Case Report

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Quick Response Code:

Website: www.jmwan.org

DOI: 10.4103/jmwa.jmwa_9_21

Attempted Intimate Partner Homicide: Case Series and Experience in a Nigerian Suburban Hospital

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Abstract:

Intimate partner homicide – an increasingly global, mental and public health issue with enormous social and economic consequences – is widely unreported and undocumented in Nigeria. This article reports attempted homicides managed in Irrua Specialist Teaching Hospital within 2 years. It aims to arouse public interest to stimulate the enactment of protective policies for vulnerable victims who are mostly women.

Keywords:

Domestic violence, intimate partner homicide, spousal homicide, suicide

Introduction

Increasing domestic violence worldwide is a major public and human rights crisis with adverse health and economic impact.[1-3] Intimate partner violence (IPV) is violence (verbal, physical and emotional) inflicted by a current or former spouse or partner in an intimate relationship. In extreme, it could result in accidental or intentional death (intimate partner homicide [IPH]) and suicidal attempts.[4-6] Men or women can be perpetrators or victims – men perpetrating severest forms, while the women often become violent out of self-defence or in retaliation.[7-10]

Rising domestic violence (including IPV) in Nigeria threatens the well-being of her women.[11-13] By 2016, homicide rate in Nigeria was 34.5 cases per 100,000 population.[14] The country's official statistics on spousal homicide are scarce and inconsistent, but newspapers and social media are awash with reports of domestic killings.[6] From global statistics, females are approximately 4–5 times the rate for male victims.[15] Firearms and knives/machetes are common weapons.[16] Others include poisons and chemicals, choking/strangulation and pushing off a ledge.[17]

There is no national legislation on domestic violence in Nigeria other than being essentially a violation of fundamental human rights.[18,19] Legal proceedings to prosecute domestic violence offenders are operational in a few states.[20,21] Civil organisations and human rights activists drive advocacy for women's legal rights and support for victims of violence.[22]

This case series reports attempted IPHs and the highlights of the care they received in our surgical unit from 2019 to 2021. This report aims to create awareness among physicians, notify public leaders (local, regional and world leaders) of this increasing menace and arouse public/national interest and discourse on the various preventive measures and protection of the vulnerable.

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Submitted: 13-May-2021
Revised: 28-Aug-2021
Accepted: 30-Sep-2021
Published: 29-Dec-2021

How to cite this article: Okomayin AA, Aigbonoga QO, Morgan E, Tagar E, Odion C, Awe OO, *et al*. Attempted intimate partner homicide: Case series and experience in a Nigerian suburban hospital. J Med Womens Assoc Niger 2021;6:136-40.

Case Reports

Case report 1

This involved a 40-year-old female (Partner A) and a 36-year-old male hunter (Partner B) who shot her from behind after she threatened to disengage. Thinking she was dead, he shot himself too. Neighbours who heard the gunshot brought them to the hospital.

Partner A

She was conscious but lethargic, pulse rate (PR) 102/min, blood pressure (BP) 120/80 mmHg and respiratory rate (RR) 22/min. The abdomen was distended and tender; there were bleeding and clear fluid discharge (suggestive of cerebrospinal fluid [CSF]) from the back wound. She had monoplegia and monoparesis of the right and left lower limb, respectively, with intact sensations. Packed cell volume (PCV) was 28%, focussed assessment with sonography for trauma revealed free intraperitoneal fluid and X-ray showed multiple radio-opaque shadows. Following resuscitation and consent, the general surgery and neurosurgical teams operated on her. Findings were hemoperitoneum (500 ml), multiple pellet perforations of the colon around the region of the hepatic flexure, partial avulsion of adjoining liver edge, retroperitoneal hematoma and a 4 cm entry wound to the right of the mid-back with CSF leakage. She had a right hemi-colectomy and closure of entry wound on the back to minimise CSF leakage. She recovered from the abdominal surgery but continued to leak CSF through the gaping wound on the back. Plastic surgeons and physiotherapists continued her management until she was discharged in a stable state and ambulant on a wheelchair.

Partner B

Partner B had a bleeding wound above the pubis with bowel evisceration. He was pale, PR 132/min, BP 90/60 mmHg and RR 24/min. Urine was bloody on catheterisation, and PCV was 24%. Following resuscitation and consent, a team of general surgery and urology operated on him. Findings were eviscerated small bowels through the entry wound, 1.5 l hemoperitoneum, multiple perforations and transections involving small bowel and the sigmoid colon, perforations on the dome and sidewall of the bladder, contused anterior abdominal wall muscles and massive scrotal hematoma. He had small bowel resection and anastomosis, sigmoid colostomy as well as bladder wall repair. The post-operative course was hampered by severe financial constraints, abandonment by his relatives and complications, such as wound sepsis, wound dehiscence, scrotal cellulitis, vesico-cutaneous fistula and ventral hernia. The fistula healed non-operatively with continuous per-urethral bladder drainage. Psycho-evaluation revealed no previous or recent mental disorder. He voids freely and awaits colostomy takedown and hernia repair.

