

THE EXPERIENCE OF POST-TRAUMATIC STRESS DISORDER AND DOMESTIC VIOLENCE

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Abstract

This review paper is designed to study the current literature on post-traumatic stress disorder (PTSD) and domestic violence. People suffering from PTSD and victims of domestic violence are at risk for many physical and mental health deficits. While there have been many factors identified that may cause the occurrence of PTSD and domestic violence, there is still a dearth in preventing these conditions more effectively. There is a need for aid provided to sufferers at the level of investigation, diagnosis, intervention and legal assistance, and a greater need for respondents to be sensitized to, recognize and deal with observable markers. Brain Electrical Oscillations Signature (BEOS) system, a neuro signature system, can be helpful in studying the neuronal activation following the experience of trauma or domestic violence to understand the experience of both better, and give a better idea about the parts of the brain that are more affected by it. This could also facilitate the treatment provided to people suffering from PTSD and victims of domestic violence.

Keywords: Domestic Violence, Neuro Signature System, PTSD, Painful Experiences

POST-TRAUMATIC STRESS DISORDER

Post-traumatic stress disorder (PTSD), despite being observable, wasn't a diagnosis till 1980, possibly due to the lack of specific biological criterion for defining it (Yehuda & McFarlane, 1997). According to Ozer, Best, Lipsey and Weiss (2003), before this time, it appeared as "fear associated with military combat and manifested by trembling, running and hiding" in DSM-II (American Psychiatric Association, 1968) and as "combat fatigue" in ICD-VIII (World Health Organization, 1967). It was only after the widespread eruption of psychiatric symptoms in veterans of the Second World War, the Korean War and the Vietnam War did these symptoms cause development in the emergence of PTSD as a formal diagnosis. Around the same time, mental health professionals came up with the term "rape trauma syndrome", a term coined for women who had been sexually assaulted and showed similar symptoms.

Clinical observations about PTSD show that it has emotional, psychological and biological effects on an individual. An event's capacity to provoke fear and helplessness is its defining feature in being perceived as traumatic (Yehuda, 2002). Those exposed to such an event, as compared to those who have not been exposed to such events, are at risk for many conditions including depression, panic disorder, generalized anxiety disorder, substance abuse as well as PTSD. The trauma may very well physically manifest itself. Traumatized people, among other symptoms, get disruptive thoughts and images, nightmares, flashbacks, are hypersensitive and are easily startled.

Psychological angst upon experiencing a traumatic event, directly or indirectly, is irregular (American Psychiatric Association, 2013). The fundamental criteria for PTSD as mentioned in DSM-V contain (a) exposure to trauma, (b) presence of disruptive and intervening symptoms through the reexperience of trauma, (c) avoidance of stimuli, (d) negative changes in cognitive and affective processes, and (e) changes in arousal and reactivity. A crucial feature of the disorder is that the impairing symptoms are associated with the traumatic event (Ozer et al., 2003). A traumatized individual, in the first month following a traumatic experience, may meet the diagnostic criteria for acute stress disorder, which may or may not be followed by PTSD. However, the individual may be at an increased risk of PTSD.

The populations intended for studies of PTSD are miscellaneous (Brewin, Andrews & Valentine, 2000). While samples have been taken from the general population, people suffering from chronic illnesses, and victims of

assault, rape, accidents and natural disasters, the population that has been studied the most extensively is male combat veterans. Similar to demographic factors, there is also variability in the risk factors that have been investigated in different studies, and the methods of investigation. Brewin et al. (2000), followed by Bisson (2007), based on their examination of several studies, have given a comprehensive list of predictive factors that can ascertain prediction of the development of PTSD following a traumatic event. Pre-traumatic risk factors are previous psychiatric history, gender, personality, lower socioeconomic status, lack of education, race, previous trauma and family psychiatric history. Peri-traumatic risk factors are trauma severity, perceived life threat, peri-traumatic emotions and peri-traumatic dissociation. Post-traumatic risk factors are perceived lack of social support and subsequent life stress. These factors do not have a strong correlation with the actual development of PTSD, but the correlation is definitely positive. Ozer et al. (2008) have further narrowed these predictors down to seven, which are prior trauma, prior psychological adjustment, family history of psychopathology, perceived life threat during the trauma, posttrauma social support, peritraumatic emotional responses, and peritraumatic dissociation. Of these, family history, prior trauma and prior adjustment show the smallest effect size, and peritraumatic dissociation shows the largest effect size. Additionally, they focused solely on two types of predictors: (a) principal characteristics of a person, for understanding psychological processing and functioning, and (b) the traumatic event itself.

