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Multimodal Counselling Therapy in the Management of Intimate Partner Violence among Married Couples in Owerri, Nigeria

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Abstract

The study investigated the effectiveness of Multimodal Counselling Therapy (MCT) in managing intimate partner violence such as all forms of wife battering, whether physical, psychological or emotional and marital rape. The study adopts pretest, post test, and control group quasi experimental design using a 2x2 method. Participants for the study included (10) identified married couples (20 subjects) experiencing domestic violence. They were randomly assigned into MCT treatment group and the control. Participants in the MCT group received treatment on multimodal therapy while the control group received placebo. Components of the MCT therapy include: empathy, rapport, anxiety management self-control, conflict resolution skills, effective communication skills, assertiveness and social skills training. Findings reveal that MCT was very effective in reducing intimate partner violence. It was also discovered that participants with higher educational level yielded more to treatment effects than their counterparts with low educational level. Recommendations were made based on the findings of the study.

Keywords: Multimodal counselling theraphy, Intimate partner viiolence, Owerri Nigeria.

Contents

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1. Introduction

Intimate Partner Violence is a behavioral condition that is often manifested within the home. This form of violence is prevalent in all climes and cultures. As Dahlberg and Krug (2002) and UNICEF (2005)would posit, it is a regular phenomenon that occurs globally in most parts of the world. It is the intentional and persistent abuse of one's intimate partner at home in a way that causes pain, distress and injury (Aihie, 2009). The National Domestic Violence Hotline (National Domestic Violence Hotline, 2007) sees domestic violence as a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. For Krug *et al.* (2002) it is any act of physical, sexual or emotional abuse by a current or former partner whether cohabiting or not. Any act or omission committed within the framework of the family by one of its members that undermines life, bodily or psychological integrity, or the liberty of another member of the same family or which seriously harms the development of his or her personality falls under this category.

Intimate partner violence (IPV) occurs in marital relationship and among other intimate partnerships practiced by same-sex, cohabiting and dating couples. This aberrant behavioral tendency is almost always veiled, given that it is often played out at the home theatre, specifically within the confines of the conjugal arena. Apart from marital relationship, other intimate partnerships exist in Nigerian society although culturally not acceptable and therefore data about that are scanty. The thrust of this study is on violence occasioned by marital relationship and how such a condition can be managed using multimodal therapy.

Abuse in marital relationship can be physical, sexual, emotional, economic and psychological although physical abuse is mostly noticed since it comes with visible and observable imprints. IPV as reported by NDVH (2007) can be manifested through blame, fright, intimidation, terror manipulation, humiliation, hurting, injuries and wounds. According to Lee (2000) signs and symptoms of violence include: message of embarrassment, shame, guilt, physical injuries on all parts of the body and sexual assault. Severe cases can lead to medical conditions such as traumatic brain injury, post traumatic stress disorder, sexually transmitted diseases, ulcer etc.

The prevalence or existence of intimate partner violence in contemporary human societies is not in doubt. As reported by Bureau of Justice Statistics (2008) out of about 59 million couples living together in the United States, 15 million experience IPV each year and more than 3 million live out serious episodes of assault. Djaden and Thoennes (2000) also noted that in the USA, each year, women experience about 4.8 million IPV related physical assault and rape cases while men are victims of about 2.9 Million physical assaults.

IPV is prevalent in parts of Third World and West Africa. According to Aihie (2009) a study carried out by IRIN (2007) revealed that 25% of women in Dakar and Kaolack in Senegal are victims of physical attacks by their partners. It is even disheartening that most of the 60% victims that reported to family members were advised to be quiet and endure the abuse. The study also reported that 56% of Indian women surveyed by an agency justified life battery for poor culinary techniques, disrespect to in-laws, inadequate mentoring of the girl-child, and leaving home without information.

