CHAPTER 1

GENERAL INTRODUCTION AND AIMS

Carol was stabbed 27 times by her partner. This incident occurred at 11h00 in the morning in the front garden of their house. Although a small crowd gathered, no one helped her. At the time of the stabbing she was pregnant with their third child. She tried to rationalise his behaviour by quoting his favourite saying: “I only do this to show you my love, I am just a bit jealous”. After being discharged from hospital, Carol and her children moved to an unknown destination. At that stage Carol’s partner was HIV positive and Carol was not. After two years he found her and begged her to take him back. She did, and he has now threatened to kill her; during one of the many physically abusive incidents he fractured her skull. She has tried to have him removed from her house, has obtained a protection order, but she is unable to get him out of her house. Carol is now also HIV positive.

After a heated argument in which Gloria “did not listen to her partner” Gloria’s ears were amputated by him. She took him back after he apologised profusely. Today, she is also missing her lower lip, which was removed by him because “she talked back when she was supposed to be quiet and listen”. Gloria decided to leave her partner – this time for good.

The above are only two of many cases that have been reported to support organisations such as People Opposing Women Abuse (POWA). Since I started working at POWA in September 2002, my impressions have led to the following questions:

What happens to abused women? Their partners kill some (also termed “intimate femicide”); some commit suicide and a few women kill their abusive partners. Some women stay and take the abuse. Some leave, only to return time and time again to the abusive relationship. Few leave never to return.

To an outsider the easiest and most obvious choice for abused women is simply for them to leave! However, this is the option least taken and seldom with much effect. All these strategies are efforts by women to cope with the abuse and reflect the strong belief that they are trapped with little choice. Many women survive because of their decision to stay with an abusive partner. What makes a woman leave and not return and why is this choice the method least preferred by women to cope with abuse? What determines the success rate of this strategy?

I then decided to investigate the processes involved in the formation and break up of abusive relationships and the processes by which abused women start new lives.

OVERVIEW OF THE PROBLEM

The impact and consequences of violence against women are far reaching. Physical and mental health problems include depression, anxiety, eating disorders, sexual dysfunction and reproductive health issues. The increased risk that women in abusive relationships may contract HIV further complicates the problems faced by abused women (World Health Organisation, 2000).

Physical injuries (ranging from light injuries to severe injuries and homicide or suicide) add to the impact of repeated and long-term emotional and verbal abuse.

The burden of the demand for health care services, for abused women who report with physical injuries, is high. The societal impact also includes indirect effects such as the drain on an economically productive workforce and the generation of a climate of fear, insecurity and intimidation (World Health Organisation, 2000).

World Health Organisation estimates of Violence against Women

It is estimated that violence against women is as serious a cause of death and incapacity as cancer and a greater cause of ill health than traffic accidents and malaria combined (World Bank, 1993). It is further estimated that one in five women world-wide have been sexually or physically abused in their lifetime. Many girls and women are repeatedly subjected to abuse. This number does not include those abused

emotionally and financially or those without severe physical injuries. Adding these would increase the number substantially (World Health Organisation, 2000).

Reliable studies have indicated that between 10-50% of women report lifetime prevalence of physical abuse by an intimate partner. Population based studies have reported that between 12–25% of women have experienced attempted rape or forced sex in their lives. Interpersonal violence was the 10th leading cause of death of women between 15 and 44 years of age in 1998. Most of these studies indicated that the perpetrators of violence against women are almost exclusively men, that women are at greater risk from men known to them and that physical abuse is nearly always accompanied by severe psychological and verbal abuse (World Health Organisation, 2000).

Statistics Canada (1993) describes in a national sample of 123 000 women that 29% of ever married or common-law wives had experienced physical abuse by a partner. The percentage in the United Kingdom was 25%, while in the United States 28% of women presented with a lifetime prevalence of being physically abused by a partner (Mooney, 1995; Straus & Gelles, 1986). The percentages were much higher for women in Africa. A study in Kenya found that 42% of women reported being beaten often (Raikes, 1990). In Uganda 41% of women reported being beaten and in Zimbabwe the percentage was 32% (Blanc, Wolff, Gage, Ezeh, Neema, & Ssekamatte-Ssebuliba, 1996; Watts, Ndlovu & Keogh, 1996). All these studies were large-scale surveys and investigated only physical abuse.

The WHO is currently undertaking a multi-country community based survey in seven countries world-wide. The preliminary results for five of the countries (Namibia, Peru, Brazil, Japan, and Thailand) found that the lifetime prevalence of physical abuse was between 19% (Japan) and 61% (Peru). The prevalence of physical abuse in the previous 12 months was between 3% and 25%. The prevalence of sexual violence was between 6% and 47%. Between 21% and 46% of the abused women never talked to anyone about the abuse and 50% to 90% never sought help, mostly because they regarded violence as normal or since they feared the consequences. More than 50% of the women never tried to leave, while half of the ones who did try to leave left more than once, mostly after their lives were threatened. They returned because they had

nowhere else to go. It was also found that women were not passive, but actively tried to find feasible solutions to end the violence (Janson, 2003).

Violence against Women in South Africa

When reviewing the incidence of physical abuse against women in South Africa, the following came to light. No current statistics regarding actual cases of violence against women are available for South Africa. The latest available statistics are for 1998, when it was estimated that their intimate partners physically assaulted 6% of adult women in the past 12 months and that 16% were ever physically abused in their lifetime (South Africa, Department of Health, 1999). There are also no statistics available from the South African Police Services for reported cases of domestic violence or other crimes committed against women by their intimate partners (I. du Plessis, personal communication, 24 April 2003).

Few population-based studies have been conducted in South Africa to determine the prevalence of these crimes. A cross sectional study was however undertaken in three provinces of South Africa (Mpumalanga, Eastern Cape and Northern Province). The lifetime prevalence of domestic violence was 24.6% (95% CI 21.5-27.6). The prevalence of domestic violence in the previous year was 9.5% (95% CI 7.5-11.5) and the prevalence of domestic violence or threats of violence in the previous year was 11.6% (95% CI 9.4-13.8). Of the women experiencing violence, 45.9% reported injury in the past year (Jewkes, 2002; Jewkes, Levin & Penn-Kekana, 2002, 2003).

Research done by the Centre for Study of Violence and Reconciliation (CSVR) has determined that in South Africa on average a woman is killed every six days by her intimate partner (Mathews, Abrahams, Jewkes, Martin & Vetten, 2003; Vetten, 2003).

Apart from formal research and official statistics the popular press tells its own story about the extent and seriousness of the problem. Headlines in newspapers stories do not reflect the full extent of the problem, since only sensational stories of brutal crimes or crimes by or committed against famous people are generally covered.

The following are headlines in only five newspapers over a six week period from 28 August to 13 October 2003.

Suicide after hacking wife to death

(*Star*, 13 October, 2003)

Wife-bashing doesn't rouse govt to act
(*Star*, 12 September, 2003)

They vowed: till death do us part: and that's exactly how their marriage ended – she got death, and he got life for arranging it.
(*Star*, 10 September, 2003)

Pastor guilty of killing wife
(*Citizen*, 9 September, 2003)

I Didn't plan my wife's murder, pastor tells court
(*Star*, 5 September, 2003)

Murder spouse 'gave three versions'
(*Citizen*, 4 September, 2003)

Husband arrested over wife's death by crossbow
(*Star*, 2 September, 2003)

Mamoepa accused of beating wife
(City Press, 31 August, 2003)

Husband deserts "trapped" wife
(*Star*, 30 August, 2003)

Hubby takes own life after shooting wife and son
(*Citizen*, 29 August, 2003)

Beware the stranger in your shadow
(*Star*, 29 August, 2003)

Limpopo woman stoned to death
(*Citizen*, 28 August, 2003)

Silent protest against violence
(*Sowetan*, 28 August, 2003)

Illustration 1: South African newspaper headlines regarding physical abuse over a six week period.

Heated debates are started each time a story is published in popular magazines and people express shock at the horror stories told. It would be impossible to attempt even to list those stories covered in one month by the popular press, which in itself tells a story.

The situation in Gauteng

In an attempt to estimate the extent of the problem of violence against women in Gauteng it is necessary to analyse the reports of People Opposing Women Abuse (POWA). The description of their clientele will also give an indication of the background characteristics of the sample frame from which participants in this study will be recruited.

Background of People Opposing Women Abuse

People Opposing Women Abuse was established in 1979 as a response to the high levels of violence against women experienced in the community. POWA was primarily initiated by volunteers and offers services to women who have experienced domestic violence, sexual harassment, rape and to adult survivors of incest. The Organisation has a strong gender sensitive stance and seeks to empower women through the process of counselling, education, advocacy and lobbying.

POWA is based in Berea, in the Johannesburg inner city area, and serves the entire province of Gauteng, with branches in Katlehong and Vosloorus in the East Rand, Sebokeng in the Vaal and Soweto. The clients are drawn mainly from the magisterial districts of Johannesburg, Vereeniging, Soweto, Randburg, Germiston, Thokoza, Kempton Park and the West Rand. POWA was the first organisation in Gauteng to set up a shelter for abused women and their children in 1984. The two shelters in the East Rand & West Rand each accommodate 10 women and their children at any given time. Although abuse of women happens across all sectors of society, POWA's focusis primarily women who come from communities with limited or no resources at all, or those who cannot afford alternative resources in their areas. These areas are some of those that historically have poor infrastructure such as no street lighting, unsafe public transport, etc. This in turn encourages an increase in crime, particularly crimes against women. These communities are also characterised by limited employment opportunities, overcrowding, lack of educational facilities, extensive

HIV/AIDS related issues and alcoholism. All these factors impact very strongly on violence against women.

Description of POWA clients during 2002

POWA served 10 000 women during 2002. This number includes 1115 clients seen in face to face interviews, 1600 telephonic counselling sessions and clients assisted with regard to legal support. Many more were helped with quick referrals (to more relevant organisations) and other information sessions, advocacy and lobbying efforts.

The following is a brief description of those clients seen during 2002 in face to face counselling sessions. The information gives of indication as the broad biographical background of the women on which this study was based. Most of POWA's clients were female and reported to POWA only once. The average age of the clients was 35 years (range: 14 to 82 years). Of all the clients 98.5% were born in South Africa, 1.2% were born in another African country and 0.3% abroad. With regard to ethnicity, 96.3% of POWA's clients were Black, 0.7% Asian, 1.4% Coloured and 1.5% White. Most of the clients were Zulu (28%), Southern Sotho (20%), Sotho (13%) and Xhosa (10%) speaking.

With regard to religion, 79% of the clients were Christian (no differentiation between Catholic and Protestant) and 14% Catholic, with only a few Muslims. The average duration of the abusive relationship was 10.25 years (range: 2 weeks to 46 years). Most of the clients were unemployed while most of the abusers were employed.

It was found that most of the abusers were husbands (64%) and boyfriends (12%) of the abused women. In 4% of cases the in-laws were the abusers while in 3% of cases the abusers were former partners (3%). Other abusers included family members, the partner's friends and strangers.

The following range and frequency of abuse were reported: rape 4% (including all types, not only in intimate relationships), sexual abuse 5% (intimate partners only), emotional abuse 31%, verbal abuse 12%, physical abuse 25% and financial abuse 23%. Most of the clients reported only one type of abuse (47%) or two types of abuse (35%) occurring simultaneously. Only 12 % of the clients reported being subjected to

three types of abuse at the same time, 5% reported four types and only one percent reported five types of abuse happening at the same time. Sexual abuse frequently occurred without other types of abuse being present at the same time. Emotional, physical and financial abuse each often occurred with one other type of abuse.

Other important issues identified in the sample included the frequent occurrence of cases where women reported that they were abused when pregnant, partners were frequently suspected of having affairs and death threats were often made towards clients. Many clients tried to commit suicide and many feared for the safety of their children. Clients frequently complained about the way cases were handled by the police (Jansen van Rensburg, 2003).

DEFINITIONS

Studies into the prevalence of domestic and gender based violence are difficult to conduct and compare. This is owing to differences in definitions used and to the influence of social and cultural norms in different countries in determining what constitutes violence.

World Health Organisation and United Nations Definition

The Declaration on the Elimination of Violence Against Women was adopted by the United Nations General Assembly in 1993. During the 49th World Health assembly in 1996, member states agreed that violence is a public health priority. Another important aspect of the 1996 assembly was the agreement on a definition of violence against women. The definition of violence against women as accepted by the WHO helps with universal consensus and in the focus of researchers world-wide (World Health Organisation, 2000). The declaration defines violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life” (Declaration on the Elimination of Violence Against Women 1993).

This definition encompasses, but is not limited to, physical, sexual and psychological violence occurring in the family. The definition also includes “battering, sexual abuse

of female children in the household, dowry related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution; and physical and psychological violence perpetrated or condoned by the state, wherever it occurs" (Declaration on the Elimination of Violence Against Women, 1993).

Definitions of the Domestic Violence Act of South Africa

The South African Government has made commitments and obligations towards ending violence against women and children under the United Nations Conventions on the Elimination of Violence Against Women. One of these is the Domestic Violence Act, which also provides specific legal definitions.

Domestic violence is defined in the Domestic Violence Act as "physical abuse, sexual abuse, emotional, verbal and psychological abuse, economic abuse, intimidation, harassment, stalking, damage to property, entry into the complainant's residence without consent, where the parties do not share the same residence: or any other controlling or abusive behaviour towards a complainant, where such conduct harms, or may cause imminent harm to, the safety, health or wellbeing of the complainant" (Domestic Violence Act No 166, 1998; Government Gazette, 2 December 1998 No 19537, p 1).

According to the Act economic abuse includes "the unreasonable deprivation of economic or financial resources to which a complainant is entitled under law or which the complainant requires out of necessities for the complainant, and mortgage bond repayments or rent in respect of the shared residence" (Domestic Violence Act No 166, 1998; Government Gazette, 2 December 1998 No 19537).

Emotional, verbal and psychological abuse include "a pattern of degrading or humiliating conduct towards a complainant, including: repeated insults, ridicule or name calling: repeated threats to cause emotional pain: or the repeated exhibition of obsessive possessiveness or jealousy, which is such as to constitute a serious invasion

of the complainant's privacy, liberty, integrity or security" (Domestic Violence Act No 166, 1998; Government Gazette, 2 December 1998 No 19537, p 3).

Harassment means "engaging in a pattern of conduct that induces the fear of harm to a complainant including: repeatedly watching, or loitering outside of or near the building or place where the complainant resides, works, carries out business, studies or happens to be: repeatedly making phone calls or introducing another person to make telephone calls to the complainant, whether or not conversation ensues: repeatedly sending, delivering or causing the delivery of letters, telegrams, packages, facsimiles, electronic mail or other objects to the complainant" (Domestic Violence Act No 166, 1998; Government Gazette, 2 December 1998 No 19537, p 3).

Intimidation means uttering or conveying a threat, or causing a complainant to receive a threat, which includes the engendering of fear. Physical abuse means any act or threatened act of physical violence towards a complainant, while sexual abuse means any conduct that abuses, humiliates, degrades or otherwise violates the sexual integrity of the complainant. Stalking in the act means repeatedly following, pursuing or accosting the complainant (Domestic Violence Act No 166, 1998; Government Gazette, 2 December 1998 No 19537).

