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Dowry-related domestic violence and complex -post-traumatic stress disorder: a case report

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Abstract

Objectives: This paper draws attention to the mental health impact of coercive practice of dowry demands, associated with domestic violence (DV) in an immigrant woman.

Methods: This study was based on a case report and selective literature review.

Results: This case history illustrates the serious mental health impacts of repeated emotional and physical trauma inflicted by a husband who was dissatisfied with his wife's dowry. Bio-psycho-social / cultural aspects of mental health treatments needed to be augmented with attention to safety, advocacy, and access to support networks.

Conclusions: Cultural factors are important determinants of mental illness. Psychiatrists need to be aware of DV and dowry when treating immigrant women.

Keywords: domestic violence, immigrant woman, dowry, mental illness

Globally 1 in 3 women suffer domestic violence.[1] Australia is no exception.[2] Domestic violence (DV) is increasingly being recognized for its serious mental health consequences[1, 3] and is found to be responsible for 8% of burden of health, predominantly mental health, for women aged 15–44 years, greater than smoking or hypertension.[4] DV is a complex issue. The ecological model of Heiss et al.[5] illustrates the interactions between societal, cultural, family and individual factors that can give men the position of power, dominance and control over women and children. The social model of women's mental health posits that women's social positions make them more prone and vulnerable to poor mental health outcomes.[6] South Asian cultures predominantly practice patriarchy, a practice that disadvantages women at multiple levels: societal, familial and individual.[7] Dowry is a South Asian cultural practice where harassment by in-laws on issues related to dowry is reported to be a major factor associated with poor mental health and suicides in women[8] and is also a determinant of DV.[8] Notably, the husband's unsatisfactory reaction to dowry is said to be strongly associated with common mental disorders in Indian literature.[9]

Australia is a highly multicultural country.[10] The intermingling of many different cultures and ethnicities results in hybrid identities and hybridization of cultural practices.[11] In this rapidly changing trans-migratory world, studying the lives of individuals is crucial to the study of cultural factors, which are increasingly recognized as important determinants of mental health.[11]

This paper presents a case report of a South Asian migrant woman, victimized by the social practice of dowry in Australia, associated with DV and its serious impact on her mental health

Case report

Ms A is a 25-year-old, recently separated woman referred by her general practitioner for the treatment of mental health impacts of DV. She was married in an arranged marriage in India to an Australian-Indian resident. A day after the marriage he stopped talking to her, he seemed annoyed and his mother repeatedly complained about dowry gifts being insufficient and of poor quality. Over the next week Ms A increasingly became anxious and sad. Over three ceremonies her parents had given extravagant gifts comprising gold and cash, expenses totalling over AUS$70,000. Indian culture is virilocal (i.e. the son stays with the family and his bride moves in).[4] Accordingly, Ms A moved in with her in-laws. Her personal gold jewellery was taken by her mother-in-law ostensibly for 'safe guarding' (but never returned). Ms A anxiously realized she was in a hostile environment from which escape was difficult. Divorce was not an

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option, a sign of shame and failure. The following week her father visited Ms A. She was traumatized by her mother-in-law exploding at him, she was dishonoured by insufficient dowry gifts and threatened to send Ms A home. Her father cried and pleaded, that would dishonour his family. He said he had spent all his life savings. Ms A felt deeply sad, helpless and humiliated. The mother-in-law relented.

Some months later, Ms A arrived in Melbourne. Her husband started making escalating demands for money. She told him he had to follow the tacit culturally accepted agreement (where the father gives a dowry, and the husband takes care of the new wife). Her 'backchat' angered him, he hit her, and slept in a separate room. She asked why he was rejecting her, he yelled abuse and hit her again saying she was costing him too much. She was given little food to eat, no access to money, and lost weight. She was often kicked out of the house on cold nights and not allowed back for hours. She would go and sit in the park nearby, alone, fearful, tearful, sad, and becoming suicidal. His sister and mother-in-law arrived from interstate, and both made threats to her life on a number of occasions. She recognized the ominous threats were dowry-related. She reported that she knew that dowry demands can lead to murders in her culture. She felt acutely fearful and ran out of the house and went to the police station obtaining an intervention order against him and his family.

