and mental sequelae, including injury, chronic pain, gastrointestinal and gynaecological problems, sexually transmitted diseases, depression and post-traumatic stress disorder (PTSD). It also affects the capacity of women to act as equal and productive partners in their society and economy. In this article we will focus on the association between IPV and PTSD and discuss implications for diagnosis and management at a primary care level.

WHAT IS PTSD?

PTSD is an anxiety disorder resulting from exposure to traumatic events. *DSM IV TR*² specifies that the traumatic event must involve actual or threatened death or serious injury or threat to the physical integrity of self or others *and* that the person's response involved intense fear, horror or helplessness. The duration of symptoms must be more than 1 month and must cause either significant distress or impairment in social, occupational or other important areas of functioning.

There are many symptoms associated with PTSD but they can be usefully grouped into 3 clusters:

- persistent intrusive symptoms
- avoidance or emotional numbing
- increased arousal (Table I).

PTSD IN IPV

IPV is a high-risk event for the development of PTSD and indeed high prevalences of PTSD have been found in this population. Studies have shown lifetime prevalence rates of 50%, with point prevalence rates of up to 31%.³ The odds ratio may be as high as 3.74 for developing PTSD compared with a non-abused sample.⁴

PTSD impacts significantly on functioning. Studies have shown that women victims of IPV have impaired quality of life compared with a non-abused sample but that those women who also met criteria for PTSD were more impaired than those who did not. In addition, PTSD severity was a significant predictor of poorer scores on a scale of mental health functioning.⁵

Co-morbid mental health problems are also more common in women with PTSD, particularly depression and substance abuse. One study found that 42.9% of

those with PTSD had major depressive disorder and severity of mood symptoms correlated with severity of PTSD. Substance use has also been found to be both a risk factor and an effect of PTSD.³ A possible explanation is that women who abuse substances are more at risk for violence and conversely those who are victims of violence use substances to cope, either by self-medicating an underlying disorder or as a means of escape. It is important to be aware that complex relationships exist between IPV, PTSD and substance use as this can have a bearing on treatment.

DIAGNOSTIC APPROACH^{4,6,7}

Screening for IPV

Most cases of IPV will be missed if not actively screened for. It is therefore recommended that all women and adolescent girls be screened in primary care. By screening it is possible to intervene earlier and prompt changes in behaviour that may lead to less morbidity and mortality — remember many victims of IPV are ultimately killed by their partners.

How to screen

- Understand and explain the limits of confidentiality — in minors IPV constitutes child abuse and there is a legal requirement to report.
- Conduct private, confidential face-to-face interviews.
- Ask direct questions — very often victims will not respond to indirect questions.
- Examples of direct questions:
 - Has your partner ever hit you or threatened you in any way?
 - Has your partner ever forced you to have sex?
 - Are you afraid of your partner?
- Sometimes it is useful to frame questions with phrases like:
 - I ask all my patients about violence in their relationships
 - I want to make sure each of my patients is safe in their relationships.
 - Try not to use terms like 'rape' or 'abuse' as many patients will not see themselves in this way.

Table I. **Symptoms of PTSD²**

- Intrusive symptoms
 - Distressing recollection
 - Dreams or nightmares of event
 - Sense of reliving the event
 - Intense distress on exposure to cues related to the event
- Avoidance or numbing
 - Avoidance of thoughts, feelings or conversations associated with the event
 - Avoidance of activities, places or people associated with the event
 - Decreased interest in activities
 - Unable to feel
 - Sense of a foreshortened future
- Hyperarousal
 - Difficulty falling or staying asleep
 - Irritability or outbursts of anger
 - Hypervigilance
 - Increased startle response

Difficulties with screening

General practitioners commonly report the following as barriers to screening:

- patients who won't admit abuse
- a lack of time
- unwillingness to become embroiled in a complex problem.

Patients who deny being abused even in circumstances where it is reasonably obvious that they are (the 'I walked into a door' patient) can be frustrating and often one feels like not helping them further. However, it is important to note that most patients if asked directly about abuse will respond and even those who don't are made aware that an avenue of help does exist, and this increases the likelihood of help-seeking in the future.

