



Violence against women and girls: Mapping the health consequences

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Abstract. Rapidly accumulating evidence indicates that gender-based violence is a risk factor for multiple physical, mental, reproductive and psychosomatic disorders affecting women. This evidence challenges traditional psychosomatic and psychoanalytic theories that women are biologically vulnerable to psychological disorder, and suggests that socially constructed vulnerabilities need to be better integrated and investigated in the biopsychosocial model of health. © 2006 Elsevier B.V. All rights reserved.

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1. Introduction

Psychosomatic medicine is informed by a biopsychosocial model of health. Yet when the psychosomatic conditions affecting women are examined, the social dimension of these conditions has not been adequately researched.

The first half of this paper will consider some long standing influences on theorising about psychosomatic disorders in women that help to explain this neglect, and the second half will focus on evidence relating to one highly significant social risk factor, namely gender-based violence. It will be argued that there is a need for more thorough integration of this evidence into understanding the aetiology of psychosomatic disorders and their treatment. Lack of investigation into the social dimensions of the psychosomatic disorders affecting women cannot be attributed to a paucity of such disorders. The high level of physical and psychological comorbidity found in eating disorders, gastrointestinal disorders and pain syndromes including chronic pelvic pain is well documented [1–4].

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With certain exceptions [3,4], careful contextualization of the way in which gendered social risk factors mediate psychosomatic disorders is rare.

2. Historical background

It is hardly surprising that the social dimension of the psychosomatic conditions affecting women has been under researched. From the ancient Greeks onwards, doctors, philosophers and scientists have been preoccupied by the apparent relationship between women's bodies, especially their reproductive organs and their emotional wellbeing. By giving the name 'hysteria' to the archetypal female malady, the uterine origin of psychological distress in women was repeatedly advanced in theory and treatment over the centuries. How women's social position or social treatment including GBV impacted on their reproductive and mental health was largely ignored until late in the 20th century [5].

Hysteria arose, according to Plato in the *Timaeus*, from a failure of reproductive functioning. Such a failure not only brought the sufferer into the 'extremest anguish' but was responsible for 'all manner of disease'—in other words, it was a classic psychosomatic disorder. Two thousand years later, little had changed. The French psychiatrist, Charcot was still insisting in the late 19th century that hysteria always had a genital or reproductive origin. This internalising model of women's psychosomatic distress was briefly challenged by Freud in 'The aetiology of hysteria' (1896) when childhood sexual trauma was cited as the primary cause of their psychological problems in adult life. But this theory met with an 'icy reception' from colleagues in the Society for Psychiatry and Neurology in Vienna and was soon replaced by one that gave causal primacy to the Oedipal complex, childhood sexual fantasies about parents, penis envy and intrapsychic conflict [6].

The theoretical movement away from the view that something traumatic actually happened to the female child to increase her vulnerability to psychosomatic suffering in adult life gave way to the idea that such suffering was unrelated to real events. Research into childhood sexual abuse was effectively stifled for more than 70 years. Even in 1989, of the 75 papers on somatization disorder published until that time, only two provided any data on patients' childhood sexual histories [7]. By failing to enquire about sexual victimization and other adverse experiences, an illness perspective was reinforced and psychosomatic suffering was decontextualized from the traumatic events and problematic social conditions that gave rise to it. Almost inevitably, this led to a misreading of the very idioms of distress that psychosomatic medicine was seeking to illuminate.

Freudian thinking dominated psychosomatic research on women for much of the twentieth century. Examples of the Freudian imprint on supposedly purely empirical research can be traced from the 1920s to the 1990s. The psychiatrist Gregory Zilboorg attributed postpartum psychosis to the fact that 'The child... has for these women more the value of a lost male organ than anything else'. Psychoanalyst Helene Deutsch conceptualized childbirth as an 'orgy of masochistic pleasure' in the 1940s in strict accordance with Freud's view that masochism was a defining female characteristic. Ringrose's research in the 1960s asserted that toxæmia in pregnancy occurred in women who were 'psychopathic deviates'. Even in the late 1980s, gender bias and dubious theoretical assumptions influenced research on reproductive functioning and psychiatric

disorder in women. Gitlin and Pasnau's comprehensive review examined evidence on the four psychiatric syndromes namely postpartum depression, premenstrual syndrome, posthysterectomy depression and involuntional melancholia. Many studies were so poorly designed their findings were unreliable and reflected unexamined myths and culturally biased attitudes to women [6].