Mental health examination revealed a sad, anxious, and fearful young woman who was suffering daily panic attacks. Sleep was disturbed with nightmares. She had poor concertation, low appetite and low energy. She reported intrusive thoughts and flashbacks of physical violence, threats to her life, and criticisms of her on the basis of insufficient dowry with frequent periods of disassociation and panic attacks. She felt suicidal but did not attempt suicide. Her self-score on the post-traumatic stress disorder (PTSD) checklist PCL-5[12] was 80 out of a possible 80. The Clinical Global Impression (CGI) score was assessed as 3/10. The core symptoms of PTSD were hyperarousal, intrusion, and depersonalisation. There was no previous history of mental illness.

Her treatment comprised bio-psycho-social approaches. She was commenced on escitalopram 20 mg daily and diazepam 5 mg nocte. Culturally sensitive trauma-based cognitive behavioural therapy (CBT) was commenced on a weekly basis. She was referred to specialist domestic violence services for safety provision. Her husband withdrew his support for her spousal visa, an application for permanent residence on grounds of DV was made. She was not eligible to receive unemployment benefits and unable to look for a job. She was provided pro bono psychiatric reports to support the intervention order against her husband, and for the immigration department, supporting her application for residency.

Progress

She received weekly trauma-focussed CBT, and crisis support. For example, she telephoned in a panicked state that her Australian residency visa was in doubt. She was advised to do slow rhythmic breathing and take clonazepam 0.5 mg. An urgent consultation with an immigration agent was arranged. Another time she reported seeing her ex-husband standing within 50 meters. She suffered an acute attack of de-personalisation needing telephone support. She suffered nightmares, panic attacks and fear. Sometimes she felt he was standing right behind her looking over her shoulders. She knew that to be not real. At other times she had to confront him in court hearings, each contact with him led to panic attacks and depersonalisation.

Escitalopram was changed over to des-venlafaxine 50 mg, due to severe insomnia and extreme anxiety, mirtazapine 30 mg nocte was added. Due to the ever-present fear of being stalked, quetiapine 100 mg nocte was prescribed. She took clonazepam on a prn basis. This combination gave her partial relief from fear, anxiety and insomnia. The PCL-5 score dropped to 55–60. Her mental state fluctuated and concentration remained low. She started applying for jobs. She was introduced to a non-governmental organization with a social network of young women with similar issues. She noted difficulty in trusting people. Her CGI score hovered at around 5–6/10

Discussion

This case report shows a previously demonstrated complex association between dowry demands, DV and mental illness.[8,13] The husband's dissatisfaction with the dowry appeared to be the major driver of rejection, abuse, violence and threats. Demands for dowry are shown to be an independent risk factor for common mental disorders and suicidal ideation.[9] In this longitudinal study dowry demands turned out to be a stronger predicator of mental illness in women than DV and husband's alcoholism. To our knowledge this is the first case report that draws attention to the association between dowry-related DV and complex PTSD. This case reveals how bullying behaviour, abuse of power and control, escalating coercive dowry demands leads to 'intimate terrorism'[14] with increasing fear and threats to life and PTSD.[3] Despite its illegality, dowry-related murders in India have steadily increased in the past decade.[15,16] They are attributed to a toxic mix of patriarchy, greed and materialism.[15,16] The exact prevalence of dowry-related DV is unknown in Australia but dowry-related DV is documented in a previous qualitative Australian research study,[13] two dowry-related murders are reported in Victoria[17] and the problem is considered substantial.[18]

As the result of repetitive stress from which there is limited escape, associated with feelings of shame, worthlessness, and defeat, some have identified a variant of PTSD, termed 'complex PTSD',[19] a diagnostic category suggested for ICD 11 but not present in DSM-5.[20]

Research is needed to determine prevalence of dowry-related DV in Australia, its impact on mental health and optimal treatments.

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