Time pressures are a very real problem in any practice. While the initial screening may take time, in the long term identifying and appropriately managing IPV saves time as consultations and inappropriate investigations for difficult-to-understand and vague complaints are reduced.

Lastly, while it is incumbent on primary care practitioners to screen for abuse, management is multidisciplinary and patients with IPV should be referred to the appropriate agency (Table II).

Post screening

The fundamentals of post-screening intervention include:

- keep good notes!
- provide support
- educate patients about IPV
- assist in safety planning
- refer appropriately
- screen for co-morbid psychiatric conditions.

Table II. **Useful contact numbers**

Mental Health Information Centre

(021) 938-9121 or toll-free
0800600411
mhic@sun.ac.za

Life Line

(021) 361-5855
0861-322-322

FAMSA

(021) 447-7951
(011) 833-2057/8
(031) 202-8987
(051) 525-2395

Depression and Anxiety Support Group

(011) 783-1474
info@anxiety.org.za

Nicro

(021) 462-0017
nicro@wn.apc.org

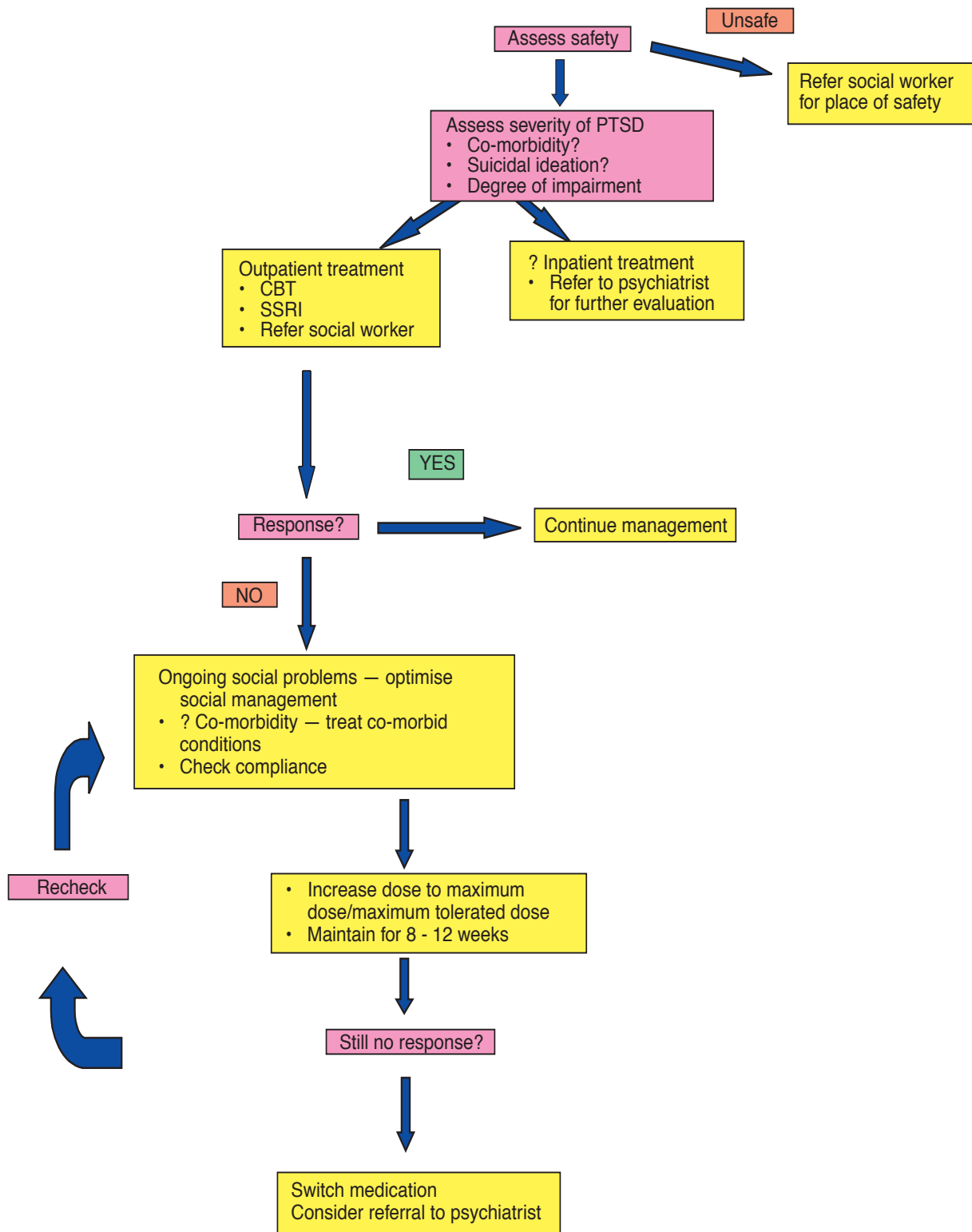


Fig. 1. A schematic approach to treatment.

Screening for psychiatric co-morbidity

Again, as with IPV, if these conditions are not actively looked for they will be missed.

Ask about PTSD symptoms:

- Does the patient ever experience nightmares, intrusive thoughts or feel as if she is reliving the event?
- Does the patient ever avoid places or situations that remind her of the event?
- Does she ever feel numbed or that she can't feel?
- Does she ever feel she has no future?
- Does she often feel keyed up, on edge or need to always be alert?

Also ask about mood symptoms and co-morbid substance use. Remember, substances need not be illicit, so ask about use of painkillers, over-the-counter medications, tranquillisers etc.

Management of PTSD

The management of PTSD in the context of IPV requires evaluation and intervention at biological, psychological and social levels. It is particularly important to assess the degree of risk in the patient's home environment, not only to physical health but also its impact on mental health. The patient may need to be removed from an abusive environment. Decisions of this nature should be made in consultation with the patient and will require input from a multidisciplinary team, in particular social work input. Community psychiatric nurses are a valuable support system both to the practitioner and the patient and can often facilitate a multidisciplinary approach.