According to Amnesty International (2004a) between one third and two thirds of women in Nigeria are believed to have been victims of physical, sexual and psychological violence, inflicted on them by their intimate partners. The situation is worse in Nigeria and the major cause is that most IPV cases are neither reported nor documented. This stems from the fact that culturally, IPV is still regarded as a family secret and married partners may not want to report their suffering for fear of stigmatization and labeling. Narayan (2000) noted that in many social contexts, intimate partner violence (physical, sexual, psychological) is supported by social norms such as a cultural ideology which promotes the primacy of men over women. In severe cases of abuse, women may not want to leave for reasons ranging from losing custody of the children, employment, lack of property, poor pecuniary standing to not being able to care for the children.

Other correlates of IPV may be poverty, low self-esteem, and low academic achievement, lack of social network, social isolation, substance abuse, and cultural male dominance. Victims may also develop difficulty in trusting others, anger and stress which may lead to depression, poor self confidence, suicidal thinking, suicidal act, suicidal ideation. It limits the victim's personal growth, productivity, socio-economic roles and physical and psychological health (Esere *et al.*, 2009). There is without doubt, an ever increasing need for the management of the trauma associated with IPV. This study is designed to offer a therapeutic panacea for couples involved in IPV through multimodal counseling approach.

Multimodal therapy is a comprehensive, holistic and systematic counseling approach that combines features from several theories towards assessing, analyzing, understanding and treating all modalities of human personality problems developed by Lazarus (1989). The therapy is grounded in social-cognitive theory, and adopts technical eclecticism that borrows techniques from many other therapeutical approaches. Such techniques include anxiety management training, behavior rehearsal, bibliotherapy, biofeedback, communication training, contingency contracting, meditation, modeling, positive imagery, positive reinforcement, relaxation training, self instruction training, sensate-focus training, social skills, assertiveness training, time projection and thought-stopping (Corey, 2005). Most of these techniques are applied in this study to build the multimodal treatment package. Kottler (2004) also maintains that the therapy guides in understanding: (a) how the client characteristically functions (b) how, where and why the presenting problem manifests itself (c) how specifically to use the profile as a blueprint for promoting change in individuals.

Multimodal therapy relies on seven broad interrelated modalities of human personality and functioning with the acronym BASIC ID where B= behavior, A= affective response, S= sensations, I= imagery, C= cognitions and other broad life style and health issues including nutrition, medication, exercise, sleep, self care. Applying multimodal therapy in this study, the therapist used didactic and psycho educational approaches such as coaching, advice-giving, skills training and home work as suggested by Webber and Mascari (2009) in managing intimate partner violence among participants. During therapy, the therapist was active, humanistic, positive and flexible as she serves as a trainer, educator consultant and role model, providing viable and usable information, construction, feedback, challenging self defeating beliefs, offering constructive criticism and suggestion (Corey, 2005); (Webber

and Mascari, 2009). The study finally ascertained the effectiveness of carefully selected multimodal treatment therapy on intimate partner violence in Owerri, Nigeria.

1.1. Purpose of the Study

The study is carried out to:

a) determine the efficacy of multimodal counseling therapy (MCT) in managing intimate partner violence among couples
b) ascertain the effect of treatment based on educational level

1.2. Research Question

1) Will MCT reduce intimate partner violence among married couples?

1.3. Research Hypotheses

1. There is no significant difference between the mean scores in violent behaviors among intimate partners in the multimodal counseling therapy MCT) and the control at posttest.
2. There is no significant difference in the treatment effect based on educational level.

1.4. Research Design

The study is quasi experimental and adopts a pre-test, post-test, control group method. The study also adopted a 2x2 design with the treatment group of multimodal counseling therapy (MCT) and control forming the row while educational levels (high and low) formed the column. The participants were randomly assigned into MCT treatment group and the control.

1.5. Participants and Setting

The population of study consists of all married couples in Owerri Municipal Council, Imo State Nigeria who are experiencing domestic violence. The actual number of couples experiencing Intimate Partner Violence cannot be determined. This is because culturally, couples would want to maintain secrecy in their domestic affairs. With the help of friends and three trained research assistants, twenty four married men and women were identified. They were asked to come along with their spouses. Those whose partners refused to honour the invitation were disqualified. Ten out of the twenty four identified subjects were randomly selected through their responses on the intimate partners violence identification questionnaire (IPVIQ) making a total of twenty participants for the study. Educational level was considered in the selection. High level (OND/NCE, HND, first degree and higher degree holders), Low level (No formal education, primary and secondary school education). The twenty participants were further administered with Intimate Partner Violence Checklist (IPVC) to collect baseline data for the study. Therapy was given to the participants on an agreed venue in Owerri. They were assigned to two groups of MCT and the control. Only those in the MCT received intervention treatment while the control received placebo.

