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Characteristics of Male Perpetrators of Intimate Partner Violence in South-South Nigeria

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Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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ABSTRACT

Aims: This study was done to identify personal characteristics of men that may be associated with partner abuse in order to provide a basis for offering counseling services, to prevent, as well as appropriately manage cases of existing abuse.
Study Design: Cross sectional survey.
Place and Duration of Study: The study was done at the General Outpatients Clinic of University of Port Harcourt Teaching Hospital, Port Harcourt, Rivers State, Nigeria; between August and November 2007.
Methodology: The examiner administered pre-tested questionnaire on adult females attending the clinic within the duration of the study. Every second patient seen by the investigator on the waiting line of a regular medical consultation visit that consented to the study was recruited until the desired sample size was got. Socio-demographic as well as drug use information of adult subjects' partners aged between 18 to 59 years was obtained.
Results: Of the 384 females investigated, age 21 – 67 years with a mean age of 31.31±8.61 years: physical abuse 41.9%, verbal/emotional abuse 49.0%, and a combined (physical/verbal) abuse

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29.9%. Partners' education had statistically significant relationship with physical abuse, P=0.018; partners' tobacco uses with verbal abuse (P=0.000), and between combined abuse and use of tobacco or cannabis, P=0.003 and 0.048 respectively.
Linear multiple regression model of physical abuse parameters: throw something at, being pushed, slapped, kicked, hit at, beaten-up, threatened or weapon used, and forced sex; P-value was 0.000, with sum of squares 60.263 and degree of freedom 9. Whereas for verbal abuse: cajoled, derogatory statements made at, name calling, and shout at, as abuse parameters; P-value was 0.000, sum of squares 72.763 and degree of freedom, 4. Both of these were statistically significant.
Conclusion: This study demonstrates a higher perpetration of verbal/emotional violence than that of physical violence (or both) by males on their partners with lack of formal education, with tobacco and/or cannabis use, as aggravating factors.

Keywords: Characteristics; male; perpetrators; intimate; partner; violence.

1. INTRODUCTION

"Although most victims of domestic violence are women in heterosexual relationship, the incidence and prevalence of domestic violence appear to be similar in male and female, and same-sex relationships" [1]. "This finding means that it is power and control rather than gender that is responsible in this syndrome. Domestic violence encompasses not only physical injury but also threats, sexual abuse, emotional and psychological torment, economic control, and progressive social isolation. It includes physical assault such as hitting, slapping, kicking and beating; psychological abuse such as constant belittling, intimidation and humiliation and coercive sex" [2]. "It also involves spiritual abuse, in which the person's religious or spiritual beliefs are used to manipulate, dominate, control or even ridicule their beliefs" [1,3]. "In fact, physical violence usually occurs in the setting of a prodrome of non-assaultive behaviour, which can occur in any combination over a varying time course" [1].

"Spousal abuse is a pattern of behaviour that may be the result of a number of different factors including learned behaviour that a child observed during childhood, and later repeats in his adult relationships. Relationship abuse has been associated with many physical and psychological sequelae, which include multiple somatic symptoms, abdominal pain, chronic headaches, pelvic pain and anxiety, depression, post-traumatic stress syndromes and other psychiatric disorders" [1,2]. "Alcohol and drug addiction, musculoskeletal symptoms, and eating disorders are other health-related sequelae of short- and long-term abuse" [1]. In a study by Black et al, "in North America, a number of demographic, personal history and personality factors were linked consistently to a man's likelihood of physically assaulting an intimate partner" [4]. "Among the demographic factors, young age, and low income were consistently associated with likelihood for a man committing physical violence against a partner. In another study, in New Zealand, it was found that poverty in the family in childhood and adolescence, low academic achievement and aggressive delinquency at young age predicted physical partner abuse by men at later age" [5].