Note: A police and firearm form was filled and submitted to the legal unit of the hospital for each patient.

Case report 2

This involved a 38-year-old woman (Partner A) and her 45-year-old male partner (Partner B), who stabbed her in the abdomen with a kitchen knife after a brief altercation. The man also stabbed himself out of fear he would be mobbed by those present.

Partner A

Partner A sustained a wound on the right side of her navel associated with pain, bleeding with clots, blood-stained vomiting, dizziness and extrusion of the omentum via the stab wound. She was fully conscious, pale with PR 100/min and BP 100/60 mmHg. Following consent, she had trauma laparotomy. Findings were 2.5 l of blood in the peritoneal cavity, multiple perforations along a 5 cm length of the jejunum and gastric perforation. She had a jejunal resection, primary anastomosis and repair of the gastric perforation. Her post-operative course was uneventful, and she was discharged in a stable clinical state.

Partner B

Partner A had a self-inflicted stab wound below his navel associated with pain, bleeding (plus clot), non-bloody vomiting, dizziness and extrusion of bowels via the stab wound. He was conscious, pale and his vital signs were PR 108/min and BP 120/70 mmHg. Eviscerated bowels appeared viable. Consent was obtained for surgery, and findings were about 1 l of blood in the peritoneal cavity, mesenteric injury and two jejunal perforations about 8 m apart. The injuries were repaired, and his post-operative recovery was uneventful until discharged. Psycho-evaluation revealed features suggestive of anger and single episode major depressive disorder without psychotic behaviour (ICD-10). This was assumed to have developed when his ex-wife, whom he was married to for 18 years (with six children), left him after he physically assaulted her following a dispute. He was deeply hurt following the separation and after several failed attempts at settlement. He became jealous when his ex-wife told him she would never return and had found another man who made her happy. His treatment included escitalopram tablets (20 mg nocte) and anger management therapy.

Case report 3

This involved a right-handed 30-year-old female attacked with a machete by her 36-year-old male intimate partner. She sustained an open wound to the left forearm as she tries to prevent a machete cut on her head following

an altercation that resulted from her refusal to prepare dinner for him. They have lived together for 10 years and have five children. At presentation, she was conscious, not pale, with PR 100/min, BP 130/90 mmHg and RR 24/min. Wound inspection revealed transections of the flexor digitorum superficialis, flexor digitorum profundus, median and ulnar nerves. The flexor tendons and the median and ulnar nerves were repaired, and she was discharged to the plastic surgery clinic after 17 days on admission.

Case report 4

This involved a 26-year-old female and her 34-year-old male ex-lover for whom she had a child. She was bathed with an obnoxious chemical agent by her aggrieved ex-lover as punishment for breaking up with him. She sustained chemical injuries to the face, both upper limbs and anterior chest wall. At presentation, she was in painful distress with PR 92/min, BP 110/80 mmHg and RR 22/min. Examination revealed bilateral ocular chemical injury and 12% total burnt surface area cutaneous chemical injury. The patient had interdisciplinary management involving plastic surgeons, ophthalmologists and psychiatrists. She has had five sessions of corrective reconstructive surgeries and is still being followed up in the plastic surgery and ophthalmology clinics.

Discussion

Murders by intimate partners constitute a substantial proportion of homicides globally – accounting for about 40% of all female murder victims and 6% of all male murder victims.[23] On average, it is estimated that 137 women are killed by intimate partners daily across the world.[16,24] Despite the paucity of data in Nigeria, spousal violence is on the increase.[6] Admittedly, the country has endured an unending timeline of harsh economic realities. Further, western urbanisation has eroded the traditional support of her extended family system. The psychological effects from these are unpredictable and could stir up emotional distress or trigger underlying mental health issues.

Intimate partner violence/IPH results from the interplay of factors (individual and socio-cultural) that cut across several levels of influence in the society. Common risk factors are prior experiences of domestic violence (childhood and inter-parental violence), drugs, alcohol and substance abuse, negative emotionality (estrangement, desperation, fear, morbid jealousy, intense anger or rage) and impulsivity or lack of restraint, history of mental illness (psychotic disorder, major depression, mania, bipolar disorder and obsessive–compulsive disorders).[25,26] Other contributing factors include the sociocultural norms of the community and circumstantial or situational factors such as access to firearms, self-defence, retaliation and economic pressures. In the first case report, the perpetrator (hunter) had access to a firearm, while the second case report demonstrated how anger/rage and jealousy could trigger homicidal acts in the absence of psychotic behaviour.