In terms of specific therapies, psychotherapy is also a valuable treatment

modality. Cognitive behaviour therapy (CBT) has the most empirical evidence for efficacy. Group treatments, particularly homogeneous groups for victims of IPV, are also effective. These groups provide support, improve self-esteem and decrease the sense of isolation that many victims of IPV experience.

Selective serotonin re-uptake inhibitors (SSRIs) are a first-line medication treatment, both in terms of efficacy and safety. Anxiety symptoms often require higher doses than depression and may take longer to respond, so a trial of 8 - 12 weeks is often required. If there is no response, consider compliance and the impact of ongoing social stress and possible co-morbid depression and substance abuse. If all the above factors are addressed and response remains a problem after an adequate trial of medication (12 weeks at maximal dose) then consider switching medication, either to another SSRI or to a different class of medication. If this still fails, psychiatric referral is suggested.

Benzodiazepines and other sedative hypnotics have no place in the long-term management of PTSD. They may be used for short-term relief of insomnia, but given the risk of co-morbid substance abuse they are best avoided. Similarly, β -blockers have no efficacy in PTSD.

It is important to note that with all modalities of treatment, warmth,

empathy and consistent support are vital.

Fig. 1 presents a schematic approach to treatment.⁸

References available on request.

IN A NUTSHELL

Intimate partner violence is common, affecting up to 55% of women at some time in their lives.

It is a high-risk factor for the development of PTSD.

PTSD in the setting of IPV is associated with higher rates of depression and substance abuse and worse functioning and quality of life.

It is important to screen all women (including adolescent girls) for IPV.

When screening ask direct questions.

If a woman is a victim of IPV assess for PTSD.

Management is multidisciplinary and includes social interventions and psychotherapy.

SSRIs are the first-line medication agents of choice.

Look at confounding issues, e.g. ongoing violence, co-morbid substance use and non-compliance when assessing poor response to medication.

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