"According to population-based surveys from Brazil, Canada, India, Spain, South Africa, etc there is a strong relationship between a woman's risk of suffering violence and her partner's drinking habits, though it may not be causal" [6,7]. "However, in South Africa, for example, men speak of using alcohol in a premeditated way to gain the courage to give their partners the beatings they feel are socially expected of them" [8].

In a study by Nabila El-Bassel et al, "frequent use of Cannabis (marijuana), cocaine and crack increases the likelihood of subsequent intimate partner violence, though that could not be said of binge drinking" [9]. "It in fact, established a causal relationship, between marijuana use and intimate partner violence and went on to state that, the experience of intimate partner violence increases the likelihood of subsequent frequent drug use" [10].

"Studies in Brazil, Cambodia, Canada, Chile, Colombia, Indonesia, Spain, United States, etc all found that rates of abuse were higher among women whose husbands had either themselves been beaten as children or had witnessed their mothers being beaten" [6,11]. "However, it is not all boys who witness or suffer abuse grow up, to become abusive themselves" [7].

This study seeks to establish some features in males with the propensity for perpetuating partner abuse.

2. MATERIALS AND METHODS

Study site: The study was carried out at the General outpatients' clinic of the University of Port Harcourt Teaching Hospital located in south-south Nigeria after receiving ethical approval from the hospital. This hospital is a tertiary healthcare institution with about 500 beds. It receives patronage of patients from Bayelsa, Delta, Akwa Ibom, Abia States, etc, all of which are in the southern part of Nigeria. The General Outpatients Clinic in which the patients were seen has about eighteen (18) doctors including four (4) consultants as staff. Over 25,000 patients are seen every year in this clinic and about 200 patients are seen each day.

Study design: This was a cross-sectional survey via examiner administered pre-tested questionnaire.

Sample size estimation: This was estimated using the prevalence of the National Demographic and Health Survey report that half of Nigeria's women have experienced domestic violence [12]. This report of 2003 used a large population and represents a wider coverage of the divergent ethnic and religious groups that make up Nigeria. It therefore appears more reliable statistically. The sample size was calculated using the formula [13]:

$$n = \frac{Z^2pq}{d^2}$$

where z = standard normal deviate usually set at 1.96 which corresponds to the 95% confidence level. P = the proportion in the target population estimated to have a particular characteristic, i.e. prevalence here 50%. d= degree of accuracy desired, usually set at 0.05.

q = 1.0 – P = 1.0-0.5=0.5 where desired n = desired sample size (when population is greater than 10,000).

Z = 95%
d = 0.05. Substituting into equation:

$$n = \frac{(1.96)^2 (0.5)(0.5)}{(0.05)^2} = \frac{3.8416 \times 0.25}{0.0025}$$

$$= 384.16 \approx 384 \text{ (approximately).}$$

Data collection: The data were collected by KI (the first author) and trained assistants, between August and November 2007. The questionnaire was interviewer-administered, with the questions asked in English language. Every second female subject, aged 18 or more years, on the queue of a regular consultation visit who met the following inclusion criteria was systematically chosen till the desired sample size was got:

Subjects:

- Who were willing to participate and gave verbal consent.
- That were, not too sick to withstand the interview session.
- That understood or spoke English language or had an interpreter available if she was illiterate.
- Who could give an account of their intimate partner relationship within the past one year.

Each patient responded only once and her identity was kept anonymous. Socio-demographic as well as drug use information of adult subjects' partners aged between 18 to 59 years was obtained.

Data analysis: Data handling and analysis were carried out using SPSS 17.0 software and Microsoft word. Summary measures were calculated for each outcome of interest; and statistical significant test determined. For all statistical tests, P- value of 0.05 or less was considered statistically significant.

3. RESULTS

The prevalence of physical abuse was 41.9 percent while that of verbal/emotional abuse was 49.0 percent and a combined (physical/verbal) abuse of 29.9 percent was observed among three hundred and Eighty-four (384) investigated females. This abuse pattern was perpetrated by 384 partners of the study population with age range between 21 to 67 years and mean age of 38.28 ±10.033 years.