The definition of domestic violence as stated by the Act includes all aspects of abuse and it also specifies terminology precisely. It is, however geared towards the judicial system and for this study seems limited in regard to the perceptions and emotions of abused women themselves (Domestic Violence Act No 166, 1998; Government Gazette, 2 December 1998 No 19537).

Definitions used by the People Opposing Women Abuse organisation

The POWA organisation's formal definition on abuse is: "… any pattern of behaviour that controls another person, causes physical harm or fear, makes someone do things they do not want to do, or prevents them from doing things they do want to do. Abuse can be verbal, emotional, physical, sexual, material or financial. Abused women usually experience multiple forms of abuse" (http://www.powa.co.za). This definition is mostly used in education and information sessions to enable women to recognise when they are actually abused.

BROADER SOUTH AFRICAN CONTEXT

A brief description of the historical context within which this study is undertaken is necessary. South Africa is a country with a violent past. Many conflict situations were handled by means of violence. Before the Great Trek, in which Dutch settlers tried to escape British rule in the Cape, wars between early white settlers and Africans as well as amongst African tribes themselves were common. The mfeqane ("the crushing" in Zulu), or also called the difaqane ("forced migration" in Sotho) was a time of suffering generated by the Zulu chief, Shaka in which thousands of people from other tribes were killed. The influence of several other conflicts also contributed indirectly to South Africa's interpersonal violence rates. These conflicts included the two Anglo Boer wars against an oppressing colonial power, the influence of the two World Wars, and a longstanding war in Angola that influenced the lives of many South African men who had to undergo compulsory national service in the defence force. The effects of the Apartheid era on non-white South Africans can today, 10 years after the first democratic elections, still be felt (http://www.lonelyplanet.com/destinations/africa/south-africa/history.htm).

These historical South African socio-political trends not only influenced personal experiences in dealing with interpersonal violence, but also played a role in shaping a society widely considered as violent though ultimately also a positive role in the continuing reform of the legislation in South Africa and the awareness raising activities of supporting organisations.

Legal context of domestic violence in South Africa

In order to combat violence against women in South Africa various efforts have been made. The Government and people of South Africa have prioritised the improvement of the status of women. This commitment is evident in the formation of the Office on the Status of Women (created by the Presidency in 1997 to establish mechanisms and procedures that will advance government towards gender equality), the Commission for Gender Equality (an independent public body which has a mandate to hold state organs, statutory and public bodies as well as the private sector responsible for promoting and protecting gender equality), the Constitution, and also various other laws, regulations and provisions. South Africa's legislation with regard to women's issues is widely regarded as the best in the world.

The Constitution of South Africa has specific sections dedicated to the rights of individuals, including women, to freedom of speech and movement, to equality (and non-discrimination on the basis of gender) and to the security of the person.

The Bill of Rights, Section 9, provides for equality, including the stipulation that everyone is equal before the law and has the right to equal protection by and benefit of the law. It also provides for "the full and equal enjoyment of all rights and freedoms" and no "unfair discrimination directly or indirectly against anyone on the grounds of gender, sex, pregnancy, marital status, social origin, etc". Section 10 provides for human dignity, Section 11 for the right to life and Section 12 for the freedom and security of the person. Section 12 also includes the right not to be deprived of freedom, to be free from all forms of violence from either public or private sources (and therefore also domestic violence) and the right not to be treated in a cruel, inhuman or degrading way. The section also includes the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction and to security in and control over one's body.

Other sections relevant to gender based violence include the freedom of belief and opinion (Section 15), freedom of expression (including receiving information - Section 16), freedom of movement (Section 21) and the rights to health care and social security (Section 27) (South African Constitution, 1996).

Specific legislation was also developed with regard to domestic violence and gender based violence. These laws include the Domestic Violence Act 1998 (that gives greater protection than the Prevention of Family Violence Act), the Maintenance Act 1998, the Sexual Offences Act (currently being revised, especially with regard to redefining rape), the Employment Equity Act and the 1996 Choice in Termination of Pregnancy Act. Although South African legislation is regarded internationally as amongst the most empowering for women of any country in the world, the correct implementation of these laws is still severely lacking.

The Domestic Violence Act 118 of 1998 recognises that domestic violence is a serious problem in South Africa and that domestic violence is not a private matter, but

a serious crime against society (Centre for the Study of Violence and Reconciliation, 2002). The Act stipulates the duties of any member of the South African Police Service as including to assist and inform complainants of their rights and gives peace officers certain rights regarding arresting suspects. It further allows for applications for and the issuing of protection orders and interim protection orders. The Act also defines the court's powers in respect of protection orders, warrants of arrest and the seizure of arms and dangerous weapons. The victims of domestic violence are afforded the maximum protection from domestic violence that the law can provide, but unfortunately the law enforcement aspect of the Act is mostly inadequate and law enforcement officers are ill informed. The act provides for the issuing of protection orders, but judicial officers (magistrates and judges) are still allowed to interpret the act using their own (often patriarchal) framework. Proving the presence and effects of emotional abuse is often a huge problem that leaves even the most sympathetic legal officers incapable of performing their duties.

RESEARCH PROBLEM, AIMS AND RESEARCH QUESTIONS

Violence against women is recognised worldwide as a serious social problem. Various interventions and legislation have been implemented not only internationally, but also in South Africa and regionally in Gauteng.

Considering the heritage of a violent society and the patriarchal system prevalent in almost all the different cultural systems in South Africa makes it easy to understand why interpersonal violence, especially violence against women, is so extensive and extreme in South Africa and Gauteng (Mathews *et al.,* 2003; Vetten, 2003). It is therefore fitting that this research study should focus on women in Gauteng.

Violence aimed at more vulnerable members of the community is very prominent in South Africa. Violence and the interventions used against it have been influenced by the political history of the country. Some people blame the escalation of violent crimes against women as being inherited from past atrocities such as the Apartheid regime. However, it seems that the incidence of violence against women is still on the increase, despite changes in the past ten years with regard to better legislation and the improvement in the lives of women (such as education and employment equity)

(Mathews *et al.*, 2003; Vetten, 2003). Women are still subjected to violence based on their gender.

Taking into account all the problems stated above and despite all the real efforts made to address these in South Africa, few women actually leave their abusive partners ,compared to those who stay in abusive relationships.

Women deal with domestic violence in different ways and many studies tend to focus on risk factors or reasons why women stay in abusive relationships (Jewkes, 2002; Jewkes, Levin & Penn-Kekana, 2002, 2003).

As part of developing a systematic research agenda at POWA, a number of studies addressing salient problems were executed with the present author as primary or single researcher in each case. Since in-house research in organisations such as POWA focuses on applicability, all the studies undertaken should have practical value either to POWA and its clients or to the broader Gender Based Violence sector. The research department of POWA was established in September 2002. Apart from developing administrative and other procedures and policies, various research projects were initiated. These can broadly be categorised into descriptive studies and intervention studies. Most of the focus was placed on describing POWA clients, services and best practices in an effort to document the status quo. Fewer intervention studies were attempted at the onset, since these would mostly have been based on the findings of the descriptive studies. Studies had as their focus either POWA clients, the organisation and its services or external organisations in the sector.

Studies may focus on POWA clients, such as general descriptions of the clients and their experiences. Specific sub groups of clients (including abused women with disabilities, illnesses or specific problems) also deserve special attention. External service providers and stakeholders that are often the topic of interest include the services that abused women often used and that referred clients to POWA (police services, medical practitioners and clinics) and also those to which POWA refer red clients to (legal and social services). Research regarding internal service provision includes monitoring and evaluation and other studies in order to improve service delivery to clients. The research studies span experiences ranging from intra-personal

levels (such as descriptions of experiences) to systems including medical professionals and other social services and to macro systems, such as cultural influences in legal aspects regarding abuse.

The following themes were addressed:

- With regard to POWA clients, a description was compiled of the success stories of women with a history of abuse and who left their partners in an attempt to start a new life and of the influence of various ecological systems on their experiences. This study investigated the intra-personal experiences in all the different phases in the formation of a relationship, the development of abuse and the decision and commitment to leave the relationship. The results of this study will aid one not only in understanding the resilience of these women, but will also assist other women for whom leaving the relationship is a viable option.
- One of the agents that could be assisted to improve its service delivery is the medical profession. An investigation of the experiences of recently abused women who seek help from medical practitioners was also carried out. Not only did the study provide a better understanding into the types of injuries sustained by abused women, but their needs were also determined.
- A subgroup of abused women comprises those affected by HIV. A three part study (including a record review, case studies and an environmental scan) investigated the impact of social service delivery to women who are both abused and HIV positive. These women's needs are substantially different from those affected by only one of these stigmatising conditions. Rather than focussing on abuse as a risk factor, this study attempted to gain a wider and deeper view of the interaction of abuse and HIV.
    - Internally at POWA, various factors influence the quality of service delivery to clients. One important aspect is stress and burnout amongst staff members. A comparative study therefore investigated the effects of two different intervention strategies to combat burnout in an organisation providing support to abused women.

The studies included in this dissertation reflect all the aspects of the systems relevant to the women's experience, including community, social structures, relational and interpersonal aspects.

In the following chapters each of the above themes are addressed in separate studies. In order to effect the most economical presentation of these investigations and to prepare for the possible publication thereof, these studies are presented in the manuscript form generally used for the submission of articles to scientific peer reviewed journals. In each case the notation and editorial directions of the journal that the article for publication is aimed at.. However, in order to enhance the readability of the manuscripts, it was decided to include tables and figures in the text, instead of attaching them as appendices.

In the concluding chapter the results of the different studies are combined and collated to provide a better understanding of the influence of all the different role players in the experiences of abused women and of the different strategies and agents involved in helping them cope with their situations.

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CHAPTER 2

SUCCESS STORIES OF WOMEN WHO DECIDED TO LEAVE THEIR ABUSIVE PARTNERS: A TEMPORAL, ECOLOGICAL APPROACH

This manuscript has been prepared according to the editorial guidelines of *Violence Against Women.*
Tables and figures have been placed in the text.

ABSTRACT

The success stories of women with a history of abuse and who left their partners in an attempt to start a new life were investigated and described. It was found that the influences of the different ecological systems (including factors from the individual level to cultural aspects) differed during different phases in the formation of a relationship, the development of abuse and the decision and commitment to leave the relationship. The results of this study not only aided one in understanding the resilience of these women, but will also assist other women for whom leaving the relationship is a viable option.

INTRODUCTION

Despite an advanced constitution and legislation that compares with the best in the world, the prevalence of domestic violence is South Africa is very high and seems to be on the increase. Mwamwenda (1999) found that one in four women is regularly assaulted by her husband while Vetten (2003) estimated that on average a South African woman is killed every six days by her intimate partner. The lifetime prevalence of intimate partner violence in three provinces of South Africa was found to be 24.5% (between 20 and 30%) (Jewkes, 2002; Jewkes, Levin & Penn-Kekana, 2002, 2003).

The results of being assaulted by an intimate partner include not only physical injury and emotional consequences (for example a loss of dignity and self worth), but also impact on other people's lives such as those of children caught up in the violent situation and witnessing the abuse (Mwamwenda, 1999; Riger, Raja & Camacho, 2002; Vermaak & Jansen van Rensburg, 2003).

The majority of women stay in abusive relationships despite the negative consequences, mostly out of fear of losing security, lack of a safe haven, being alone, economic dependence, love or surviving on moments of great happiness (Borochowitz & Eisikovits, 2002; Groenewald, 2000; Motigoe & Gilchrist, 1996; Mwamwenda, 1999). Many other reasons have been given for women remaining in an abusive relationship, including social isolation, financial difficulty, fear and lack of support (Follingstad, Runge, Ace, Buzan, & Helff, 2001; Groenewald, 2000). A minority of abused women however do take steps to leave and some decide to leave the abusive relationship permanently. Ellsberg, Winkvist, Peña and Stenlund (2001) found that leaving an abusive relationship temporarily helped the women in making the final decision to leave. Women underestimate the risk and their likelihood of returning to an abusive relationship and as many as 66.7% return to an abusive relationship before finally deciding to leave (Gondolf & Heckert, 2003; Griffing, Ragin, Sage, Mandry, Bingham & Primm, 2002; Martin *et al*, 2000). A third of women who stayed in shelters and returned to their partners were abused again within two years (Fleury, Sullivan & Bybee, 2000). It seems that a central feature of the decision to leave is the woman's self-concept and her perception of choice (Belknap, 2002; Busch & Wolfer, 2002) and not the severity of the abuse (Arias & Pape, 1999)

or the duration of the abuse (Rollstin & Kern, 1998). Some aspects help women to stay committed to their decision to leave, such as staying in a shelter, receiving counselling and the recognition of domestic violence as a crime (Angless, Maconachie & Van Zyl, 1998).

It seems that the whole "leaving" process is an opportunity for women to develop themselves and to redirect their energy and gain new insights into themselves and their circumstances (Lynch & Graham-Bermann, 2000; Senter & Caldwell, 2002). Several shifts in thinking about the abuse are needed before leaving (Anderson & Saunders, 2003; Martin *et al.*, 2000). Few and Bell-Scott (2002) have described four stages in the leaving process, including: separation from the abusive partner, re-establishment of social networks and self-empowerment.

Various approaches have been used to examine women's experiences of abuse. Some authors focused on experiences of women who stayed in abusive relationships or on the causes of abuse (Frisch & MacKenzie, 1991; Herbert, Silver & Ellard, 1991; Hilbert, Kolia & Van Leeuwen, 1997; Martin *et al.*, 2000; Rusbult & Martz, 1995; Truman-Schram, Cann, Calhoun & Vanwallendael, 2000) while other more qualitative studies investigated the process of leaving (Angless, Maconachie & Van Zyl, 1998; Burke, Gielen, McDonnell, O'Campo & Maman, 2001; Eldar-Avidan & Haj-Yahia, 2000; Molina, 1999; Patzel, 2001). A few studies have focused on the "post-leaving" period (Dutton & Painter, 1993; Mechanic, Weaver & Resick, 2000; Mertin & Mohr, 2001; Tutty, Bidgood & Rothery, 1993).

The focus of studies on women abuse, domestic violence (DV) and gender based violence (GBV) is mostly determined by the current dominant theoretical approach or the legal developments in the relevant country. This explains the shift from investigating intrapersonal processes (psychoanalytical theories) to investigating broader socio-cultural issues (macro systems, such as determined by feminist theory that is still widely used today). This study focused on experiences of abused women, from the formation of the relationship through the development of abuse and adjusting to a new life after leaving the abusive partner. An ecological approach is therefore more relevant in the present study. Due to the complexity and the interplay of different systems on women's experiences of abuse the ecological model can be used

to organise theories and literature on research findings. It is also used as a guide for data analyses.

Abuse and abusive relationships are of such a nature that a functional understanding thereof cannot be captured by single factor approaches. Similarly deterministic approaches cannot explain why not everyone abused as a child becomes an abuser and why not all abusers were abused as children (Brewster 2002). Making use of an ecological perspective offers a more comprehensive integrated multi- factoral model that acknowledges that behaviour is determined by a variety of factors, including factors within the person, families, social structures and the larger socio-cultural environment (Curry, Hassouneh-Phillips & Johnston-Silverberg, 2001). The interplay between people and their socio-cultural environment is of utmost importance.

It has been argued that interpersonal violence arises as a result of a combination of different factors, including individual, social, economic and political factors. Although some theorists such as members of the feminist community are reluctant to acknowledge factors other than for example patriarchy and male dominance in the etiology of abuse, lately researchers are supporting the use of models and theories that include various levels and systems (Heise, 1998).