DOMESTIC VIOLENCE

The term domestic violence is primarily used to refer to intimate partner violence, but the term is not limited to partner violence (World Health Organization, 2012). It can refer to abuse on and by any member of the family. Domestic violence is terrorizing patterns of behaviour between any two people who are or have been intimate partners or family members, notwithstanding their sex or age (Sohal, Feder & Johnson, 2012). Sadly, while all these behaviour patterns can have an adverse effect on physical or mental health, not all are illegal, although there is a country-to-country difference. From the legal point-of-view, for the most part, incidences of physical or sexual assault have been focused on. It, however, cannot be ignored that emotional abuse is also detrimental to health. These perpetrators often desire and revel in control over their partner or family member. Domestic violence also includes practices such as genital mutilation, forced marriages and honour-based violence.

Patterns of behaviour exhibited in domestic violence may be physical, sexual, emotional or financial (Staffordshire Women's Aid, 2008). Physical violence may include hitting, pushing, kicking, choking, biting, pulling hair, cutting, scratching, burning, withholding medication, and even attempted murder or murder. Sexual violence includes force to engage in sexual intercourse, use of objects during intercourse against the partner's will, forcing the partner to watch or engage in pornography or engage in sexual acts in front of other people, or forcing the partner to engage in an unwanted sexual act. Emotional abuse is a wide umbrella, including but not limited to humiliation, degradation, threats, isolation from friends and family, etc. Financial violence may include denying the partner of money for basic necessities such as food, clothes, rent, or stealing money from them. It is important to note that intimate partner violence is the predominant type of domestic violence in all communities, which is why would be most likely to be existent generally (Sohal et al., 2012). Although intimate partner violence can be a result of women being violent with their male partners, and violence is seen in same-sex partnerships too, the majority of the burden of intimate partner violence is borne by women as they are victims of intimate partner violence by existing or ex partners.

Evidence suggests that female victims of domestic violence do make efforts to ensure their safety and the safety of their children. They are often not passive victims, but make judgements about how to protect themselves and their children (Heise, Ellsberg & Gottemoeller, 1999). There are also different reasons why women choose to stay in violent relationships. These reasons may be concern for their children's physical, emotional and financial well-being, their own financial instability, fear of retribution or losing their children, fear of rejection from friends, family and society, and love and hope that their partner is changing or will change. Alternatively, the factors that do urge women to leave their abusive partners are violence escalation, the realization that their partner will not change and that the violence is impacting the children.

The ecological mode, consisting of four factors, is the most widely used model for understanding violence (Heise & Garcia-Moreno, 2002). These factors are individual factors, relationship factors, community factors and societal factors. Understanding these factors would entail comprehension of why violence occurs in the domestic setting. Some of these factors may be associated with the perpetrator, some may be associated with the victim, and some, with both. Individual factors that are consistent with increased likelihood of violence are young age, low level of education, first-hand or second-hand experience of trauma in childhood, sexual abuse, substance abuse, psychiatric disorders, past history of violence and abuse. Relationship factors that are consistent with increased likelihood of violence include conflict and discontentment in the relationship, one-partner dominance, financial pressure, multiple affairs of one partner and disparity of educational level of both partners. The community and societal factors that are associated with likelihood of violence are unequal

gender norms, low socioeconomic status, lack of civil rights (especially women's rights), general view of domestic violence in the society, social acceptance of violence as valid in a marriage, and increased levels of violence in the society.