Table 1 shows socio-demographic characteristics of the subjects' partners. Of the 384 partners of the study population, age range was 21 to 67 years old. The mean age was 38.28 ±10.033 years. Seventy-nine (20.6%) of the subjects' partners were below 30 years while 305 (79.4%) were over 30 years old. Twenty-five (6.5%) of the subjects' partners had primary, while 123

(32.0%) had secondary and, 236 (61.5%) had received tertiary education. Three hundred and seventy-seven (98.2%) of the subjects' partners were Christians, one (0.3%) was a Moslem, four (1.0%) believed in traditional religion, and one (0.3%) each belonged to Eckankar and Grail message respectively. Three hundred and sixteen (82.3%) of the subjects' partners were employed and 68 (17.7%) were unemployed.

3.1 Partner Biodata and Abuse Perpetration

In Table 2, only partner education has a statistically significant relationship with perpetration of physical abuse, P=0.018.

In Table 3 there is no statistically significant relationship between partner socio-demographic characteristics and perpetration of verbal abuse.

In all, a larger percentage of those who consumed alcohol, tobacco, and used hard drug (cannabis) perpetrated intimate partner abuse. None of the subjects' partner or subjects themselves was on any medication for mental illness.

In Table 6, there is a statistically significant relationship between partner drug use in perpetrating physical abuse (P=0.000). There is also a similar significant relationship between drug use and verbal or combined abuse, P=0.000 and 0.00 respectively.

Table 1. Socio-demographic characteristics of the subjects' partners

		Frequency	Percentage
Age:	<30 years	79	20.6
	>30 years	305	79.4
Educational	Primary	25	6.5
Status	Secondary	123	32.0
	Tertiary	236	61.5
Religion	Christian	377	98.2
	Moslem	1	0.3
	Traditional	4	1.0
	Others eg Eck, Grail	2	0.5
Employment Status	Employed	316	82.3
	= Unemployed	68	17.7

Table 2. Sociodemographic characteristics of physically abusive partners

Characteristics	Frequency	Percent	χ^2	p-value
Partner Age				
<30 years	26	32.9	3.320	0.068
>30 years	135	44.3		
Partner Education				
Primary	17	68.0	8.032	0.018
Secondary	46	37.4		
Tertiary	98	41.5		
Partner Religion				
Christian	156	41.4	5.336	0.149
Moslem	-	-		
Traditional	3	75.0		
Other eg Eck	2	100.0		
Partner Employment				
Employed	134	42.5	0.270	0.603
Unemployed	27	39.1		

Table 3. Socio-demographic characteristics of verbally/emotionally abusive partners

Characteristics Age (years)	Frequency	Percentage %	X^2	p-value
< 30	38	48.1	0.029	0.864
>30	15049.2			
Edu. Status				
Primary	11	44.0	4.158	0.245
Secondary	53	43.1		
Tertiary	124	52.5		
Religion			1.317	0.245
Christian	183	48.5		
Moslem	-	-		
Traditional	3	75.0		
Others eg Eck, Grail message	2	100.0		
Employment status				
Employed	159	50.3	1.317	0.251
Unemployed	29	42.6		

Table 4. Distribution showing partner alcohol use and frequency

Partner Alcohol Use	Frequency	Percent
No alcohol	215	56.0
Occasional (social) drinker	158	41.1
Regular drinker	2	0.5
Addicted	9	2.3
Total	**384**	**100.0**

Table 5. Distribution showing partner drug use and prevalence

Drug used	No	Yes	Total
Alcohol	215(56.0%)	169(54%)	384(100.0%)
Tobacco	347(90.4%)	37(9.6%)	384(100.0%)
Cannabis	378(98.4%)	6(1.6%)	384(100.0%)