An ecological approach can be used to explain different types of violence, including self directed, interpersonal violence and collective violence. It is also used to explain interpersonal violence aimed at different targets or victims, from children, and women to elderly (Bronfenbrenner, 1979; Garbarino, 1985; Garbarino & Crouter, 1978; Heise, 1998; Schiamberg & Gans, 1999). The World Health Organisation (WHO) also uses an ecological approach when discussing violence against women. The organisation's viewpoint is that a combination of individual biology and psychological characteristics, social, economic and political factors all determines violence against women. There are "multiple spheres of influence" that can shape risk factors (World Health Organisation, 2002). The WHO states that the influences of the different systems can also be protective and should not only seen as negative risk factors (World Health Organisation, 2002).

The risk factors described by the WHO include four interdependent levels of analysis, namely: individual, relational, community and societal dimensions. Recently theorists have extended this taxonomy by adding a fifth level. In the present study the different levels are grouped as different systems and the following terms are used. The first system is termed the *individual level* and the second, that includes the interpersonal relationships, is called the *microsystem*. The third system is called the *mesosystem* (representing the interplay between aspects of the individual's environment), the fourth is the *exosystem* or the community level and the five is the *macrosystem* that includes the culture at large (Heise, 1998).

An understanding of the interrelatedness of the different levels of functioning is very important in understanding their concurrent and synergistic dynamics. This approach centres on the complex multiple causal nature of violence and provides opportunities for intervention on different levels. However, when the temporal character of chronic violence is considered, the ecological approach to its understanding becomes even more complex than described. These five systems are not merely different levels of interpretation, but should rather be seen as different systems that are all mutually influencing each other in a complex and circular manner over time and not only operating on different levels (mostly lower levels) where each contributes to the overall effect. The interaction of the systems over time reflects ongoing mutual changes that cannot be captured by a cross sectional perspective alone.

The following is a brief description of each system, with relevant examples of factors found in each system. It aims to classify relevant research findings under appropriate systems.

Individual level

This system includes the intra-personal aspects such as biology, intra psychic functioning and personal history factors that influence the behaviour of individuals. It clarifies the possibility of a person becoming a victim or perpetrator of violence. Demographic variables such as age, education and income, psychological and personality disorders and the abuse of substances are all included in this system. Although most of these factor do not seem to play a role, poverty appears to be identified as a high risk factor in that women are more exposed to violence in poorer

communities (Sev'er, 2002; Sutherland, Sullivan, & Bybee, 2001; Tolman & Raphael, 2000). Peters, Shackelford & Buss (2002) however found that older women are less at risk than younger women. It also seems that married couples are less at risk than cohabiting couples (Brownridge & Halli, 2002). A personal history, such as a tendency to behave in an aggressive way or a history of abuse (including childhood abuse), is also included in the individual level (World Health Organisation, 2002).

Factors found to be relevant for this system include ontogenic factors (features that shape the individual's developmental experiences or personality in response to microsystem and exosystem stressors) for both the abused and the abuser. For the female victim of abuse, being the witness of interparental violence is an important factor (Coker, Hall Smith, McKeown & King, 2000). For the male abuser, being abused as a child and having an absent or rejecting father was found to be important (Heise, 1998; Markowitz, 2001; Romans, Poore & Martin, 2000).

The psychological aspects of the abuser include the use of violence and aggression as a result of childhood experiences (for both the perpetrator and the abused), personality traits (e.g. the need for power and being socially anxious), head injuries, psychopathology (antisocial personality disorders) and personality disturbances (borderline personality disorders). Poor impulse control, poor self-esteem and substance abuse by the abuser (Frye, El-Bassel, Gilbert, Rajah & Christie, 2001; Schumacher, Feldbau-Kohn, Smith Slep & Heyman, 2001; Torres & Han, 2003; Willson *et al.*, 2000) and pornography (Shope, 2004) have also been the focus of studies in the past (Brewster, 2002; Wood, Welman & Netto, 2000). Stroshine and Robinson (2003) found that abusers who have criminal records and who carry a weapon also have a greater tendency to use violence against a partner.

Biological factors are also deemed to be important. Studies have determined that testosterone levels do influence the actual aggressive behaviour of men, especially in conjunction with their having a Type A behaviour pattern (Berman, Gladue & Taylor, 1993; Gladue, 1991). Behavioural genetic studies of intimate violence are also undertaken to examine the extent to which genetics and the environment contribute to individual differences in intimate violence (Hines & Saudino, 2002).

Studies focused on the psychology of abused women included aspects such as self-blame, denial, loyalty to the marriage, learned helplessness, Post Traumatic Stress Disorder (PTSD), dissociative identity disorder, depression and feelings of being responsible for helping the perpetrator (Coolidge & Anderson, 2002; Dutton, 1993; Laporte & Guttman, 2001; Lundy & Grossman, 2001). Shame and guilt also plays a major role in keeping the woman trapped in her situation and often lead to the depression and anxiety experienced by these women (Bean & Möller, 2002; Buchbinder & Eisikovits, 2003).

According to the learned helplessness approach, abused women have a perception that they lack control and therefore do not even attempt to escape the violence. It would seem that this is especially true for women in multiple abusive relationships, including those having histories of being abused as children (Avery, Hutchinson & Witaker, 2002; Brewster, 2002).

"Battered wife syndrome" is believed to develop over time because of an extreme fear and belief that there is no escape or choice. This syndrome is often used in court cases regarding women who kill their abusive partners and is widely contested (Stevens, 1999; Walcott, 2000). It includes repeated cycles of violence which create learned helplessness behavioural patterns and symptoms such as low self-esteem, self-blame, anxiety, depression, fear, and the loss of belief in the possibility of change (Brown & Barbosa, 2001; Walker, 1979, 1984, 1992; Wiehe, 1998). Consequently the woman does not try to escape her abusive circumstances.

"Stockholm syndrome" is also often used to describe the behaviour of abused women. Women relinquish all control and see no way out of the abusive situation because of the physical and psychological threats made by the abuser. The loss of control is mostly due to the influence of occasional displays of kindness and support from the partner. The interpersonal isolation that these women are subjected to makes them emotionally dependent on the abuser (O'Leary & Maiuro, 2001).

The above mentioned approaches, that focus on the abused women's functioning, disregard all other aspects such as the perpetrator's characteristics, or social and cultural aspects and put all the blame on the woman for not leaving the relationship.

They portray the women as victims who are incapable of making any decisions. Aspects such as depression and low self esteem are seen as the cause and not the possible result of an abusive relationship. These theories are therefore regarded as extremely limited in explaining the dynamics of abusive relationships (Levendosky & Graham-Bermann, 2001). Most of the previous studies used a particular approach (level of interpretation) to explain only one aspect of abuse (e.g. its causes or reasons for leaving). The interpersonal context is usually used to investigate and explain the causes of abuse. In the present study the focus is on all levels and systems related to all the different phases in the development of an abusive relationship and the "leaving" process.

Microsystem

The microsystem is represented by the immediate interpersonal and social context. It includes the abusive relationship, but also other important relationships that shape the individual's responses to abuse. These relationships include intimate partners, family, friends and peers. All these relationships can have an influence on the risk of being a victim or perpetrator as well as on the development of the abusive relationship and the consequences thereof (including leaving or staying in an abusive relationship). The effect of such relationships therefore also influences to a large extent the recovery from abuse. This system is most often used to investigate the risks of and decisions regarding the future of an abusive relationship (World Health Organisation, 2002).

Aspects important in the microsystem include direct interactions with others and the subjective intrapersonal meanings assigned to these interactions. Family dynamics generally define the context and nature of abuse. Traits and interactional styles found to be important in the immediate context of the abuse include male dominance in the family, male control of wealth in the family, marital conflict and the use of alcohol (Heise, 1998). Women tend to disclose the abuse to a family member, yet many male family members will advise them to stay in the abusive relationship. This result could however be attributed also to the cultural background of the woman concerned (Yoshioka, Gilbert, El-Bassel & Baig-Amin, 2003).

According to researchers using the family systems approach, all family members play a role in the "construction" and maintenance of the abusive relationship. Abusive

tendencies can also be transmitted over generations. Family system approaches focus on the interpersonal processes and dynamics rather than on micro issues such as intrapsychic ones or macro issues such as the influence of the larger cultural background (Worthington, 2003; Zosky, 1999).

According to the social learning view, aggression is a learned behaviour. People learn behaviour through watching others and model their behaviour accordingly. Aggressive behaviour can also be learned through the reinforcement of the individual's own aggressive behaviour. If reinforcement occurs the behaviour will continue. Factors that increase the likelihood of aggression occurring in a specific situation include past experiences, current reinforcements, beliefs, and perceptions relating to aggression, social variables and environmental variables. This theory accepts the notion of intergenerational transmission (Bandura, 1973; Baron & Richardson, 1994; Brewster, 2002; Ragin, Pilotti, Mandry, Sage, Bingham & Primm, 2002).

Relationship satisfaction seems to be moderated by relationship status, in that serious dating relationships were found to be less satisfied than those less serious (Katz, Kuffel & Coblentz, 2002). Partner withdrawal, demands and controlling behaviours were associated with physical aggression in men, yet not in women (Katz, Carino & Hilton, 2002). It was also found that the most likely time for a woman to be killed was after announcing that she was leaving the abusive partner (De Voe & Smith, 2002; Mathews, Abrahams, Jewkes, Martin & Vetten, 2003; Vetten, 2003).

Motherhood seemed to act as a buffer against the abuse from a male partner and was a source of strength (Irwin, Thorne & Varcoe, 2002), but the threats made by partners, that a woman might lose her children in custody cases when she decided to leave (Levin & Mills, 2003) or the deliberate abuse of children in order to harm the mother psychologically (McCloskey, 2001) have severe negative implications. Children are also often hurt when they act in defence of their mothers (Hall & Lynch, 1998). All these negative influences of interparental violence on children also affect the mother's decision to leave or stay. The effects on children include PTSD symptoms (Kerig, Fedorowicz, Brown & Warren, 2000) and conduct and behavioural problems (Grych, Wachsmuths-Schlaefer & Klockow, 2002; Sullivan, Bybee & Allen, 2002; Sullivan,

Juras, Bybee, Nguyen & Allen, 2000; Waddell, Pepler & Moore, 2001). This is even evident after leaving the partner, and even in the shelter environment (Hall & Lynch, 1998; Stephens, McDonald & Jouriles, 2000; Ware, Jouriles, Spiller, McDonald, Swank & Norwood, 2001), and influences the experience of abuse later in life (Humphreys, 2001a, 2001b).

The relationship between a mother and her children influences the experience of abused women. Not only does abuse influence and challenge parenting styles, but mothers and children are mutually influenced by witnessing other being abused (Jouriles *et al.*, 2001; Levendosky & Graham-Bermann, 2000; Rhea, Chafey, Dohner & Terragno, 1996; Vermaak & Jansen van Rensburg, 2003). Child abuse seems to be present in many cases of domestic violence and women abuse (Magen, Conroy, Hess, Panciera & Simon, 2001; McCloskey, Treviso, Scionti & Pozzo, 2002).

Another interesting and important relationship is that between abused women and their pets. Pets not only offer emotional support, but concern for a pet is also often the reason why women leave an abusive relationship (Faver & Strand, 2003; Flynn 2000a, 2000b, 2000c).

Mesosytem

This newly differentiated part of the model comprises the interplay between aspects of the person's socio-cultural environment. For example the system includes associations and relationships between the immediate family and other systems such as the extended family, the neighbourhood and the work place (Chatzifotiou & Dobash, 2001). It also includes links with social support institutions such as non-governmental organisations (e.g. POWA), social services, the police service and the courts (Heise, 1998).

Social support is crucial especially during the phases where an abused woman is seeking information (confirming the abuse), contemplating leaving and during the actual leaving process, and involves the provision of financial, social and spiritual support (Davis, Taylor & Furniss, 2001; Gilbert, 1996; Humphreys, Lee, Neyland & Marmar, 2001; Schoeman & Ferreira, 2002; Thompson *et al.*, 2000; Yoshihama,

2002). Being isolated from social support is also one of the aspects sustaining abuse and causes women to remain in abusive relationships (Yoshihama, 2002).

The police service is one of the earliest and most important resources for women trying to deal with abuse (Arscott-Mills, 2001). Studies have mostly found that women experience police responses to be unsatisfactory and frustrating and that a lack of understanding exists (Hoyle & Sanders, 2000; Shoham, 2000). It seems that police personnel are more helpful when children are involved (Hutchison & Hirschel, 2001). Many women also do not lodge complaints out of fear and humiliation (Apsler, Cummins & Carl, 2002; Shoham, 2000). The positive aspect is that empowered "victims" make choices that are less coerced by their circumstances (Hoyle & Saunders, 2000). Further along the legal system, courts also do not provide women with the necessary assistance and understanding. Cassidy and Trafimow (2002) found that women were often blamed for the violence and Osthoff (2002) established that some women were even arrested and prosecuted for abusing their husbands, who were actually the perpetrators. All of this leads to secondary victimisation of abused women, which is taken even further in the defence strategies used in domestic violence felony trials that still manipulate common myths and misconceptions (Biggers, 2003; Hartley, 2001). Domestic violence is seldom seen by court officials and judges for the serious issue that it is (Andrews, 2000; Weisz, 2002). One negative consequence of the inactivity of the legal system is that women deplete all their options to deal with the violence and then kill their partners as a last resort to escape the violence (Bradfield, 2002; Leonard, 2000, 2001; Mathews, *et al.*, 2003; Vetten, 2003). However, negative effects were also present in countries that have instituted policies and laws such as mandatory arrests (Ho, 2000; Renzetti, 2001; Smith, 2000). These policies and even domestic violence laws can be seen as part of the larger macrosystem in that they govern larger institutions, but they are also influenced by, for instance, patriarchally dominated systems such as the male dominated court systems, where individual interpretations of the law play an important role in prosecuting male perpetrators and in custody cases (Smith, 2001). Court support (as also provided by POWA) clearly has a positive effect for the women involved in legal actions (Bell & Goodman, 2001).

Health care services are also often involved in women abuse issues. Some men would manipulate and abuse their partners by withholding or changing medication (Lamberg, 2000). Abused women also often reported first to health care professionals, including medical practitioners and nurses at private practices, clinics and hospitals (Gottlieb, 1998; Pakieser, Lenaghan & Muelleman, 1998).

Many studies focused on the importance of screening female patients for signs of abuse (Chamberlain & Perham-Hester, 2002; Ejaz, Bass, Anetzberger & Nagpaul, 2001; Ernst & Weiss, 2002; Goff, Byrd, Shelton & Parcel, 2001; Griffin & Kossn, 2002; Heinzer & Krimm, 2002; Mazza, Dennerstein, Garamszegi & Dudley, 2001; Mazza, Lawrence, Roberts & Knowlden, 2000; Riggs, Caulfield & Street, 2000). Screening could help especially since Kernic, Wolf and Holt (2000) found that many abused women were previously hospitalised for abuse related injuries. Yet mandatory reporting of abuse by health care workers is not always considered favourably by abused women (Sachs, Koziol-McLain, Glass, Webster & Campbell, 2002; Walton-Moss & Campbell, 2002). Health care facilities are also often used to determine the prevalence of women abuse (Bradley, Smith, Long & O'Dowd, 2002; Pakieser, Lenaghan & Muelleman, 1998).