Victims are primarily females due to gender inequalities and imbalance of power.[27] Women were the principal victims in the four scenarios reported. IPH is recognised as an essential risk factor for death and disability among women.[28,29] The female victim in case report 1 is yet to ambulate without a wheelchair. While men are more likely to perpetuate severe domestic violence, they are less likely to report domestic violence perpetrated by a female partner.[30] Perpetrators of IPH are substantially more likely to commit suicide following the homicidal act.[16] This was observed in two of the cases reported and demonstrated extreme despair despite claims of doing it out of fear of the consequences of murder.

The injuries sustained vary and depend on the method(s) of homicidal assault and part of the body where the impact is inflicted. The severity of initial insult, promptness of emergency rescue effort and first aid measures and availability and access to definitive care are the major determinants of the overall treatment outcome. Management should be multidisciplinary and holistic. Core management principles consist of emergency care for life-threatening injuries, definitive wound care, treatment of instigating or precipitating risk factors and rehabilitation (mental, psychological and social) of the victims and culprit (where applicable). The psychological effects on the victims are daunting despite recovery from the physical insult. Disabilities and deaths occurring from these violent acts cause significant economic loss to the family and society. Mental healing may require social justice and compensation for the victim.

Prevention is golden, requiring the involvement of stakeholders at all levels – the communities, religious groups, institutions and the government.[31] Preventive and protective measures for the vulnerable include legal policies to prosecute spouses who abuse their partners, national policies for those charged with assault against an intimate partner (e.g., the batterer intervention programme), governmental/non-governmental victim support programmes and gun laws.[32-34] In Nigeria, legislators, civil societies and activists must sustain the push for enacting federal laws and stronger national response and support for domestic and intimate partner violence issues. Partners who decide to stay together could benefit from various cognitive and behavioural therapies such as domestic conflict containment

programme, behavioural couple's therapy and physical aggression couples treatment.[35,36]

Conclusion

IPV and spousal homicide in Nigeria are on the rise and mostly under-reported and undocumented. At present, it is more or less a neglected menace. The prevention and mitigation of the consequences of IPV should both be proactive and comprehensive. This requires a good family support system, enactment and enforcement of local and national policies to punish gender violence offenders as well as support of the international community. Any approach that is short of this, in commitment and order, is at best only palliative.

Ethical consideration

Verbal permission to publish each case report was obtained from the patients. The initials of patients' names and their occupations were not mentioned to ensure their confidentiality and anonymity. The hunter was mentioned only to explain his access to a firearm.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patients have given their consent for their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