Table 6. Distribution showing partner drug use among different abuse types

Abuse Type	Drug	Yes	No	χ^2	p-value
Physical	Alcohol	73(45.3%)	88(54.7%)	96.2	<0.001
	Tobacco	21(13.0%)	140(87.0%)		
	Cannabis	4(2.5%)	157(97.5%)		
Verbal	Alcohol	85(45.2%)	103(54.8%)	96.8	<0.001
	Tobacco	29(15.4%)	159(84.6%)		
	Cannabis	5(2.7%)	183(97.3%)		
Combined	Alcohol	54(47.0%)	61(53.0%)	63.2	<0.001
Abuse	Tobacco	19(16.5%)	96(83.5%)		
	Cannabis	4(3.5%)	111(96.5%)		

4. DISCUSSION

Ideally, intimate partner relationship should be a complimentarily peaceful and happy coexistence between two people. However, certain circumstances may cause misunderstanding and disharmony in a relationship where there should be no abuse especially physical abuse. In this study, 384 females with an age range between 18 and 59 years with a mean age of 31.31±8.61 years participated.

Of these, the prevalence of physical abuse was 41.9 percent and verbal/emotional abuse 49.0 percent with a combined prevalence of 29.9 percent. The combined prevalence in a Turkish study was 52 percent with verbal abuse being the most prevalent, accounting for 53.8 percent

followed by physical abuse with 38.3 percent [14]. A similarly higher prevalence of verbal abuse 40.1% than physical abuse 30.4% was reported in Uganda [14]. These differences in the prevalence of verbal abuse in the various studies could be due to the fact that what constitutes verbal violence is subjective as some women regard it as normal and culturally acceptable [15] while others detest it. The higher prevalence of verbal abuse as compared to physical abuse could be due to pressures of life both from outside and within the home and as pointed out, can be done with a smile [16] but it is perhaps more sinister than overt physical abuse. Long after the black and blue bruises and broken bones from physical abuse might have healed, verbal abuse continues to silently erode its victim's self-worth.

Prevalence of physical violence in Nigeria have been reported to be 46% in Nnewi by Ilika et al. [15], 28% in Zaria by Ameh et al. [17] and 31.3 percent seen among Oyo state civil servants [2]. A WHO report, of nearly 50 population-based surveys from 36 nations around the world, find 10 to over 50% women to be physically assaulted by intimate partners during their lifetime [18].

Verbal/ emotional abuse was more prevalent in those females with tertiary education than lower levels of education in this study, just as in those of extended families and monogamous marriages. This may probably be due to the fact that, if the male partner was less educated, he may feel threatened by the status variation and acts differently.

It is also noteworthy that studies done in this area have not looked at the role of female factors involved in male perpetration of intimate partner abuse.

There was a statistically significant difference between the prevalence of physical abuse among partners with primary education (68.0%) compared to those with tertiary education (41.5%), P=0.018. This is similar to the findings by Ilika, et al. [15] in which violence against women was more in partners with lower level of education. The lower level of partner education with attendant lower income may frustrate the men owing to the loss of their cultural role as money providers [19]. It also reduces the ability of men to live in a manner that they regard as successful. Unemployment (recent or long-term) and the stress of looking for work increases the risk that a man will physically abuse his wife [19]. There was no significant difference in partner employment status and age group to perpetrating either physical or verbal abuse in this study. This agrees with findings by Niel, et al in several Southern African countries in which there was no convincing association with age, income, education, household size and remunerated occupation with partner physical violence [20]. On the contrary, Gonzales de Olarte and Llosa showed in their analysis of data from Peru that men who were employed inflicted more violence than men who were unemployed [21]. Blau and Blau also said that socioeconomic inequalities, drives the effect of other factors such as poverty, race and geographical location on violence [22]. This provides a useful reference for arguing that inequality rather than absolute deprivation produced by poverty was a risk for interpersonal violence. It seems this requires further studies to ascertain, as interpersonal violence appears to be a deep-rooted phenomenon that, like other social phenomenon, is influenced by a wide range of causes at societal, community, relationship and individual levels [22].