Other studies focussed on the health consequences of women abuse, which vary from homicide and suicide (Jewkes, 2000; Sharps, Koziol-McLain, Campbell, McFarlane, Sachs & Xu, 2001; Walton-Moss & Campbell, 2002) to serious head injuries (Jackson, Philp, Nuttall & Diller, 2002; Rudman & Davey, 2000; Valera & Berenbaum, 2003) and the intersection between violence against women and their contracting HIV (Garcia-Moreno & Watts, 2000; Jansen van Rensburg, Serumaga & Nkadimeng, 2003; Jewkes, 2000). Studies have also investigated the impact of violence on physical health (Hegarty, Hindmarsh & Gilles, 2000; Kernic, Wolf & Holt, 2000) and on mental health, especially the presence of Post Traumatic Stress Disorder and depression symptoms (Bennice, Resick, Mechanic & Astin, 2003; Campbell, 2002; Jones, Hughes & Unterstaller, 2001; Mertin & Mohr, 2000, 2001; Street & Arias, 2001; Sutherland, Bybee & Sullivan, 2002; Wingood, DiClemente & Raj, 2000). Assessments (for example neurological) of abused women were also reported, but this is a very linear approach and could be one which blames the abused woman (Deering, Templer, Keller & Canfield, 2001; Stringham, 1999).

Most importantly, for women who decide to leave their abusive partners health care workers could play an important role in empowering and in referral to social support systems (Hathaway, Willis & Zimmer, 2002; Ulbrich & Stockdale, 2002). Information about women abuse should be incorporated into the training and work of medical and paramedical personnel not only to improve the understanding of the issues abused women have to face, but also to enable women to be assisted in a way that will reduce the health consequences and burden on the health care system (Barrier, 1998; Eyler & Cohen, 1999; Gottlieb, 1998; McCaw, Berman, Syme & Hunkeler, 2001; Merrell, 2001; Yam & Orandell, 2000). This has been advocated for a number of years in South Africa (Jacobs, 1998; Jacobs & Suleman, 1998; Motsei, 1994). The role of health care professionals should include documentation of injuries, information giving and referrals (Jansen van Rensburg & Van Staden, 2003, in print; Jewkes, 2000).

Exosystem

The exosystem includes the collective context of social relations within the socio-physical environment such as institutional, social, work environments and home neighbourhoods. The social structures (both formal and informal) that are expressed in an exosystem can manipulate, restrict or determine the nature and occurrence of abuse. Risk factors at this level include determinants such as population density, high levels of unemployment and low socio-economic status, the isolation of the woman and her family and peer group behaviours and influences (Heise, 1998).

The work environment is not only important in an economic sense to provide an abused woman with financial security and an increased chance of leaving successfully, but also plays an important part in providing self-esteem and endorsing her decision-making abilities (Brown, Reedy, Fountain, Johnson & Dichiser, 2000; Chronister & McWhirter, 2003). However, women may be forced into low-income employment due to gender discrimination and employment may also lead to increased violence from the partner (Riger, Ahrens & Blickenstaff, 2000).

Macrosystem

The macrosystem includes all socio-organisational structures and the ways in which they are expressed, maintained and changed by the general views, beliefs and attitudes in the culture at large. It includes all the broad organisational structures that help in the creation of a climate in which violence is either nourished or hindered (World Health Organisation, 2002). Specific aspects that are important in women abuse include aspects of legislation and policies, the general norms of what constitutes "acceptable violence", a patriarchal system, and social and economic inequalities. They also include the effects of collective violence such as wars, unrest, and political conflict, as is still evident in South Africa (World Health Organisation, 2002).

Intrapersonal, interpersonal and social factors residing primarily within the lower order systems, such as the notion that masculinity is linked to dominance and toughness and rigid gender roles, have major recursive influences on women abuse and the characterisation of the macrosystem (Astbury *et al.,* 2000; Lee, Sanders Thompson & Mechanic, 2002; Markward, Dozier, Hooks & Markward, 2000; Schoeman & Ferreira, 2001; Taylor, Magnussen & Amundson, 2001). Other factors in the macrosystem include religious and/or socio-political endorsement of male entitlement or ownership over women, the approval of physical chastisement of women and a cultural ethos that condones violence as a means to settle interpersonal disputes (Heise, 1998).

Ayyub (2000) found that in Islam, tradition and patriarchy determines that the family and honour are more important than, for example, filing for a divorce by an abused woman. It might seem that religions are blamed for condoning abuse, but on the opposite side, religion and participation in religious activities are also seen as preventative and protective factors. The frequency of attending religious meetings was found to be inversely related to the frequency of abuse (Ellison & Anderson, 2001). This could be due to the greater internal resources that buffer one against distressing feelings through a woman's stronger connection with herself and higher powers (Humphreys, 2000).

Feminist theory was the driving force behind the development of research into women abuse and gender based violence. Feminists emphasise the role of violence in

maintaining control over a female intimate partner. Social structures support social inequalities that lead to the perpetuation of male dominance (Jewkes, Levin & Penn-Kekana, 2002, 2003; Mwamtemba, 1999). They also explain partner abuse, on the basis of traditional gender role expectations and historical imbalances of power between men and women in patriarchal societies. Men are therefore perpetrators and women are unable to leave an abusive relationship due to lack of economic and political power (Eisikovits & Buchbinder, 1999, Jasinski, 2001). Present views in feminist theory emphasise the importance of power and control. This was instrumental in many endeavours to eliminate violence against women, the formation of organisations working in women's issues and in drafting legislation. The concept is however limited in that it puts all the blame on male perpetrators. It focuses on macro issues, such as male privilege in a patriarchal society, and fails to explain violence in matriarchal systems, violence in same sex female relationships and violence by female perpetrators against their male partners (Lundy & Grossman, 2001).

One problem in using a macrosystemic perspective is that it renders one defenceless in legal and social aspects. Women abuse should be seen as a human issue and not merely a gender issue (McNeely, Cook & Torres, 2001).

Timing of events

Crucial to the investigation into recovery from abuse (and a feature that makes this study different from those investigating risk and protective factors) is the timing of events and factors in the development of the abusive relationship; in the degeneration of the abusive relationship; the breaking of the relationship; and the re-establishment of new non-abusive relationships.

In a shift of focus from identifying causal factors, this study focuses on the positive aspects that make victims become victors. The information gained can help those women already exposed to violence to take the first steps towards a new life.

METHODOLOGY

Terminology

In addition to the ethical and practical issues in gender based violence, another important operational issue is the use of definitions (Jewkes, Watts, Abrahams, Penn-Kekana & García-Moreno, 2000). When broadly operationalised, the term gender based violence includes all types of violence directed towards any person (male or female) on the basis of the particular person's gender. However, in this study the type of violence investigated and used for the inclusion criteria is strictly reserved for violence committed against women and therefore excludes violence against men. Domestic violence comprises a type of interpersonal violence that takes place in an intimate relationship, but also includes violence against other members of a family unit, and violence amongst intimate partners in same sex relationships (Jewkes *et al.*, 2000; Watts, Heise, Ellsberg & García-Moreno, 1999). It also excludes violence committed by perpetrators other than an intimate partner (Jewkes *et al.*,2000; Watts *et al.*, 1999). This study does not disregard the fact that some men are also subjected to violence from their female partners (Migliaccio, 2001; Mwamwenda, 1998) or that violence is found in same-sex partner relationships (Cruz & Firestone, 1998; Hassouneh-Phillips & Curry, 2002; Merrill & Wolfe, 2000; Poorman, 2001). It does however recognise that the most common form of violence is against women and perpetrated by a male partner.

It must be noted that the definition for this study of sexual abuse includes marital rape, but excludes rape by a stranger. This limiting definition of sexual abuse is used to exclude participants who are rape survivors (abused by a stranger or on one occasion only) and to focus rather on abused women in long term relationships.

The definition as described by the WHO and the Domestic Violence Act demarcates the field studied in this research. Although it is considered important to have clear terminology and definitions of domestic violence, categories of abuse are not put to participants nor are participants restricted in any way by pre-defined definitions of types of abuse. It is an important aspect of this study to recognise the "voices" of these women also in determining and defining the types of abuse that they were subjected to. There is therefore no definition stipulated at the onset of the study into which category women's experiences are supposed to fall. The participants

themselves will define the categories and definitions. Definitions therefore will be clearly definable only at the end of the study, to take into account the individual experiences and perceptions of participants (World Health Organisation, 2000).

It would seem that the most appropriate term to use in the present study would be violence against women by an intimate partner. It is, however, acknowledged that other authors focusing on the same population (abused women) have used different terms (domestic violence and gender based violence). The terms will therefore be used as synonyms (Ellsberg & Heise, 2002; Ellsberg, Heise, Peña, Agurto & Winkvist, 2001; Jewkes *et al.*, 2000; Watts *et al.*, 1999).

Interview schedule

An interview schedule was developed to capture data across all the different systems and phases of an abusive relationship.

The different sections of the questionnaire include:

- Biographical data (current and while in abusive relationship).
- History of abusive relationship and relationship to abuser.
- Definitions of different types of abuse as relevant to each individual participant.
- Factors related to attraction phase, development of abuse, attempts to save the relationship, reasons for staying in the abusive relationship, attempts to leave the relationship, leaving for good, remaining separated and advice to other women.

Some of the biographical data was collected using closed-ended questions and categories. Questions on the abuse and development of the relationship were all open-ended. The open-ended questions allowed for the capturing of the processes behind the narratives of the women interviewed.

The section on types of abuse did not contain set definitions of the different types of abuse. Different categories were presented to the participant, including emotional, verbal, financial, physical and sexual abuse. The participants were asked to indicate

whether they had been subjected to each of the types of abuse while in the abusive relationship. They were also asked to describe and define each type of abuse and to provide examples. This information was used for dual purposes. On the one hand, imposing definitions on the different types of abuse would limit the disclosure of abuse. This is due to the fact that the interpretation of a type of abuse (e.g. financial) differs from woman to woman. A woman might not regard her situation as abusive due to lack of awareness. Verbal and emotional abuse were also not presented in one category, since it was found in previous studies that these types of abuse are often interpreted as different entities by abused women (Jansen van Rensburg, 2003). On the other hand, data collected in the description section contained valuable information on the women's self-definition of abuse and gave an indication as to the extent of the abuse they were subjected to.

Relevance of interview schedule

The relevance of the interview schedule was assessed with the accessible sample population in mind. Evaluators were asked to comment on all questions in the interview schedule. They had to consider aspects such as the relevance of language (level of understanding of the participants), appropriateness for the clients and ethical issues.

The relevance of the interview schedule was tested by seven POWA staff members from the different offices, therefore representing all the different clusters of clients. Six of these staff members were social workers and one was a clinical psychologist. All of the evaluators had more than four years of work experience in the field of gender based violence. Two of the evaluators had experience in research (one as a field worker and the other had completed a research project for a master's dissertation in the field of gender based violence).

Pilot interviews

The finalised version of the interview schedule was piloted on a small sample of five women who resided in the POWA shelters. They differed from the study sample only in that they had only very recently left their abusive partners (less than three months previously). Minor adjustments to wording were made to facilitate better interpretation and to limit distress.

Sample

The participants in the study were all women who had been abused by an intimate male partner in the past. All the women had started a new life after leaving an abusive partner. The only other inclusion criterion was that the woman must have adapted to a new life already. Most of the women were recruited from the POWA files for women who stayed in the shelters, while others were recruited by word of mouth.

All the participants who were previous POWA clients were recruited by the shelter managers of the shelters in which they resided, to ensure confidentiality and not to breach the trust relationship between client and counsellor. The counsellor explained the research study and methodology to the client during the initial contact and obtained consent for disclosing their information to the researcher, who then contacted the participant to set up an interview date and venue.

Incentive

A monetary incentive of R80 was paid to each participant. This was in an attempt to provide travel money (a stipend) to the participants to allow them to travel to the interview venue. It is believed that providing the incentive did not skew or bias the information.

General description of sample

The 14 women who participated in the study ranged in age between 31 and 56 years, with the average age being 41.7 years. The ages of the women at the time of their leaving the abusive relationship were between 30.5 and 43 years of age (average 37.3). Most of the respondents (78,6%) were between 35 and 40 years of age. Of the 14 women, 3 (21%) were White, 1 (7%) Asian and 10 (72%) were African.

All the interviews were conducted in English although English was the first language of only three of the women interviewed. Half of the women were Sotho (3), Tswana (2), or Zulu (2) speaking. Other languages included Afrikaans, Ndebele, Pedi and Shona.

All the women were residing in the Johannesburg area in the Gauteng province of South Africa at the time of the interview. Most of the women still resided in close proximity to the area in which they had lived while they were in the abusive relationship. One woman moved from KwaZulu-Natal Province to Gauteng shortly after leaving the abusive relationship and another from Bulawayo in Zimbabwe.

Of the 14 women interviewed, four had completed Grade 11, six had completed Grade 12 (matric) and four had attended a college or university after completing Grade 12.

Of the 14 women, six worked full time during the time that they were in the abusive relationship, and six were unemployed. One woman was a student and another had temporary employment only. During the time of the interview 11 women were working full time, two were working part time and one was unemployed.

Most of the women (n=7; 50%) had an income lower than R500 per month at the time of the abuse. Of the 14 women two (14%) had an income of between R500 and R1000 per month, four (28%) between R1000 to R5000 and only one woman had an income of above R5000 per month.

At the time of the interview most of the employed women were earning more than at the time when they had been in the abusive relationship. Of the women, two (12%) earned less than R500 per month, nine (62%) between R1000 and R5000 per month and one more than R5000 per month.

All the participants' abusive partners were men. Most of the participants were married to the perpetrator of the abuse (n=13, 93%). Two women were abused by their boyfriends. In five of the cases another person contributed to the abuse, in all of these cases an in-law. Most of the women subsequently divorced their abusive husbands (n=8, 57%), while two were in the process of divorcing their husbands. Three were widowed. Most remained single, and were not involved in a relationship at the time of the interview. Two women were in a serious relationship (for both these participants the abusive relationship was ended more than 5 years ago).

At the time of the interview 13 women (93%) had a biological child/children living with them. On average each of the women had 1.7 children. In total 23 children (11 boys and 12 girls) were living with their mothers at the time of the abuse. Only two of the children (of different mothers) were not living with their mothers at the time of the abusive relationship. The average ages of the children at the time that the mother left the abusive relationship were 11.9 years (range between 1 and 22) for all children and 12.5 (ranging between 8 and 22) years for boys and 11.3 (ranging between 1 and 20) for girls. All the boys were older than 8 years of age, while most of the girls were older than 8 years of age (67%).

Participants had sustained between 6 months and 22 years of abuse by a partner; most of them (n=11) had been abused for 10 or more years, while three had been abused for less than a year. It seems that women either left the partner very early in the relationship or very late.

The time that elapsed between leaving the abusive relationship and being interviewed for the study was on average 4.6 years (range between 6 months and 13 years). Most of the women had left their partners two years or more before the interview (n=9), with only two participants who had left less than a year previously.

All the participants reported being emotionally and verbally abused by their partners: 12 reported that they were physically abused, 11 were financially abused and 10 sexually abused. A further description of the definitions provided by the participants regarding the different types of abuse that they were subjected to will follow in the next section.