1.6. Instruments

Intimate partner violence identification questionnaires (IPVIQ) and intimate partner violence checklist (IPVC) used for data collection in this study have thirty items each on four point scale of strongly agree, agree, disagree and strongly disagree. The instruments yielded to a test retest reliability of 0.74 and 0.81 respectively after two weeks interval and adequate content validity after scrutiny by two professionals in guidance and counseling and one in measurement and evaluation.

1.7. Procedure for Data Collection

Data were collected at pre-test, treatment and post-test stages. The baseline data were established using IPVC. Treatment was based on a multimodal counseling therapy. There were five sessions of treatment that lasted for 90 minutes each. The MCT treatment packages include:

Session I

- Creation of rapport
- General briefing on the aims of the therapy
- Signing of the contract form

Session II

- General discussion on all forms of violence among intimate partners (physical, sexual, emotional, psychological)
- Teaching on empathy and rapport

Session III

- Discussion on the causes of domestic violence
- Teaching on self control and effective communication skills
- Rehearsal on the skills learnt.

Session iv

- Discussion on the consequences of intimate partner violence
- Lectures and training on social and assertiveness skills

Session v

- Teaching on conflict resolution skills
- Tasks and assignments, progress verification, feedback

2. Results

Research question: will MCT reduce intimate partner violence among couples.

Table-1. Data for mean scores of MCT reduction of intimate partner violence among couples

S/N		Pre-test X	Post-test X	Treatment effect
1.	Does not permit my meeting and interacting with friends	2.8	1.3	Positive
2.	Restricts interaction with my family members	3.2	1.7	P
3.	Does not permit my handling money	3.6	1.8	P
4.	Does not permit me to make choices of items	3.2	1.4	P
5.	Does not allow me to buy things myself	3.1	1.4	P
6.	Irritated, suspicious, angry if I talk to other men.	3.5	1.6	P
7.	Accuses me of being unfaithful	3.0	1.5	P
8.	Insists on always knowing where I am	2.8	1.5	P
9.	Treats me like a servant	2.8	2.2	P
10.	Does not allow me to partake in decision making	3.2	1.6	P
11.	Keeps away from home for days/weeks without informing me	2.9	2.2	P
12.	Keeps away from home for days/weeks without giving me money	3.1	1.3	P
13.	Unfaithful to me and keeps extra-marital relationships	3.7	2.7	N
14.	Does not react against his relatives when they insult me	3.1	1.6	P
15.	Teams up with his relations against me	3.2	1.5	P
16.	Insults me in front of others	2.9	2.3	P
17.	Threatens to harm me physically	3.1	2.4	P
18.	Slaps me	2.9	1.6	P
19.	Beats me on other parts of the body	3.0	1.8	P
20.	Twists my arms	2.7	1.5	P
21.	Pushes/shakes me or throws something at me	3.2	1.5	P
22.	Kicks me	2.9	1.8	P
23.	Pulls my hair	3.2	1.7	P
24.	Pushes me with fist or some objects	3.0	2.2	P
25.	Drags me	2.8	1.7	P
26.	Inflicts burns on me	2.8	1.9	P
27.	Ignores me purposely by not having sexual intercourse with me	3.2	1.6	P
28.	Has sexual intercourse with me forcefully when I am not interested	3.1	2.6	N
29.	Attacks me with knives or some other weapons	3.2	1.8	P
30.	Forces me to engage in un-natural sexual practice which I hate.	2.5	1.3	P

2.1. Testing the Hypotheses

1. There is no significant difference between the mean scores in the violent behaviours among intimate partners in the MCT and the control group at post-test.