The critical conceptual distinction sex and gender was not made until late in the 20th century. In consequence, the biological and social determinants of ill health in women were often confounded. Not surprisingly, research on differences in rates of psychiatric disorder between men and women has often focussed on identifying the biological basis of these differences. Biological risk factors investigated include responses to stress including differences in hypothalamic–pituitary–adrenal axis activation and cortisol levels; differences in levels of such neurotransmitters as serotonin as well as genetic and endocrinological differences including the possible role of ovarian steroids [8–10].

3. Gender disparities in psychological disorders

Marked gender differences in rates of psychological disorder have been documented [11–13]. Women compared with men experience significantly higher rates of depressive disorders (major, minor, dysthymia); certain anxiety disorders including panic disorder and posttraumatic stress disorder (PTSD), some phobias including agoraphobia; somatoform disorders, certain personality disorders such as borderline personality disorder; eating disorders such as anorexia nervosa and bulimia and significantly higher rates of psychiatric comorbidity.

An increasingly large and consistent body of evidence confirms the critical relationship between GBV and an increased likelihood of psychological disorder. GBV is a major public health and human rights issue according to the World Report on Violence and Health [13]. Globally between 10% and 69% of women report physical abuse by an intimate partner at least once in their lives; between 6% and 47% of adult women report being sexually assaulted by intimate partners in their lifetime and more than 20% female children have been sexually abused [13].

All but one of the psychological disorders noted above in which women predominate coincide with the disorders that have been repeatedly reported in studies on the mental health consequences of GBV. The only exception concerns substance use and alcohol dependence [1,3,14]. In the large U.S. Comorbidity Survey [11] men had more than twofold rates of these disorders compared with women. However, women affected by GBV have very high rates of these disorders [1].

4. Risks, rights and health

The phenomenon of GBV indicates that the behaviours usually termed 'risk factors' are in fact gross violations of the human rights of girls and women. The pluripotential for health related harm of GBV is its most defining characteristic and one that needs to be investigated within psychosomatic research. Fatal outcomes include murder where IPV has been identified as the most common risk factor; suicide where severe, long-lasting IPV is associated with a significantly increased risk; maternal mortality and AIDS-related deaths where GBV involving sexual coercion and physical violence has

been linked to 3-fold increases in risk of HIV in studies from Rwanda, Tanzania and South Africa [13].

Nonfatal outcomes affect multiple dimensions of health including reproductive health. GBV-affected women experience higher rates of unwanted pregnancy, abortion, sexually transmissible infections, abnormal cervical cytology, gynecological disorders including pelvic inflammatory disease, urinary tract infections and chronic pelvic pain. They have higher rates of miscarriage, poor pregnancy weight gain, abruptio placentae, intrapartum haemorrhage, preterm delivery, low birthweight infants and perinatal death [2,16].

Physical health consequences of GBV include injury, functional impairment, physical symptoms, poor subjective health and permanent disability [2,14]. Chronic conditions include classical psychosomatic conditions such as pain syndromes including back and neck pain, irritable bowel syndrome, gastrointestinal disorders, fibromyalgia, eating disorders, chronic sleep problems, insomnia and nightmares [2,3,17]. Health risk behaviours are increased including smoking, alcohol and drug use, over and undereating, unsafe sexual behaviours and physical inactivity and patterns of health care utilization change [1,15].

5. Stress and immune functioning

Increasingly, researchers are investigating the impact of GBV on stress and immune responses in women. Interestingly, this research positions alterations in immune functioning or stress responses as *consequences* of various forms of GBV unlike earlier research that regarded such differences as predictors or *causes* of gender disparities in psychological disorders like depression.

Evidence to date indicates that women with a history of intimate partner violence (IPV) compared with nonabused controls have higher levels of evening cortisol, higher levels of morning and evening dehydroepiandrosterone (DHEA) [18] and manifest a significant decrease in immune regulation over herpes simplex virus type 1 [19]. Currently, depressed women with a history of childhood abuse have been reported to have increased pituitary-adrenal and heart rate responses to stress [20]. Furthermore, an MRI study of women with severe CSA, 71% of whom had PTSD, found reductions in left hippocampal volume [21].

6. Summary

Research evidence on the multiple, intricately interrelated health consequences of GBV argues strongly for psychosomatically oriented researchers to elucidate the mechanisms by which socially entrenched gender-based violence produces compromised physical, psychological and neuropsychological functioning. A life course approach is essential because early abuse and adversity predicts revictimization and early sexual trauma has been linked to increased sensitivity to the depressogenic effects of stressful life events [22].

Research that attends in an equally rigorous fashion to the social as well as biological and psychological dimensions of the biopsychosocial model of health is required. As Jordan [23] notes, it is imperative to examine contextual factors and not assume that 'the person presenting with pain *is* the problem'. Multiple human rights violations are associated with GBV. The link between health and human rights deserves to be better understood.

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