Participants were requested to reveal how many times they had attempted to leave the partner, before leaving for good. Many participants left the abusive relationship on a first attempt (n= 6; 43%). Seven participants left permanently on a second attempt, and only one left at the fourth attempt.

The participants' willingness to disclose and discuss intimate details of their abusive relationship must be noted. All the participants felt that they benefited from participating in the interviews. The general feeling was that they were not only

provided with an opportunity to confirm their successful transformation, but that the topic of abuse was deemed important enough to be researched. They all displayed pride in being invited to participate and share their "success stories" and to be regarded as victors over their abusive situations.

It would seem that the women were about 40 years of age, with children around 10 years of age, when they decided to leave after being abused either for a very short time or after more than 10 years.

Interviews, data collection and analysis

All interviews were conducted in a private and secure venue by the same interviewer. The anonymity of the client was guaranteed and all information treated as strictly confidential. Informed consent was obtained from each participant. Referrals for counselling and legal services were available to all participants. All participants were carefully monitored to identify distress.

An interview schedule was used during the interview itself, aided by the use of an audio tape recorder. Interview responses were recorded by hand and audio taped only where participants consented. When available, audiotapes were used to supplement the interviewer's notes. The audiotapes were used to enhance interaction between the researcher and the participant, by limiting the distraction of writing detailed notes.

Directly after the interview, field notes were made on the researcher's general impressions of the interview. These notes included observations on the participant, such as manner, confidence level, etc. The field notes also briefly described the participant's narrative, those aspects that made her unique, without capturing the detailed descriptions of what she discussed.

The audiotapes were listened to as soon as possible after the interview. The listening was repeated until a clear understanding was gathered from the conversation. The questions on the interview schedule were then one by one completed again by listening to the tape and adding more information (as captured by the recording). This process was repeated at least three times. A clean interview schedule was then used onto which the completed notes were transferred. This completed interview schedule

included direct quotes of words and phrases (similar to a transcription) used by the participants as well as interpretations and notes made by the researcher throughout the whole process (inclusive of the interview, field notes, and final transcription) (Green & Wallat, 1981; Mays & Pope, 2000).

The method of using audiotapes to augment written notes was used instead of transcribing the interviews verbatim, to enable the researcher to deal with the different issues in a clear and logical way. By focusing on the different questions a clearer understanding of the answers was obtained, instead of simply trying to capture individual words or incomplete sentences. Care was given to capture aspects such as repeated words, emphasis placed on certain words, and non-verbal aspects of the interviews (such as laughter, etc) (Chiroro, 2004).

The completed notes were entered into a database along with the demographic data obtained. Content analyses of responses were conducted by coding them into main themes and these were reviewed for consistency and distinctness (Breakwell, Hammond & Fife-Schaw, 1995). Common themes were analysed as a unit, as they related to different stages of the abuse and to different systems involved in the abusive relationship and recovery process.

Collateral, archival data included POWA intake forms and session notes, medical practitioners' reports; communications with the shelter managers, counsellors and social workers who were at the shelter at the time of the participants' stay were also included where relevant and where consent could be obtained. Newspaper clippings of interviews with some of the participants and reports in a popular magazine were also used. This also helped with recall, especially with women who had left their partners more than five years before the study (Eisikovits & Winstok, 2002; Yoshihama & Gillespie, 2002). Consent was obtained from participants before any attempt to locate files or other collateral information was made.

Validity and reliability

The validity of the data collected in this study can be established through various strategies. Various other kinds of information were used to supplement the interviews, including archival material such as case files, newspaper clippings and medical

reports. Direct quotes obtained from field notes and tape recordings of the sessions were also used. Only one interviewer did all the interviews to reduce the effects of multiple researchers. Checks were carried out with some of the participants, after the data was collected to determine that the information was correct. Reliability was ensured by cross referral between field notes and tape recordings and by multiple listenings to the tape recordings. Other methods included the use of debriefing to combat counter-transference, the initial relevance testing of the interview schedule, the gender matching of the interviewer and the respondents and making sure that the sample was appropriate (Breakwell, Hammond & Fife-Schaw, 1995; Morse, Barret, Mayan, Olson & Spiers, 2002).

Ethical issues in gender based violence research

Research on violence against women, more than any other subject of research, requires the acknowledgement of specific ethical issues such as safety (the physical and mental well-being of both participant and researcher), privacy, confidentiality and interviewer skill (Watts *et al.,* 1999).

The study should also be beneficial in that it has scientific soundness, uses participation as a form of intervention, has practical value and disseminates properly interpreted results in a way that will enhance social change (Ellsberg & Heise, 2002; Jewkes *et al.,* 2000).

Physical safety of participants and the researcher

Research on violence against women has the inadvertent potential to cause harm or distress. Threats to physical safety could be due to retaliation from an abusive partner and psychologically there is the possibility that respondents will become distressed by recalling painful events and experiences of abuse (Ellsberg & Heise, 2002; Ellsberg, Heise *et al.,* 2001). Every effort was made to ensure the physical safety of participants in the present study. Complete privacy and confidentiality was guaranteed throughout the study to all participants. The counsellor who had dealt with each participant during her therapy was asked to initiate contact with potential participants. Care was taken to ensure the safety and secrecy of the interview venue.

Psychological well-being of participants and researcher

Although interviews involve the reliving of painful and disturbing events most women actively chose to proceed with the interviews. The researcher's own attitudes and beliefs on domestic violence have a large impact on the data obtained and the participant's willingness to disclose facts. Interviewers frequently share the same stereotypes, misconceptions, and biases about victims that are dominant in general society. Interviewers can easily blame victims or hold other destructive attitudes that can prevent an interviewer from responding appropriately, sensitively and supportively. This can harm the respondent's self esteem and restrict the ability of the interviewer to obtain good-quality data (Ellsberg & Heise, 2002; Ellsberg, Heise, *et al.*, 2001; Jewkes *et al.*, 2000). The psychological effects on both the participant and the researcher can be best described by means of the concepts transference and counter transference.

Transference and counter transference

A very important factor in the methodology of research into women abuse and violence against women is the traumatisation of both the participant and the researcher due to reliving the experiences of the violence. Transference is a psychotherapeutic construct and is more often used to describe clinical contexts. It refers to the transfer of experience from one interpersonal context to another and it affects both participants in a therapeutic setting (Bisbey, 1993; Gill, 1982; Schimek, 1983).

Although transference would not be as important as counter transference in the present study and in research settings, transference on the part of the researcher seemed to be important. In an effort to limit expressions of this transference, the researcher completed the interview schedule as if she were also a participant. This was done before the first interview took place. This was useful in understanding the feelings of participants, as they had to handle the same issues during the interview process, such as reliving experiences that were hidden or forgotten.

Counter transference refers to the unconscious processes affecting the researcher. It can be defined as the reactions of the researcher to the participant and her transference. It is considered inappropriate or negative, but it can also be a major

source of information for the researcher as it reflects the researcher's global orientation. Counter transference should therefore not only be seen as a secondary reaction of the researcher to the participant, but also as preceding it and contributing to the structure of the interaction (Freedman & Lavender, 1997; Giami, 2001; Kreene & Rosenkrantz, 1986).

Through gaining mutual understanding and trust between researcher and participant, a sustained reflection between them took place during the interview. Through this the integrity of the information provided by the participant was strengthened. In addition to the ethical and methodological issues described, the following factors also help participants to talk about their experiences of abuse (Hathaway, Willis & Zimmer, 2002). Knowledge about and understanding of abuse by the researcher, care and interest in helping, taking time to listen, issues around the gender of the interviewer all help contain the fear, embarrassment and shame felt by abused women (Ellsberg & Heise, 2002; Ellsberg, Heise *et al.*, 2001).

The emotional toll of empathising with repeated stories of women's despair, physical pain and degradation can become an intensely personal and emotional experience that calls for regular opportunities for debriefing. To combat the negative aspects of counter transference the researcher attended regular debriefing sessions with the POWA clinical manager. The debriefing was done as the demand arose after each interview session. Some of the cases were of an extreme nature, resulting in demanding situations for the researcher. The cumulative effects of listening to different women with very taxing violent histories could, without debriefing, have easily resulted in a disheartened researcher.

Beneficence

There exists an ethical obligation to maximise the possible benefits both to study participants and to a wider group of individuals. The study should be methodologically sound and researchers competent not only to do the research but also to ensure the well-being of the participants (Council for International Organizations of Medical Sciences, 1991; Watts *et al.*, 1999).

Research participants welcome the opportunity to tell their stories if they are asked to do so in a sympathetic and non-judgemental way, especially if questions are not vague and ambiguous (Ellsberg & Heise, 2002; Jewkes *et al.,* 2000; Watts *et al.,* 1999). Interviews convey the message that violence is a topic worthy of discussion and not a shameful or unimportant issue. The importance of ending an interview on a note that emphasises a woman's strengths and tries to minimise distress is also very important (Ellsberg & Heise, 2002; Watts *et al.,* 1999).

Respect for individuals

The use of informed consent as a pre-requisite for performing social science research is one of the most important tools with regard to respecting the autonomy and protection of vulnerable people, in this case abused women. In the present study a full disclosure regarding the aims of the study and the methodology was given to all participants, since this information would not have influenced their participation or the quality of the data collected.

Balancing risks and benefits

The most important aspect to take into consideration when planning research regarding violence against women is the balance of the potential risks and the possible benefits. Concurrent with this is the risk of not doing research on a topic that warrants investigation. In other words, the cost of not doing a project and the risks of ignorance, silence and inaction should also be considered.

In addition to taking all the described issues and effects into consideration a "safe" environment was provided for each respondent in the present study, with responses phrased in a non-judgemental, supportive, respectful way that conveyed to the participant respect and an honest interest in the value of their information.

RESULTS

All the participants reported being emotionally and verbally abused by their partners,: as noted above 12 were physically abused, 11 were financially abused and 10 sexually abused.

Definitions of abuse

Instead of predetermined definitions of abuse, participants were asked to describe each type of abuse that they were subjected to. These descriptions were used to define each type of abuse.

Verbal and emotional abuse

These two types of abuse were presented to the participants to define separately. Often these terms are used as synonyms, yet they might have different meanings to abused women, as was the case in this study.

All the women reported being emotionally abused and all women reported being verbally abused. Of the 14 women who reported that they were verbally abused, only three stated that they regarded verbal and emotional abuse as the same concept, yet they provided different statements to clarify each of the two types of abuse.

It is clear from the definitions provided by the participants that verbal abuse is perceived more as the actual acts by the abuser, while emotional abuse is more related to the feelings provoked in the abused woman. The two concepts are therefore closely related, but do represent different aspects (that could be missed if only one term were used).

Verbal abuse was related to offensive language use and shouting, especially in a degrading manner in front of other people (including the children, family and friends) (43%). Many women felt that verbal abuse was the constant communication to her that she was useless, stupid and unattractive. Name-calling happened frequently (36%), as well as accusations that she was having affairs and threats to kill her or harm someone close to her (a child or a pet).

Some women felt that verbal abuse was also the difficulty they experienced in communicating with the partner, mostly by being ignored, which rendered them powerless. Sexual aspects were also mentioned, including being called sexually unattractive and descriptions of private sexual acts being related to strangers. These were all part of being rendered powerless and of damage being done to her already low self-esteem.

Emotional abuse on the other hand was related more to the feelings that the verbal abuse provoked. The women were always unhappy and a low self-esteem resulted in all cases, as well as an inability to access support or help. The threats and verbal insults made them expect and fear the sudden eruption of physical violence. There was a paradox in that they felt emotionally vulnerable when left alone and isolated (for instance when locked into their homes) yet felt happier when not with their partner.

Physical abuse

The definitions provided by the participants of this study included severe beatings (83%), which included slapping, punching, kicking and pushing. Their definitions included threats to either hurt her or her children (25%).

Three participants reported that children were also physically abused and another two reported that children were often witnesses to the abuse. Property was also damaged and this was considered to be physical abuse.

A participant responded that she was *not* physically abused, but only strangled once and hospitalised on various occasions. This, as well as the fact that many women included the injuries that they sustained (mostly to the face) and the severity of the injuries (lost teeth, damaged eye and fractures), indicates that these women underestimate the occurrence of physical abuse. They denied being subjected to physical abuse or downplayed the seriousness of the abuse, probably due to the effects of emotional abuse and its consequence (denial of the abuse).

Objects used in physical abuse included fists, knives, and any object in close proximity. This and the fact that the injuries were sustained in prominent places such as the face indicated that physical abuse is not premeditated, but a spontaneous act.

Financial abuse

Most respondents (82%) felt that they were financially abused in that the partner did not maintain them and did not provide for them and the children in terms of basic needs such as food, clothing and school fees.

Financial abuse also included the fact that a woman's money (and even property) was taken from her and controlled by him. In some cases the money was taken by force. In many cases the woman (regardless of her income) had to contribute more to the household than the partner.

The abusive partner controlled all money, with the abused woman having no insight into his income, or control over spending it (being not allowed to go shopping). The buying of alcohol was often listed as financial abuse.

Other issues in financial abuse concerned the non-payment of bonds and the fact that credit was stopped during abusive times in the relationship. Arguments over financial matters often preceded other types of abuse.

Financial abuse was actually another way of exercising power over the abused women, regardless if this was her money or his. It was also about the power to control her financial needs. Even in cases where the woman was properly maintained and could ask for any material thing, she was not allowed to handle the money and did not have any money to spend herself. The control over physically handling money was taken from her.

Sexual abuse

Most of the women reported that they regarded sexual abuse as being forced to participate in sexual activities (60%). Her partner owned her body (paying of lobola was an excuse used) and could do "whatever and whenever" he wanted. Half of the women remarked on this.

Two women reported that when they approached their partners sexually they would be refused on the grounds that they were unattractive to him. Two also reported that they were often embarrassed by remarks about their private sex life made by the partner to other people.

Pornography was blamed for sexual abuse. Other aspects were the prohibiting of the use of contraceptives and one forced abortion. This has large implications for abused women's reproductive health and freedom of choice.

As one respondent remarked: " He wanted to show his power over me, it had nothing to do with love".

Conclusion on definitions of abuse

Financial abuse as defined by the South African Domestic Violence Act does not include the exclusive control of money by one party, as defined by the participants in this study (Domestic Violence Act No 166, Government Gazette, 2 December 1998 No 19537, p 1).

Verbal and emotional abuse is usually described as one type of abuse, often called psychological abuse (Domestic Violence Act No 166, Government Gazette, 2 December 1998 No 19537, p 1; http://www.powa.co.za; World Health Organisation, 2000). The definitions of the other types of abuse concur with those offered by POWA and the World Health Organisation (Domestic Violence Act No 166, Government Gazette, 2 December 1998 No 19537, p 1; http://www.powa.co.za; World Health Organisation, 2000).

Overlap between various types of abuse was prominent in this study and is also evident from other sources. Examples of this include the classification of threats as being either physical or emotional abuse and the control of money as being either financial or emotional abuse.

Abuse in essence is the power of one party over the other. In all the types mentioned this power and control was based on sexual and gender differences between two people, leaving one party vulnerable (in these cases the women).

Phases in the abusive relationship

Factors were investigated in the different phases in the development of the abusive relationship. These phases included the following time frames:

- Attraction phase: the initial attraction, before the abuse started.