Christian religion seems to protect against abuse compared to other religious groups like Eckankar or Grail message, even though these constituted less than one percent (2) of the study population. This observation needs to be investigated further. There was also no abuse associated with the only Moslem in the study. However, in a study conducted among Muslim men and women in England, men used Islam to justify violence against women, whereas women used religion as a source of strength and a negotiating vehicle for the cultural and religious taboos imposed by their spouses [23].

Their use by the perpetrator resulted in an increased prevalence in this study. Alcohol use appears consistent as a risk marker for partner violence across different settings [2,6,24]. Population-based surveys from Brazil, Canada, India, Spain, South Africa, etc also found a relationship between a woman’s risk of suffering violence and her partner’s drinking habits [8,9]. There is however, debate about the nature of the relationship between alcohol use and violence whether it is truly causal. Many researchers believe that alcohol operates as a situational factor, increasing the likelihood of violence by reducing inhibitions, clouding judgment and impairing an individual’s ability to interpret cues [25]. In a study by Nicole et al, on American soldiers, heavy drinkers (22 or more drinks per

week) were 66% more likely to be spouse abusers than were abstainers [26]. Alcohol use by the victim at the time of event was also related to the perpetrator's drinking habits, although fewer victims, overall, were reportedly drinking during the event [26]. There was a statistically significant relationship between partner tobacco use and perpetration of verbal abuse, P=0.000; just as it was with cannabis use for combined abuse, in this study. As already stated above, frequent use of cannabis, cocaine and crack increases the likelihood of subsequent intimate partner violence though that could not be said of binge drinking. It in fact, established a causal relationship, between marijuana use and intimate partner violence and went on to state that, the experience of intimate partner violence increases the likelihood of subsequent frequent drug use [27,28,29].

The findings from this study, though have added to the wealth of knowledge, cannot be generalized because it was a hospital-based study and the sample size is not a representation of the target population. This study demonstrates a higher perpetration of verbal/emotional violence than that of physical violence (or both) by males on their partners with lack of formal education, tobacco and/or cannabis use, as aggravating factors.

5. CONCLUSION

It can be concluded from this study that the use of alcohol, tobacco and cannabis by male partners, and unemployment/job seekers (in males) are strongly associated with intimate partner abuse. Secondly, women with tertiary level of education men with lower income associated with verbal/emotional abuse.

CONSENT

As per international standard or university standard, Participants' written consent has been collected and preserved by the author(s).

ETHICAL APPROVAL

The approval to undertake the study was sought and obtained from the Ethical Review Committee of the University of Port Harcourt Teaching Hospital, Port Harcourt.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. Elaine JA. Violence in intimate relationships and the practicing internist: New "Disease" or New Agenda? Annals of Internal Medicine. 1995:123(10):778-781.
2. Olufunmilayo I F, Adedibu L A, Adeniran O F. Intimate partner abuse: Wife beating among civil servants in Ibadan, Nigeria. African Journal of Reproductive Health. 2005;9(2):54-64.
3. Domestic Violence. EmedicineHealth. Available:www.emedicine.com. Accessed 18/9/2011.
4. Jethá EA, Lynch CA, Houry DE, Rodrigues MA, Chilundo B, Sasser SM, Wright DW. Characteristic of victims of family violence seeking care at health centers in Maputo, Mozambique. J Emerg Trauma Shock. 2011;4(3):369-73.
5. Moffit T E, Caspi A. Findings about partner violence from the Dunedin multidisciplinary health and development study. New Zealand. Washington, D C, National Institutes of Justice; 1999.
6. Moreno MF. Intimate Partner violence. Revista Panamericana de Salud Publica. 1999;5:245-258.
7. Caesar P. Exposure to violence in the families of origin among wife abusers and martially nonviolent men, violence and victims. 1998;3:49-63.
8. Jewkes R, et al. The prevalence of physical, sexual and emotional violence against women in three South African provinces. South African Med. Journal. 2001;91:421-428.
9. International Clinical Epidemiologists Network (INCIEN). Domestic Violence in India. Washington, D C, International Center for Research on Women and Center for Development and Population activities; 2000.
10. Abraham N, Jewkes R, Laubsher R. I do not believe in democracy in the home: men's relationships with and abuse of women. Tyberberg, Centre for Epidemiological Research in South Africa, Medical Research Council; 1999.
11. Nabila E B, Louisa G, Elwin W, et al. Relationship between drug abuse and intimate partner violence: A longitudinal study among women receiving methadone. Am. Journal Public Health. 2005; 95(3):465-470.
12. Kolawole AO, Uche C I. Perceptions of Nigerian Women on domesticviolence:

Evidence from 2003 Nigeria Demographic and Health Survey. African Journal of Repr Health. 2005;9(2):38-53.
13. Araoye MO. Research methodology with statistics for Health and Social Sciences. Nathadex publishers, Ilorin; 2003.
14. Ilika AL, Okonkwo PI, Adogu P. Intimate partner violence among women of childbearing age in a Primary Health Care Centre in Nigeria. Afr J Reprod Health. 2002;6(3):53-58.
15. Faruk K, Orhan D. Domestic violence against women in Sivas, Turkey: Survey study. Croat Med Journal. 2006;47:742-749.
16. Domestic Violence. Wikipedia. Available:www.pubmed.com Accessed: 3/10/2011.
17. Ameh N, Kene TS, Onuh SO, Okohue JE, Umeora OU, Anozie OB. Burden of domestic violence amongst infertile women attending infertility clinics in Nigeria. Niger J Med. 2007;16(4):375-7.
18. WHO. Violence Prevention Activities, 2000-2004. 2005;1-8.
19. Ahmed AM, Elmardi AE. A study of domestic violence among women attending a medical center in Sudan. Eastern Mediterranean Health Journal. 2005;11(1/2):164-174.
20. Andersson N, Ho-Foster A, Mitchell S, Scheepers E, Goldstein S. Risk factors for domestic physical violence: national cross-sectional household surveys in eight southern African countries. BMC Womens Health. 2007;7:11. DOI: 10.1186/1472-6874-7-11
21. Gonzales OE, Gavilano IP. Does poverty cause domestic violence? Some answers from Lima. In: Morrison A R, Biehl M L, eds. Too close to home: Domestic violence in the Americas. Washington, D C, Inter-American Development Bank. 1999; 35-49.
22. WHO. The Economic dimensions of Interpersonal Violence. 2004;1-70.
23. Junaid AR, Fariyal FF, and Jill D. Attitudes of Pakistani men to domestic violence: a study from Karachi, Pakistan. J M H G. 2005;2(1):49-58.
24. Kyriacou DN, et al. Emergency department based study of risk factors for acute injury from domestic violence against women. Annals of Emergency Med. 1998;31: 502-506.
25. Flanzer JP. Alcohol and other drugs are key causal agents of violence. In: Gelles R S, Loseke D R, eds. Current controversies of family violence. Thousand Oaks, C A. Sage. 1993;171-181.
26. Nicole SB, Thomas H, James EM, Laura S. Drinking and spouse abuse among U.S Army Soldiers .Alcohol Clin Exp Res. 2004;28(12):1890-1897.
27. El-Bassel N, Gilbert L, Wu E, Go H, Hill J. Relationship between drug abuse and intimate partner violence: a longitudinal study among women receiving methadone. American journal of public health. 2005 Mar;95(3):465-70.
28. Caldwell JE, Swan SC, Woodbrown VD. Gender differences in intimate partner violence outcomes. Psychology of violence. 2012 Jan;2(1):42.
29. Rakel ER. The family physician: In textbook of family practice, Robert Rakel (Ed). 6th Edition. W B Saunders Company. 2002;3-42.

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