Table-2. ANCOVA Statistics of post-test scores of treatment groups

Sources of Variation	DF	SS	MS	F-CAL	F-CRITICAL
Rows	2	4218.75	2109.38	39.86	3.49
Columns	1	490.44	490.44		
Interaction	1	490.44			
Within	19	5199.63			

Baseline mean score =MCT =95.10 and control= 94.30

The hypothesis one is rejected based on the fact that the ***f-cal*** of 39.86 is greater than the ***f critical*** (3.49) at 0.05 level of significance (see Table 2).

2. There is no significant different in the treatment effect based on educational level at post-test

Table-3. ANCOVA statistics of post-test scores of high and low educational levels

Source of Variation	DF	SS	MS	F-CAL	F-CRITICAL
Btw.(Col.)	12	731.46	565.73	5.83	4.10
Error	7	438.94	62.71		
Corrected total	19	1170.40			

= $p<0.05$

Hypothesis two is also rejected. The data presented in Table 3 shows that the ***f.cal*** of 5.83 is greater than ***f critical*** of 4.10 at 0.05 significant levels.

3. Discussion of Findings

The result of the study shows that the MCT was very beneficial to subjects exposed to the therapy. Reductions in intimate partner violence of participants were demonstrated in the difference between the pre-test and the post-test scores as shown on Table 1. Data as presented on Table 1 reveal that at pre-test all the items in the questionnaire were significant which implies that all the twenty participants used for this study were involved in domestic or partner violence. The result became positive at post-test which is attributed to the MCT treatment effect.

It is pertinent to note that treatment effect did not change infidelity, extra-marital relationship, sexual abuse and exploitation and its concomitant emotional consequences on participants. This confirms the findings of Esere *et al.*

(2009) that intimate partners especially women experience sexual harassment, exploitation, assault and intimidation but are not reported because of associated social stigma. Culture and religion as noted by Afro News (2007)are also reasons why assaulted partners may continue to endure abuse. In a similar study by Chima (2013) culture was seen as supporting and fuelling male chauvinism and jingoism and show of superiority. On the other hand, Christian tenets that are anchored on the indissolubility of marriage "till death do us part" may contribute to continued endurance and suffering in troubled marriages.

The result as presented in Table 2 on the efficacy of multimodal counseling therapy reveals that there is significant difference in the mean scores of those in the treatment group and the control at post-test. The ***f-cal*** (39.86) which is greater than the ***critical f*** (3.49) portrays the efficacy of multimodal counseling therapy. The potency was demonstrated in its capability in reducing the violent behaviors of intimate partners against each other. This corroborates the assertions of Lazarus (2005); Corey (2005) and Webber and Mascari (2009) that multimodal therapy is a comprehensive, holistic and systematic counseling approach that combines features from several theories towards assessing, analyzing, understanding and treating all modalities of human personality problems including marital violence.

It is also evident from this study that there is a significant difference in the treatment effects of participants based on educational level (high and low) at post-test. The treatment favored participants with higher educational level than their counterparts in the lower rung. This may be as a result of the fact that an educated person understands his or her self worth and also financially and economically independent unlike their counterparts who as a result of educational level are disadvantaged. This goes to confirm the assertions of Esere *et al.* (2009) that IPV may be as a result of poverty, low self-esteem, low academic achievement, cultural male dominance etc. It also supports Chima (2006) position that education influences women empowerment at the same time boosts their image in public life, politics and employment.

4. Conclusion and Recommendations

From the foregoing, it can be seen that this study has portrayed the efficacy of multimodal counseling therapy in bringing calmness and reducing aggression and violence among intimate partners. It has also demonstrated the importance of education given that treatment favored more participants with higher educational levels. Based on findings emanating from the study, it is recommended thus:

1. There is need to involve all stakeholders made up of religious groups, institutions, community members, psychologists, counselors and government in anti-domestic violence campaign.
2. There is need for seminars, workshops on the ills of intimate partner violence.
3. Increased emphasis should be laid on marital and family counseling and intimate partners should seek the services of professional and competent marital counselors to keep their marriages alive.
4. There is need for pre-marital counseling and platonic courtship before engaging in a marital relationship. Emphasis should be on establishing unconditional love for one another and ascertaining compatibility of partners.

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