- Development of abuse: the start of the abuse and its duration.
- Reparations: aspects that could have saved the relationship from breaking up and the abuse from happening.
- Staying in the relationship: factors that made her stay in the relationship despite the abuse.
- Returning: factors that contributed to some women attempting to leave and returning to the abuser before the final decision to leave permanently.
- Final leaving process: aspects that made her leave permanently.
- Remaining separated: aspects that contributed to her sticking to the decision not to go back to the abusive relationship.

Attraction phase

Women were asked what the factors were that had led to the attraction to the partner. The following were recurrent themes expressed by the women.

Emotional aspects played a large role in the attraction, with 29% of women reporting that they were in love, although 21% felt no love. The relationships were often formed during school going years (36%) and developed from friendships (50%).

The main attraction was due to specific characteristics in the partner, including intellectual and physical aspects and also a caring personality. He was usually seen as “my type”.

Some participants (29%) however reported that they did not feel any attraction to him from the start. These relationships usually started on the rebound, or as a way of getting out of the family home. Their families (21%) forced some into the relationship and marriage.

Development of abuse

Many aspects were regarded as contributing to the development of the abuse. Him shaving affairs (50%) and his jealousy (50%) were cited most often. Other factors involving personal characteristics of the abuser included the lack of trust, the use of alcohol, his being controlling and in need of power (with a high sex drive) and being

possessive and even obsessive. He did not maintain her or the children, restricted her whereabouts and isolated her from other people (even being locked into the house).

Aspects of herself that she blamed included: her having a better income or education than him, her low self-esteem or that she had become involved in the relationship at too young an age. Previous abuse was mentioned by three participants: one was abused as a child, one in a previous relationship, and another witnessed inter-parental abuse as a child.

With regard to the relationship between the two parties only one comment was raised. A communication breakdown between them was mentioned.

His parents' over involvement was blamed more often than she blamed her own parents' inaction. Friends were also often blamed for not helping her, recognising the abuse or taking action against his abusive behaviour.

Culture was only mentioned once, and this was in relation to differences between the cultural backgrounds of the two parties and not in relation to blaming one or another culture as being more condoning of abuse. The current political situation was mentioned, in that difficulties developed in the relationship due to couple being evicted from their home.

Reparations

When asked what would have saved their relationship from breaking up, most of the women responded that nothing would have helped (57%). Many responded with hatred towards their previous partners (21%) even though years had passed since she had left. They commented on the fact that he would never change and that she should have left earlier than she did. They felt they had exhausted all their options and tried every possible solution, as these quotes illustrate: "Abuse is something inside, he will do it again" and "No one can change him".

After much probing they did reveal some aspects that could have helped save the relationship. These included: true love, respect, honesty, faithfulness and better communication.

Some external support structures were also mentioned that could have helped had they been in place during the time of the abuse. The abuser's family was often mentioned (36%). The women felt that they were subjected to secondary abuse because of the inaction of his family, who could have acted more strongly against the abuse. The church and friends could also have played a larger role. The police service was criticised for the role that they played in promoting abuse. This was due to the fact that women were rendered defenceless, due to the police promoting the myth that husbands have the right to physically abuse their wives and to demand sex as a marital right. Emotional abuse was not regarded as an offence by the police officer or the legal system.

Staying in the relationship

Only one woman remained in the abusive relationship because she was in love with the abuser. Some hoped that he might change (21%) and others because he begged them to stay (14%). In 29% of the cases he made threats to kill her if she tried to leave.

Some intrapersonal aspects that were mentioned as reasons why the women remained included emotions of failure, blame, shame, low self-esteem, and loneliness. A participant remembered: "He kills you slowly by shouting – one day you'll just not get up".

Of the women who had children, 67% stayed because of their children, of which two stated prominently that they stayed until the children were old enough to make their own decisions.

Some women were forced, due to circumstances, to remain with the abuser. These issues included the fact that they had no other shelter or were financially not able to cope on their own. Many (57%) feared rejection by their families.

For a few women, culture and tradition dictated to them not to leave the marital home, even in the presence of abuse, while others were not aware of their rights and had little knowledge of abuse and the fact that they were being abused.

Returning

Only six women reported that they had left the abusive partner in a previous attempt to escape the violence. Reasons that they provided for their decision to return to the abusive relationship included the fact that the abuser pleaded for her to return (33%) and promised to change (50%). Parental pressure and pressure from friends and police officers also contributed to their decision, as did loneliness and financial difficulties.

Final leaving process

The final decision to leave was in all cases attributed to a major critical event. As one woman remarked: “My life – he would kill me”. During this event the abused women realised that escape was the only way to stop the abuse (“I had to do what I had to do”). These events included a physically abusive incident that threatened her life (36%). Some women were hospitalised in intensive care after sustaining gunshot wounds or fractures.

In seven cases (50%) the children urged the mother to leave. In one case the rape of a grandchild (and the subsequent disclosure of abuse of a daughter) acted as the trigger. In two cases children tried to commit suicide and in one case the abused woman tried to commit suicide herself. Two women realised the seriousness of the situation after they were at the point of going into action after contemplating killing the abuser, as one remarked: “One will die, him or me, I would have killed him”.

In some cases the critical events were indirectly related to the abuser, but re-definition of the woman’s situation resulted. This included obtaining a degree, a father who passed away and being in a serious accident. One participant decided to set limits to actions and left after the abusive partner contravened the rules.

Some factors that were mentioned can be regarded as assisting factors that helped the women come to the decision to leave or that aided them in the process of leaving. These included aid from organisations, counsellors, work colleagues, churches and religion. Awareness and interaction with other women in similar situations also helped them.

Remaining separated

"The point of being over is very important". This remark by one of the participants summarises the issues raised by the other participants.

It was mostly memories of the abuse and the effects of the abuse that kept women from returning to the abusive relationship. Many women still hated the abuser ("I hate him thoroughly – I can kill him") and most realised that he would never change, especially since some men became involved in another relationship soon after the woman left.

For some, the realisation that the children were better off without the abusive parent was clear. For most, their new found happiness and the realisation that she had her own life and choices and even new friends kept them from returning to the relationship, even when financial difficulties were experienced. They felt they were independent, stronger and could develop themselves. For one participant: "There was a time I was pleasing my husband not knowing myself, I have that happiness now". Some appreciated the security and well-deserved rest in the shelter where they were housed. For two women the only solution was to move and the distance between them and the abusers made it possible to keep to the decision to leave.

Threats (even attempted murder, and one partner hiring a hit man) were taken very seriously at this stage. This made women keep to their decision to leave even more firmly, although they had to ensure the safety of themselves and their children.

Temporal distribution according to ecological model

The following table fits the results in an ecological model. The representation aims to clarify the temporal distribution of factors into the five systems of the ecological framework, as discussed previously.

It is clear from Table 1 (page 56) that the personal level (especially regarding the abuser) is involved more often, in all the different phases, than any other level. The time when the decision was made to leave finally and the reasons for not returning to the abuser were mostly due to internal personal factors of the abused women.

DISCUSSION

The sample of women who participated in the study reflects the fact that domestic violence and women abuse are found across all classes, races, cultures and age groups (Andrews, 2000; Jewkes, Levin & Penn-Kekana, 2002, 2003; Mashishi, 2000).

In a study of South African women who have been abused for eight or more years the same factors were found, that contributed to abuse and the reasons why women stayed in abusive relationships (Butchart, Motingoe & Mabogoane, 1996). As in the present study, alcohol, extra marital affairs and accusations played a role as well as the involvement of children. Women left due to the escalation of violence and the extension of violence to the children. Many contemplated killing the abuser or attempted suicide. The present study further classified these factors and extended the study to include the whole relationship (from formation or attraction until factors helping her to remain without the abuser).

As is evident from this study it seems that psychological abuse (verbal and emotional abuse) is usually present before the commencement of physical abuse (Henning & Klesges, 2003). This, and the fact that psychological abuse occurs more often than physical abuse, can explain the fact that the women reported being physically abused less. Abusive men also impose definitions of abuse on women which minimise her experience of abuse and control the way in which she responds to it (Cavanagh, Dobash, Dobash & Lewis, 2001). The women also seemed to do little about the abuse - and many women never leave an abusive relationship. This might appear to be passive and is at some stage the best way to deal with the abuse and a time to reflect on strategies to leave (Lamberg, 2000). It should be the time for intervention and in helping women plan their next course of action.

Personal factors from the individual system seemed to be located within both the partners in the initial attraction stages. This included emotional and physical attraction between the partners. One participant mentioned the witnessing of inter-parental violence. It would be unrealistic to see this as a risk factor for her being a victim of her partner's abuse, as previously reported by other studies (Coker *et al.*, 2000).

Table 1: An ecological distribution of factors reported to a play a role in the development and conclusion of abusive intimate relationships

		PHASES OF RELATIONSHIP						
		Attraction	**Development of abuse**	**Reparations**	**Staying**	**Returning**	**Final leaving**	**Remaining separated**
ECOLOGICAL SYSTEMS	**Personal: Her**	Love Rebound	Higher education Better income		Failure Blame Self-esteem		Critical event Cognitive	Memories of abuse Hate New found happiness Re-definition of self
	Personal: Him	Attraction: Physical Intellectual	Affairs Jealousy Alcohol	Love Respect Honesty	Pleaded Threats	Pleaded		
	Micro (relationship)	Friendship	Closeness Communication breakdown				Would be killed	Physical distance
	Meso (socio-cultural environment)	Family pressure	Inter-parental violence Abused as child His parent's involvement	Police Family Friends	Children Shelter Finances	Police Parents Friends	Children NGO's Religion	New friends
	Exo (socio-physical environment)						Awareness of abuse issues	
	Macro (culture)				Culture Tradition			

A move took place in that some women blamed the abuser more for the break-up of the relationship and the development of the abuse. Other factors, such as affairs, jealousy and alcohol were also blamed often (Heise, 1998). Changes in these behavioural aspects and in his feelings could have saved the relationship. The fact that she remained in the abusive relationship was mostly attributed to her low self-esteem and to him either threatening her or pleading with her and making promises to change for the better. Shame and guilt were also previously found to play a major role in preventing women from leaving an abusive relationship (Bean & Möller, 2002; Buchbinder & Eisikovits, 2003).

The final stages in leaving were attributed more to her strength and intra-personal processes (e.g. memories) than to anything regarding his personality. The women relied on their own inner strength and resilience in remaining distant from the abuser. Cognitive aspects were very prominent in these stages. Women had to "think" about themselves, work through thoughts and plan the process of leaving in order to be able to make a final commitment not to return to the abuser.

Ellsberg and co-workers (2001) found that women more often left temporarily than to seek help from outside. The same could be true for the participants of this study. While some left temporarily, few ever mentioned looking for help on occasions before they themselves decided to leave the partner permanently. They did not ask family, friends or any other formal support systems. Yet when asked what could have saved the relationship they reported mesosystem factors, such as support from family, friends and other organisations.

Mashishi (2000) found for people from the same sample (POWA clients) that the main reason for remaining in an abusive relationship was that they "loved the husband". Yet in this sample staying was attributed more to negative feelings, threats, the children's welfare and financial needs.

Financial reasons for remaining in the abusive relationship were also found by Barnett (2001), Bosman-Swanepoel (1996), Butchart, Motingoe and Mabogoane (1996) and Nurius, Macy, Bhuyan, Holt, Kernic and Rivara (2003). These women, however, left the abusive relationship despite being in a worse position financially after leaving.

Yet at the time of the interviews most had moved on and developed themselves in such a way that they were financially independent and some even more successful than what they experienced while being in the abusive relationship.

Children and their welfare played a major role in keeping women trapped in an abusive relationship and also in urging them to leave an abusive relationship. This seeming paradox is easily explained if the ages of the children are considered. It seems that women are wary of leaving while the children are younger. When they reach a certain age and the mothers can actually see the consequences of their staying in an abusive relationship or they voice their opinions (such as wanting to leave the abusive parent) the mother decides to leave. In some cases the children were harmed by the parent or tried to commit suicide. Threats to harm the children were also reported in this study, also resulting at some stages in her remaining in the relationship; but also to trigger her leaving the relationship later on. The importance of educating women about the influence of abuse on the children even at a very young age should be a priority (Hall & Lynch, 1998; Levin & Mills, 2003; McCloskey, 2001; Vermaak & Jansen van Rensburg, 2003).

Threats of killing the abused wife should be taken very seriously especially during the time that she is planning to leave, since many women are in fact killed at this point (De Voe & Smith, 2002; Mathews *et al.*, 2003; Vetten, 2003). Leaving should be a planned event, when the abuser is not present. Threats of more violence, even after the relationship ended, were also very serious since many women are still assaulted even after two years after leaving an abusive partner (Fleury, Sullivan & Bybee, 2000). Moving away when possible and not having contact with the abuser, when possible, is one of the best strategies to prevent an ex-abuser to stop stalking a woman.

Some aspects of the mesosystem mentioned by the women included the ineffectiveness of police officers and the lack of family and friends' involvement. The use of religious activities to help with the coping phases was also mentioned, especially in that these helped her re-define herself and helped in raising her self-esteem. Although injuries were present (in some cases very serious) none of the participants ever mentioned the health care profession as being a factor in them

remaining or leaving the abusive relationship. This absence of one of the most important systems, and one with which all the women in the study had close links, is alarming. Medical professionals should play a larger role in not only detecting abuse, but also in educating, empowering and referring women timeously.

Few aspects of the exosystem were mentioned by the participants. It is, however, important to consider the benefit that awareness of abuse would have had for these women's experiences. Many of the other issues, such as the lack of understanding of the involvement of children, could be directly linked to this system. The financial situation and lack of resources can also be linked to the work environment. "Street committees" are also often used (although not mentioned in this study) in trying to mend relationships and are based on home neighbourhoods and elders "counselling" couples. This might also have a negative effect in that women could be urged to stay in a harmful relationship. Further research into these aspects would be of great value.

The seeming uninvolvement of the macrosystem, could be due to the fact that these women do not realise the importance of culture in the development of abuse and of influences such as a patriarchal system, because they are so involved in lower level survival. It would, however, seem that the lower levels are more important, especially in the decision to leave. In this sample the women did not mention that the culture, or higher, systems contributed to the development of the partner in becoming an abuser, although the importance of these systems (in the South African context) has been researched and proven previously (Jewkes, Levin, Penn-Kekana, 2002, 2003). Abused women are more likely to believe that society gives consent to abusive behaviour through its silence (Hightower & Gorton, 2002; Nabi & Horner, 2001). The contribution of the higher systems would be more in terms of advocacy and public awareness of abuse issues. The presence of a domestic violence act and other legislation was appreciated, but the application of these (by either the police service or the legal system) was lacking. Even on these levels the abused women blamed individuals and not the system (e.g. the police officer and the police service).

The internal personal dimension of the women's thinking and decision making process is the most important aspect of the ecological system. Although other systems contribute to the experiences, the actual decision to leave rests with the intrapersonal

aspects of re-defining the self and coming to a very personal decision to leave, that has very little to do with perceptions of other systems and the availability of their support, even if these contribute to her understanding of the leaving process. Some of these women had no support and suffered financially after leaving and were without resources including basic needs. Yet they decided to leave even though they judged other systems as lacking in real support.