References

1. Krug EG, Mercy JA, Dahlberg LL, Zwi AB. The world report on violence and health. Lancet 2002;360:1083-8.
2. World Health Organization. Global and Regional Estimates of Violence against Women Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence. Italy: World Health Organization; 2013.
3. Dillon G, Hussain R, Loxton D, Rahman S. Mental and physical health and intimate partner violence against women: A review of the literature. Int J Family Med 2013;2013:313909.
4. Solanke BL. Does exposure to interparental violence increase women's risk of intimate partner violence? Evidence from Nigeria demographic and health survey. BMC Int Health Hum Rights 2018;18:1.
5. García-Moreno C, Jansen H, Ellsberg M, Heise L, Watts C. WHO Multi-Country Study on Women's Health and Domestic Violence against Women: Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva: WHO Press, World Health Organization; 2005. p. 206. Available from: http://whqlibdoc.who.int/publications/2005/924159358Xeng.pdf. [Last accessed on 2021 Feb 03].
6. Aborisade RA, Adedayo SS, Shontan AR. Spousal homicide in Nigeria: Socio-psychological profiles of men who kill their wives. J Manage Soc Sci 2019;8:457-502.
7. Heimer K, Wittrock S, Unal H. Gender, crime and the economic marginalization of women. In: Heimer K, Kruttschitt C, editors. Gender and Crime: Patterns of Victimization and Offending. New York: New York University Press; 2005. p. 115-36.
8. Lawson J. Sociological theories of intimate partner violence. J Hum Behav Soc Environ 2012;22:572-90.
9. Archer J. Sex differences in aggression between heterosexual partners: A meta-analytic review. Psychol Bull 2000;126:651-80.
10. Swan SC, Gambone LJ, Caldwell JE, Sullivan TP, Snow DL. A review of research on women's use of violence with male intimate partners. Violence Vict 2008;23:301-14.
11. CLEEN Foundation. Public Presentation of Findings of the National Crime Victimization and Safety Survey in Nigeria: CLEEN Foundation; 2013.
12. Organisation for Economic Co-operation and Development. Social Institutions and Gender Index: Nigeria Profile. 2014. Available from: http://genderindex.org/country/nigeria. [Last accessed on 2021 Oct 22].
13. Benebo FO, Schumann B, Vaezghasemi M. Intimate partner violence against women in Nigeria: A multilevel study investigating the effect of women's status and community norms. BMC Womens Health 2018;18:136.
14. National Bureau of Statistics. Crime statistics. Nigeria. April, 2016.
15. Campbell JC, Glass N, Sharps PW, Laughon K, Bloom T. Intimate partner homicide: Review and implications of research and policy. Trauma Violence Abuse 2007;8:246-69.
16. Caman S. Intimate Partner Homicide Rates and Characteristics. Thesis for Doctoral Degree (Ph.D). Stockholm, Sweden: Department of clinical neuroscience – Karolinska Institutet; 2017. p. 1-82.
17. Noah Y. Incidence and dimension of violence against women in the Nigerian society. A case study of Ilorin Township. Centrepoint J 2000;10:65-76.
18. Nnadi I. An insight into violence against women as human rights violation in Nigeria: A critique. J Polit Law 2012;5:3.
19. Bazza HI. Domestic violence and women's rights in Nigeria. Societies Without Borders 2010;4:175-92. Available from: https://scholarlycommons.law.edu/swb/vol4/iss2/6. [Last accessed on 2021 Oct 24].
20. Onyemelukwe-Onuobia C. Eradicating domestic violence in Nigeria (½). Daily Times. 2012 Nov 18.
21. Canada: Immigration and Refugee Board of Canada, Nigeria: Domestic Violence, Including Lagos State; Legislation, Recourse, State Protection and Services Available to Victims; 2014, NGA 104980. E. Available from: https://www.refworld.org/docid/54816e14.html. [Last accessed on 2021 Jul 24].
22. Eze-anaba I. Domestic violence and legal reforms in Nigeria: Prospects and challenges bepress Legal Series. Working Paper 1507; 2006. Available from: https://law.bepress.com/expresso/eps/1507. [Last accessed on 2021 Oct 24].
23. Ben-Zeez A. Why do (some) men murder the wives they love? Is killing out of love possible? In: Psychology Today. Sussex: Sussex Publishers, LLC; 2014. Available from: https://- www.psychologytoday.com/blog/in-the-name-love/201409/whydo-some-men-murder-the-wives-they-love. [Last accessed on 2021 Mar 05].
24. UNODC, Global study on homicide: Gender-related killing of women and girls; Vienna. 2018. p. 10.
25. Capaldi DM, Knoble NB, Wu Shortt J, Kim HK. A systematic review of risk factors for intimate partner violence. Partner Abuse 2012;3:231-80.
26. Abramsky T, Watts CH, Garcia-Moreno C, Devries K, Kiss L,

Ellsberg M, *et al*. What factors are associated with recent intimate partner violence? Findings from the WHO multi-country study on women's health and domestic violence. BMC Public Health 2011;11:109.
27. Wallace H, Robertson C. Intimate partner abuse and relationship violence. In: Family Violence: Legal, Medical and Social Perspectives. New York, Abingdon, UK: Routledge; 2016. p. 48-50.
28. Begg SJ, Vos T, Barker B, Stanley L, Lopez AD. Burden of disease and injury in Australia in the new millennium: Measuring health loss from diseases, injuries and risk factors. Med J Aust 2008;188:36-40.
29. Norman R, Schneider M, Bradshaw D, Jewkes R, Abrahams N, Matzopoulos R, *et al.* Interpersonal violence: An important risk factor for disease and injury in south Africa. Popul Health Metr 2010;8:32.
30. Dutton DG, Nicholls TL. The gender paradigm in domestic violence research and theory: Part 1 – The conflict of theory and data. Aggress Violent Behav 2005;10:680-714.
31. Aihie ON. Prevalence of domestic violence in Nigeria: Implications for counselling. Edo J Couns 2010;2:1-8. [doi: 10.4314/ejc.v2i1.52648].
32. Zarling A, Bannon S, Berta M. Evaluation of acceptance and commitment therapy for domestic violence offenders. Psychol Violence 2017;9:257-66.
33. Banks L, Crandall C, Sklar D, Bauer M. A comparison of intimate partner homicide to intimate partner homicide-suicide: One hundred and twenty-four new Mexico cases. Violence Against Women 2008;14:1065-78.
34. United Nations Office on Drugs and Crime. Statistics and survey section. In: Global Study on Homicide 2013. Vienna: United Nations Office on Drugs and Crime; 2013.
35. Adams D. Treatment models of men who batter: A profeminist analysis. In: Yllo K and Bograd M, editors. Feminist Perspectives on Wife Abuse. Sage Publications, Inc.; 1988. p. 176-99.
36. McCollum EE, Stith SM. Conjoint couple's treatment for intimate partner violence: Controversy and promise. J Couple Relatsh Ther 2007;6:71-82.