Intimate partner violence and domestic violence can leave the victim at risk for many conditions, some of which may be severe (Heise & Garcia-Moreno, 2002). Research also suggests that the impact of abuse can linger long after the violence has stopped. The impact on the victim can be in the form of injury, damage to physical and mental health, suicide, sexual and reproductive health, murder and ill effect on children. Female victims may also have to endure violence during pregnancy which may result in miscarriage, stillbirths, premature labour and birth, fetal injury, etc. It is believed that intimate partner violence may also account for increased maternal mortality rate, although this association is not highly recognized.

ADDRESSING THE ISSUES

Studies of coping strategies in trauma literature have primarily focused on two strategies (Littleton, Horsley, John & Nelson, 2007). These coping strategies are either problem-focused or emotion-focused. Emotion-focused strategies can further be broken down into approach-focused or avoidance-focused. Problem-focused strategies directly deal with the distress-causing problem, while emotion-focused strategies focus on managing the emotions that arise from having a problem at hand. A Person x Situation model has been developed that describes an interaction between five variables: (a) personality, (b) affect regulation, (c) coping, (d) ego defences, and (e) the utilization and mobilization of protective factors and resources to aid coping (Agaibi & Wilson, 2005).

Treatments available for PTSD range from psychological to pharmacological interventions (Cusack et al., 2016). Trauma-focused psychological interventions such as cognitive therapy and exposure therapy directly address thoughts, feelings and memories of the trauma, whereas non-trauma-focused psychological interventions such as relaxation and stress inoculation training help the individual deal with the symptoms being experienced. Trauma-focused psychological intervention are preferred to pharmacological intervention by clinicians, the latter being viewed as an adjunct rather than the primary treatment method. However, this preference is not univocal, and there is still scope to determine the most efficient treatment method. Moreover, evidence of the efficacy of treatments is insufficient to determine which treatment method is more effective for which group of people.

In recent years, many studies have worked on strategies that might help prevent domestic violence (Bott, Morrison & Ellsberg, 2005). These approaches include civil reforms and criminal legal frameworks, advocacy campaigns to raise awareness about the current scenario and existing legislation, involving non-profit organizations, changing behaviour patterns and outlook to bring about social change, incorporating attention to violence in sexual and reproductive health services, promoting social and economic empowerment of women and girls, building response services for domestic violence victims in all communities, school-based programmes to raise awareness and sensitize members of the society at a young age, and providing early intervention services to at-risk families. Victims of domestic violence who seek healthcare often find themselves not having their needs catered to, or even recognized (Heise et al., 1999).

Neuro signature system, a technique developed only in the past two decades, can prove to be helpful in the study of experience of individual trauma. Mukundan (2009) developed a system called Brain Electrical Oscillation Signature (BEOS) system as a neuro signature system that identifies autobiographical memory based on neuronal activation through experiential knowledge based responses (EK) recorded. BEOS is increasingly being used in forensic investigation, but its usage in clinical diagnosis and neuropsychological investigation can be further explored. This neuro signature system can be made use of to determine areas of the brain that are greatly affected by the experience of PTSD and domestic violence and therefore, may require more focus.

CONCLUDING THOUGHTS

Help providers are often unaware, apathetic or judgemental towards victims, which might add to the trauma of the sufferers when they are looking for support and empathy. Such victims can be referred legal aid and counselling intervention following diagnosis and investigation. In comprehensive treatment of sufferers of PTSD and victims of domestic violence, neuro signature system can be used to understand the experience of PTSD or domestic violence and help, in accordance to their individual experience, can be provided to them. Those working in the emergency services setting can be acquainted with the investigation, diagnosis, intervention and legal aspects of dealing with trauma and domestic violence. They can be sensitized to deal with the sufferers and victims, and core human skills can be honed to diffuse the emotions of those involved,

allowing them to cope more readily with their situation. Moreover, inclusion of non-profit organizations can be increased, and provisions can be made to formally have them be a part of the process in sensitive matters. Such organizations can help an individual deal with the situation counselling intervention as well as legal or financial aid. There is a greater need to exactly understand the experience of individualized trauma in cases of PTSD and domestic violence, and deal with the problem more effectively.

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