It is therefore of extreme importance to become more intrapersonally focused when working with abused women for whom the option to leave an abusive husband is feasible. There should be a move away from being focused on interpersonal, socially or externally directed decision making processes towards an intrapersonal frame of reference as the key to successfully concluding the abusive relationship. It appears that this is the only way in which leaving the relationship becomes a viable option. Table 2 records the advice given by the women in this study.

CONCLUSION

The women interviewed showed exceptional strength and determination in what happened (Farr, 2002). With the exception of one woman (who expressed forgiveness, yet with bitterness surfacing during times in the interview) none of these women have moved to the stage of forgiveness. The resilience of these women should be admired. They have exceptional strength in overcoming difficult circumstances and all suffered more hardship after leaving the partner (especially financially) before they could be regarded as successfully moving to a new life.

This study provided valuable insight into the use of an ecological model in the different phases of an abusive relationship, especially when working with abused women on a personal level. It provided valuable insight into the systems they deem relevant during each decision making phase. It is therefore very important to use interactive systems approaches, where mutually influencing interactional processes, are identified rather than focusing on causal and risk factors (Schoeman & Ferreira, 2000).

Table 2: "Voices of Advice"

This study attempted to give abused women voices. The following statements are aspects of the advice that the fourteen women expressed to help other women in similar situations.

1. "Believe in yourself, don't be a people's pleaser, don't worry about what they say, do what is good for you."
   "Look in yourself, have that bright light in yourself. One day you'll be there, follow that light."
2. "Move fast, you cannot change him."
3. "It is not true when you are told that you are useless." "Leave when it start – he'll do it again."
4. "Get out, he will not change and your kids will grow up wrong." "Don't ever go back, leave the first time for good and start a new life."
5. "Get out as soon as you can – just pack and go, he won't change." "Don't think that your kids are benefiting, he will rape his own daughter, you are suffering, it's your decision, your choice."
6. "Stand up for your rights, be strong and you will be respected by others."
7. "Be strong, think before you act and learn to say no."
8. "Be strong it worked for me." "Tell yourself: This is over."
   "You must find that point when it is over."
9. "Don't waste 20 years – leave early, if it doesn't work, he will never change."
10. "Have the power to say NO from the start, when he loves you set boundaries of what can and can not be done." "Don't hide and keep secret from the family, speak in power." "There are other women like you." "Say NO to sex if you don't want it, it is your body."
11. "Be strong, pray, go to church, meet with other women, do not keep it secret or be embarrassed, leave early." "He will not change, he will change you." "I wasted everything – money, soul, spirit, I was empty inside – dead." "Go for counselling, you are not mad."
12. "Get out early, your family and friends have no real idea of what is going on." "Your culture and traditions might be wrong." "Get professional help and talk about it, you are not alone." "Don't believe what he says." ***"DREAM"***
13. "Leave after the first time, don't waste 24 years." "There are good men out there." "You can survive on your own and be successful."
14. "There is more to life than abuse." "Make up your mind quickly, decide what is best for you, you are important." "Your children will be more hurt is you stay, life is better out there." "Heal your mind, body, soul, spirit by extending forgiveness, get rid of the bitterness by going for counselling, pray, value yourself and your life, you are beautiful and unique – you can make it."

"You are at the edge of a cliff, don't know whether to jump or not. If you decide to jump one of two things will happen, it is either God will catch you when you fall or He will teach you how to fly".

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CHAPTER 3

PHYSICALLY ABUSED WOMEN'S EXPERIENCES AND EXPECTATIONS OF MEDICAL PRACTITIONERS

This manuscript has been prepared according to the editorial guidelines of *South African Family Practice*.
Tables and figures have been placed in the text.

ABSTRACT

Objective. To investigate the frequency of physically abused women's medical consultations, the anatomical location of their injuries and the perceived support given by medical practitioners.

Sample. Comprised of 42 physically abused women who made use of the services of the People Opposing Women Abuse (POWA) Organisation. The group was culturally mixed with an average age of 35.7.

Design. Descriptive *ex post facto* semi-structured questionnaire/interview survey.

Results. Of the 31 (73.5%) physically abused respondents who indicated that they had visited a medical practitioner, only 7 (23%) visited their general practitioner on more than three occasions. Overall 13 (42%) respondents were accompanied. Most (n=20; 65%) acknowledged to the practitioner that their injuries resulted from gender based violence and the same number also identified the abuser. A large majority (n=26; 84%) recommended that medical practitioners consider a more comprehensive approach to their treatment. Suggestions included better medical treatment, emotional support, referral to other health workers, referral regarding legal issues and contacting the abusive partner.

Face and neck injuries were mentioned most frequently (n=27; 67.5%). Trunk injuries (n= 19; 47.5%) were mostly found on the lower back and thorax. Limb injuries (n=25; 62.5%) were often sustained on the upper limbs. On the lower limbs, the areas above

the knee were most frequently injured. Overall, most of the injuries were located in publicly visible areas.

General practitioners are often the first professionals that physically abused women come in contact with. More effort should be made to inform practitioners of the unique composition and acuteness of these women's needs.

INTRODUCTION

This study explored the expectations, experiences and recommendations of a sample of domestic violence survivors upon presenting their injuries to medical practitioners. The frequency of consultations with medical practitioners was also recorded. In order to ascertain whether patterns of injuries can be discerned, the general physical location of injuries sustained during domestic violence was also noted. In is argued that this composite information will contribute to the diagnostic indicators used to inform medical practitioners when dealing with cases of chronic domestic violence.

Violence against women and in particular intimate partner violence has always been a socio-medical concern. However, up to a decade ago, the prevalence rates of intimate partner violence in South Africa have been purely speculative due to the lack of national surveys and reliable statistics.[1] Recent community based prevalence studies conducted in three SA provinces determined that these women have a 24.6% lifetime likelihood of being exposed to physical violence.[2,3]

Although other types of abuse are also found (e.g. emotional abuse), physical abuse seems to be most prominent with the widest health implications.[4] Health problems associated with gender based violence include injuries, HIV, sexually transmitted diseases and mental health problems. Gender based violence is also a cause of mortality from homicide and suicide in South Africa, with femicide (homicide of women by an intimate partner) as the most serious form of violence against women. It was found by a study done in Baltimore that femicide victims frequently contacted medical practitioners before they were killed, which presented opportunities to prevent their deaths.[5]

Depending on the seriousness of their injuries, women who have been beaten by their partners are compelled to visit health institutions for treatment. Besides acute injuries, these women may present with somatic symptoms such as headaches, backaches, fatigue, abdominal and pelvic pain, recurrent vaginal infections and symptoms of depression.[6] A study conducted in Alexandra on the location and nature of injuries showed that 18% of cases included multiple injuries (2-5 body locations) and a further 17% required hospitalisation for fractures (skull, jaw, limbs, sternum and ribs), deep scalp and facial lacerations and penetrating chest wounds.[1]

Medical practitioners are often the first professionals that women traumatised by gender based violence come in contact with, but it seems that they have a poor record of identifying victims of domestic violence.[1] Even the British Medical Association (in a 111 page report) is calling on medical practitioners to play a greater role in identifying abuse, helping survivors to disclose the abuse, and to ensure that survivors receive advice and support.[7] In Omaha it was found that abused women tend to turn to medical practitioners for social and directional support.[8]

However, clinicians often struggle when addressing domestic violence. For example, in 1998 it was found that a sample of South African medical practitioners were of the opinion the issue was too sensitive, they were too busy, or that it was unnecessary to address abuse.[4] This could be due to the fact that clinicians lack training in dealing with the causal context in which violence based injuries are sustained. A recent local study reported that only 9.7% of medical practitioners received training in domestic violence.[9] Other reasons stated for the noninvolvement of medical practitioners include that they do not know what to say, that it is traumatic for them to listen to their patients describing violence and they have trouble empathizing with the victim's helplessness. As a consequence, the abused women's experiences of isolation and despair were likely to increase due to clinicians treating them for injuries and somatic complaints without exploring reasons for the injuries. The abusive partner furthermore frequently controls the health care attention being received by accompanying the injured partner to the medical practitioner, controlling medical aid and other health benefits and even through controlling dietary requirements.[10]

Motsei[1] argued that the role of health workers should include providing initial and accurate identification of abuse and that they should ask indirect questions in a non-judgmental and supportive manner. Privacy is very important, especially separating the women from her partner when examining her. This is especially important when women present with multiple injuries or no history to explain injuries. Medical practitioners should also keep accurate records and medico legal reports to include aspects such as the nature and extent of injuries, extent to which injuries are consistent with the assault, description of the incident by the woman and the treatment given. In addition to treatment, it is suggested that medical practitioners provide referrals, follow ups and develop closer networks with social services, legal agencies and the police.[1,4,11]

A recently canvassed sample of South African medical practitioners were of the opinion that they are adequately empathising with abused patients but they also agreed that they could play a more extended role in prevention and treatment.[9] Respondents in the study treated on average 11.4 patients with abuse related injuries per month (SD 13.4). Most of these practices were in predominantly white neighborhoods. Only 15.1% of the patients disclosed the abuse to the practitioners and in only 12% of the cases did the practitioner raise the issue although they suspected abuse in 16.9% of the cases. With the exception of one respondent, all acknowledged that the prevalence and impact of domestic violence was greater than what practitioners generally assume.

Most research into injuries sustained by physical abuse and medical practitioners' role in treatment focused on the medical practitioners' attitudes and roles.[12,1,9] Few studies focused on the abused women's perspective.[4,13] Yam[14] investigated a group of battered women's experiences in New Jersey and reported that respondents were of the opinion that emergency staff did not understand the chronic context of the injuries they sustained. Whilst they were satisfied with treatment of their physical injuries, the causes of the injuries were generally not properly addressed. They had difficulties in disclosing the abuse mostly due to fear, embarrassment and lack of resources.

Roles for the health sector in breaking cycles of abuse are increasingly being recognized in South Africa and there appears to be a growing awareness of the need

for appropriate interventions such as documentation, information giving and referrals.[6]

METHODOLOGY

People Opposing Women Abuse (POWA) counsellors surveyed women who contacted them with physical abuse complaints. The counsellors were instructed in the research objectives and methodology after which they helped each consenting participant to complete the survey questionnaire. By doubling as fieldworkers for this study, the counsellors were instrumental in obtaining sensitive information, ensuring that the participants interpreted the questions correctly and providing support if required during and after the survey. Also, by making use of counsellors as fieldworkers a support base was provided, thereby countering possible ethical problems that otherwise could have jeopardised the study. Ethics committees of both POWA and the University of South Africa reviewed and sanctioned the study beforehand.

Sample

All POWA offices and shelters (Berea, Sebokeng, Soweto, Vosloorus, Katlehong) were included in the study. A sample of convenience consisting of 42 women was recruited during January and February 2003. Women who presented at POWA offices and shelters during this time were invited to take part in the study. A 100% response rate was obtained. Their ages ranged between 23 and 57 years of age, with the average age being 35.7 years (SD 7.75). Nearly half of the participants (n=19; 45%) were between 30 and 39 years old. The sample consisted of 12 Sotho, 10 Xhosa, 9 Zulu, 6 Tswana, 2 Pedi, 1 Afrikaans speaking participants as well as two women who did not indicate their home language. Whereas the questionnaire was formulated in English, it was in each case administered by a counsellor able to speak the mother tongue of the participant in order to help clarify possible misunderstandings.

Measurement

Apart from biographical information, the questionnaire probed the following themes:

- the number of abuse related visits to medical practitioners

- the relationship of an accompanying person (if relevant) and whether the accompanying person was present during the examination
- the nature of treatment and the recommendations made by the medical practitioner
- participants' experiences and expectations of treatment provided
- identifying the anatomical location of the injury/ies sustained. This was done with the use of a body map consisting of an outline of a female figure. Participants were requested to colour the area on the body map where injuries were located. Two body maps were used to probe two possibly different incidents in each participant's abuse history. The first map was used to explore the occasion when the participant was injured most and sustained the worst injuries. The other body map was used to investigate injuries sustained in the most resent physical abuse incident. In cases where the latest incident was also the worst incident only one map was used and only once recorded as the most recent injury. For this reason, the total numbers of worst and most recent injuries do not correspond.

RESULTS

Of all the women who reported that they were physically abused and suffered physical injuries, 73.4% (n=31) sought help from a medical practitioner. More than a quarter of the women in the original sample never visited a medical practitioner, regardless of the extent of their injuries.

Of the 31 women who have been treated by a medical practitioner, 35% (n=11) only visited the medical practitioner once, 30% visited twice, 13% visited three times and 23% visited more than three times.

More than half of the women (n=18, 58%) reported that they went to the medical practitioner on their own, while the rest (n=13, 42%) reported that at least on one occasion they were accompanied by another person. In 31% of the cases this accompanying person was a neighbour and in another 31% of cases it was a family member (e.g. mother, child, sister, sister in law). In 23% of the cases the abusive

partner accompanied the woman. One woman was accompanied by a friend and another by a police officer. In more than half of the cases (54%) the accompanying person was also present when the woman was examined by the medical practitioner.

In most instances (n=20, 65%) the abuse and perpetrator was reported to the medical practitioner, either by the woman herself or by the accompanying person. Nearly 20% reported the abuse, but contributed it to a person other than the abusive partner to protect the perpetrator. In this sample, only two participants (7%) did not acknowledge the abuse to the practitioner.

Without self disclosure, a large percentage of the women (n=21, 68%) were of the opinion that the medical practitioner would not have diagnosed the true cause of their injuries. Only seven practitioners (23%) diagnosed on their own account the abusive origin of their patients' injuries. Two participants lied when asked and one believed that the injuries were not prominently visible and therefore not recognisable as caused by domestic violence.

Only four medical practitioners were perceived to actually address the cause of the abuse. Two contacted the partners of the women, one referred the client to POWA and another encouraged the woman to open a case of assault with the police.

Most women (n=26, 84%) believed that medical practitioners can do more to help women in their situation. One third of their suggestions dealt with the actual medical treatment they received, placing emphasis on regarding their injuries in a more serious light. Although some (13%) wanted medical practitioners to counsel them regarding their emotional well being, most women (74%) expected practitioners to be able to refer them to appropriate resources such as social workers, psychologists or organisations such as POWA. The majority of women (65%) were of the opinion that medical practitioners could be more aware of the legal aspects of domestic violence cases. These include administrative issues such as having more fully and correctly completed forms (e.g. the J88) and helping, referring, and encouraging them to open a legal case against the perpetrator. Some women also suggested that practitioners become more directly involved with their well being as long term patients by making

follow up calls and offering to contact the abusive partner - especially to explain the extent and danger of the injuries they sustained.

Anatomical location of injuries

Results presented in Table 1 refer to the anatomical classification the participants'. The analysis was based on the full complement of 42 participants. For the majority of women (n=26, 64%) the most recent time they were injured was also the time they were injured the most. This appears to indicate that the nature and seriousness of the injuries tend to get worse with each violent incident. Injuries were mostly sustained to the head and neck area. Overall, reports of injuries were also similar for the time when the participants were injured most and for the most recent time that they were injured. The trunk (including thorax, abdomen and pelvis) was also injured in more than 45% of the participants. This percentage remained the same for the most recent as well as for the worst episode of physical abuse reported. Whereas the category of 'most recent injuries' also contained episodes of 'worst injuries' the correspondence between the two overall categories reflect a stable pattern of injuries over time.

Table 1: Anatomical location of abused women's injuries

Injury location	**Recent injuries**		**Worst injuries**	
	n	**%**	**n**	**%**
Head, Face and Neck	27	67.5	13	65
Trunk	19	47.5	9	45
Limbs	25	62.5	8	40

Injuries to limbs were also reported frequently. The incidences of these however differed for the two time periods. It would seem that participants regarded injuries to limbs as less serious, as they reported this with a lower frequency when asked about the most violent injuries.

In order to capture the widest range of responses, both global indications of injury locations as well as more detailed accounts were recorded. For this reason, the reported percentages do not add to 100. For the most recent incidences, injuries to the head and neck area were most frequently found in the face; with the eyes and mouth injured most often (see Table 2). Injuries sustained during the worst incidences were found to be located on the head and skull area rather than the face.

Table 2: Head and neck injuries sustained by a sample of abused women

Injury location		Recent injuries		Worst injuries	
		n	**%**	**n**	**%**
Head		9	22.5	10	50
Face		22	55	6	30
	Eye/s	6	15	4	20
	Nose	2	5	0	0
	Mouth	6	15	2	10
	Ear	2	5	1	5
Neck		3	7.5	3	15

Injuries to the trunk were mostly located on the lower back and the thorax, especially the breasts (see Table 3). When participants were asked to indicate the location of injuries during the episode they considered to have been the worst, they indicated injuries they sustained to the abdomen to be more serious.

Table 3: Trunk injuries sustained by a sample of abused women

Injury location		Recent injuries		Worst injuries	
		n	**%**	**n**	**%**
Back		12	30	4	20
	Upper	4	10	2	10
	Lower	12	30	3	15
Thorax		8	20	4	20
	Breast/s	5	12.5	0	0
Abdomen		6	15	6	30
Pelvis		2	5	3	15

The upper limbs were injured more often than the lower limbs during the most recent incident of abuse (see Table 4). In the upper limb, injuries were mostly found on the left limb and usually on the arm and forearm. This would indicate defensive injuries where the left arm and forearm is used to shield the face and head from blows or stabs.

Table 4: Limb injuries sustained by a sample of abused women

Injury location		Recent injuries		Worst injuries	
		n	%	n	%
Upper limbs		23	57.5	5	25
Right		12	30	2	10
	Shoulder	6	15	0	0
	Arm	5	12.5	0	0
	Forearm	5	12.5	2	10
	Hand	3	7.5	0	0
Left		18	45	4	20
	Shoulder	4	10	0	0
	Arm	5	12.5	2	10
	Forearm	7	17.5	2	10
	Hand	4	10	1	5
Lower limbs		15	37.5	7	35
Right		10	25	4	20
	Thigh	7	17.5	1	5
	Knee	0	0	2	10
	Leg	5	12.5	1	5
	Foot	1	2.5	0	0
Left		11	27.5	5	25
	Thigh	10	25	3	15
	Knee	1	2.5	1	5
	Leg	3	7.5	1	5
	Foot	0	0	0	0

There was no preference for the side of injury in the lower limbs. Injuries were located with the same frequency in both left and right limbs. Most often the thighs were injured. The location of injuries for the worst incidents was more or less the same except that the upper limb was indicated less often.

DISCUSSION

Whereas the use of a sample of convenience places some limitations on the external validity of the results, this is counterbalanced by a greatly under researched and elusive population. For as much as this sample group can be regarded as representative of abused South African women who have approached non governmental organisations for support, the results of this study should be corroborated and refined by follow up investigations. Nevertheless, it appears that the majority of participants in this study initially contacted medical practitioners for

professional care and support. About half of these women also visited the practitioner more than once. When taking into account that the perceived seriousness of their injuries seem to progress over time, it is important that medical practitioners make correct diagnoses as timely as possible.

Most of the participants indicated that they voluntarily disclosed the abusive origin of their injuries, but suggested that their medical practitioners could be more pro-active in recording and gaining better insight into the context in which the injuries occur as well as suggesting appropriate action in addressing the cause. In addition to short term emotional support, referral to relevant health professionals and organisations (including legal aid, social services and organisations specifically geared towards helping abused women). As reported by some earlier studies they also expected medical practitioners to be more active in networking with the police and in coordinating efforts to help stop the violence.[4,6,11] Also consistent with other studies, this sample group emphasised the importance of properly recording the nature of their injuries and the contexts in which they took place as well as fully completing relevant documnetation.[6,11,1]

Most women indicated that they were injured in more than one anatomical location per violent incident. Injuries sustained during physical abuse were mostly found in the head and neck area, although injuries to the trunk were also frequently indicated. Injuries to the limbs were more frequent during times when the injuries were not considered serious. The anatomical location of injuries during the most recent incident of physical violence was mostly in the face. Other injuries were located in anatomical sites that would indicate protective actions especially in guarding the face. The location of injuries sustained during more serious violent incidents was mostly found on the head (skull and face) and the abdomen. As with the present study, multiple injuries (2-5 locations on the body) were also reported by other studies and serious injuries were found to be skull fractures, deep scalp and facial lacerations and injuries to the breast and abdomen.[4,1]

CONCLUSION

Domestic violence appears to be prevalent in South Africa and medical practitioners are frequently the first professionals to be approached for help. As such it is important that practitioners be informed of the unique composition and acuteness of these women's needs. Abused women frequently present to medical practitioners in search of not only medical treatment of their physical injuries, but also in an attempt to seek understanding and direction in how to address the cause(s) of their injuries. Given the socio-medical nature of this problem, medical practitioners have a responsibility to gain greater awareness of physically abused women's plight and how to deal with it effectively.

In order to aid the diagnostic process, an attempt was made to gain systematic information on the anatomical location of injuries most frequently presented by abused women. In this sample, injuries were mostly directed to the face and involved anatomical areas related to defensive actions in protecting the face.

Whereas the client base of organizations such as POWA are usually from lower socio-economic groups, it should be recognized that physical abuse occurs across all socio-economic levels and is of concern to all general practitioners.

And when all is said and done, the incidence of gender based violence and how it is dealt with remains a critical indicator of the regard a society has for its own fabric.

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CHAPTER 4

HIV AND WOMEN ABUSE: CASE MANAGEMENT

This manuscript has been prepared according to the editorial guidelines of *Maatskaplike Werk / Social Work*.
Tables and figures have been placed in the text.

ABSTRACT

Violence against women makes women more vulnerable for contracting HIV/AIDS. Women who are abused and are HIV positive are an important group of women who need special attention in research as well as counselling and accessibility to social services. This article comprises the results of three substudies: (1) a record review on HIV issues raised by POWA clients, (2) longitudinal in-depth case studies of abused women who are also HIV positive, and (3) an environmental scan investigating service delivery. The results revealed that although a high percentage of abused women acknowledge that their partners are having affairs, the women do not reveal their status or do not go for testing. Services and other social support are under-utilised by abused women.

INTRODUCTION

Violence against women is an important factor that increases the vulnerability of women in contracting HIV/AIDS, both on a biological and social level. Women who are abused have limited negotiation skills with regard to safer sex practices and many of the male partners are having affairs that also increase the risk of contracting HIV. People Opposing Women Abuse (POWA) has been working in the field of violence against women for 25 years. Lately it has become more evident that larger numbers of women are either HIV positive or are at increased risk of contracting the virus.

Women who are abused and are HIV positive have complex issues to deal with and are faced with stigmatisation and subsequent isolation due to being both abused and HIV positive.

In South Africa the percentage of HIV positive females is greater than that of males (Gilbert & Walker, 2002). Specific situations are of special importance when considering HIV and women. Testing in South Africa frequently occurs at antenatal clinics and there many pregnant women learn for the first time that they are HIV positive and have to deal with all the implications thereof (Mfusi & Mahabeer, 2000). This brings about not only specific fears for the patient, but also the possibility of being victimised (Scherr, Hackman, Mfenyana, Chandia & Yogeswaran, 2003). Other social care workers are also at risk of responding negatively and placing blame on those at risk or infected (Cobb & DeChabert, 2002).

In South Africa the prevalence of abuse is between 20-30% and 1% of women are raped each year (Jewkes, 2000). Gender inequalities and intimate violence directed at a female partner have already been established as a risk factor in contracting HIV (Ackermann & De Klerk, 2002; Garcia-Moreno & Watts, 2000; Jewkes, Levin & Penn-Kekana, 2003; Walters, Simoni & Harris, 2000). Many abused women fear contracting HIV (Wingood, DiClemente & Raj, 2000). A study in the United States found that of the 68% of women who reported experiencing abuse during their lifetimes, 65% of these women had already been abused before they were infected and 33% experienced abuse after they became infected. Interestingly, the severity of the abuse increased the likelihood of the women reporting their HIV-seropositive status (Sowell, Phillips, Seals, Murdaugh & Rush, 2002). Gielen, McDonnell, Wu, O'Campo and Faden (2001) found that 63% of HIV positive women had been sexually or physically abused at least once.

However, abuse is not only linked to HIV in a general manner; physical abuse could be a direct cause of the increased risk women have of contracting HIV. Domestic violence interferes with measures to prevent infection, such as condom use negotiation and the discussion of HIV (Jewkes, Levin & Penn-Kekana, 2003). This is still more true in relationships where sexual violence is part of the domestic violence.

This is, however, not only true for long-term relationships. Sexual violence is surely the most important way in which violence is linked to HIV infection. Because the threat of immediate violence is more important than possibly contracting HIV, women often resign themselves to sexual demands and violence (El-Bassel, Gilbert, Rajah, Foleno & Frye, 2000; Go *et al.,* 2003; Hoskins, 1998). In South Africa rape is a common occurrence and the importance of preventing and helping women who might be or become infected is crucial.

The distribution of not only Post Exposure Prophylactics (PEP) to rape victims, but also Anti Retroviral Therapy (ART) is very important, but these treatments warrant special long term care of patients. The problems with follow up sessions and compliance with treatment regimes should also be seen against the cost of not responding to HIV health care (Decosas, 2003; Denenberg, 1997; Wutoh *et al.,* 2001).

Not only medical care and support are needed for HIV infected women, but with the additional burden of abuse and the depression that is associated with both issues, social and psychological support are also vital (Gielen *et al.,* 2001, Leslie, Stein & Rotheram-Borus, 2002; Valente, 2003).

There were four broad aims of the study, each with its own methodology.

To collect statistics regarding women who seek counselling for abuse, women who are aware of their HIV status, and women who have considered HIV/AIDS a factor in their abusive relationships.

To identify women who are aware of their HIV status (or have specific fears regarding their possible positive status) and who report for counselling regarding being abused. Also to follow their development for an extended period in order to investigate the problems they are facing. Problems include those regarding their HIV positive status, the abusive relationship, supporting their children, responses from the partner and family regarding testing, the role of violence in managing HIV/AIDS, and the socialisation patterns of women following their being diagnosed as HIV/AIDS positive.

To do an environmental scan (geographical survey)in order to investigate the accessibility of social and health services to abused women who are also HIV positive in the areas served by POWA.

METHODOLOGY

Record review

A record review of the files of clients for the period January 2002 to December 2002 was done. Data was collected from all available case notes of face-to-face sessions with women who approached POWA for counselling. All data was treated confidentially and anonymously. Biographical data was extracted from the POWA intake forms. For other issues such as HIV status and affairs by partners, a content analysis of case notes was performed. This meant that the issue had to be prominently mentioned by the client and recorded by the counsellor to be included in the calculations. The frequencies of occurrences of these issues are therefore an under estimate, since some clients did not volunteer the information or the issues raised were not recorded. The results therefore should be considered as an under representation of actual cases. Descriptive statistics were performed to determine frequency and averages.

Individual case studies

Their POWA counsellors recruited participants for the follow up study and all gave informed consent. Due to the difficulty of identifying women who experience abuse and know their HIV positive status, the sample was limited to only four women from different areas. The women were interviewed bi-weekly to determine changes in their situation, including difficulties experienced in social and health care and the nature of their relationships. In-depth interview data was content analysed in order to determine common themes and changes in themes over time.

Environmental scan

To investigate the accessibility of services to women, municipal and other governmental sources were examined. The collection of the information was mainly done through observations, informal questions and visits to specific organisations in the areas where the women in the case study were residing.

RESULTS AND DISCUSSION

Record review results

In total, 1115 client files were analysed of clients reporting for face-to-face counselling sessions at POWA during 2002. The average age of the clients was 35 years. The average number of clients who suspected their partners of having affairs was 21.5%. The number of clients who disclosed their HIV status was very small (n=27, 2.5%, of whom 12 were rape survivors). This was a reflection of a general trend not to disclose one's status (mostly due to stigmatisation). It could however also have been due to the fact that POWA staff deal with violence against women and that clients and counsellors alike therefore did not consider HIV status to be an issue to be discussed during sessions. It might have been that clients and counsellors did not yet consider violence as a risk factor for HIV and did not want to risk the confidential relationship set up in the counselling sessions.

In only one case was HIV addressed by a counsellor. This was alarming since some clients did disclose their HIV positive status (n=27) or reported a close family member or partner to be HIV positive (n=8) or expressed the fear of being HIV positive (n=9). Many reasons could be found for the inactivity of counsellors in dealing with HIV/AIDS issues. The first of these reasons could be that counsellors themselves do not feel knowledgeable and confident in talking about and discussing HIV/AIDS issues and rather focus on what they believe their duty and field of expertise to be (e.g. gender based violence). Referrals of clients to other HIV specialist organisations also did not occur in any of the cases. Mainstreaming of HIV issues into all POWA activities to increase counsellors' knowledge and skills, and referral information have therefore become a priority for POWA.

Individual case studies

Anyanda (Sebokeng) and Betty (Katlehong)

Due to the limited number of sessions with these two participants few themes could be validly extracted. Anyanda did reveal that she was concerned about her status due to her history of abuse by her husband and the frequent occurrence of his affairs. Anyanda was still seeing her husband and apparently they were still sexually involved, which increased her risk of contracting HIV or being re-infected. Betty also

feared being HIV positive since her husband was HIV positive. Anyanda's and Betty's status was never confirmed due to their fear of going for testing.

Catherine (Berea)

Catherine was HIV positive with a history of abuse and she had also been raped on three different occasions. She was pregnant when first interviewed and delivered her baby just before the project was terminated. She contracted HIV during one of the rape incidents.

She had experienced difficulties since her youth. She struggled financially and was mostly unemployed. A friend supported her and different organisations helped her with regard to the basic survival of herself and her children. Her housing and financial situation never really improved during the research study period. Various organisations monitored and supported her physical health during her pregnancy. She experienced difficulties regarding obtaining information on HIV/AIDS issues and in access to treatment to prevent the transmission of HIV to her baby. She received treatment and milk for her baby while she took part in a research study. With regard to her physical health she managed those aspects within her control. She started physical exercise in the form of long distance running which she seemed to enjoy and excelled in, which also contributed to her mental wellbeing.

Her preparations and plans for the care of her children (19 years, 7 years and the new-born baby) when she becomes ill and is unable to take care of them were unsatisfactory. It seemed that her concern was basic survival and not planning for the future. Social support was mostly obtained from formal institutions and organisations and not from family and friends (whom she seldom mentioned in her discussions and who apparently lived in another province). She visited different organisations, including a community centre and POWA, for counselling.

Some of her negative experiences regarding social service provision included dealing with the South African Police Services when laying rape charges, and the fact that she had to use different services during different stages and when different problems arose. For instance some shelters only deal with pregnant women and she had to find another shelter after the birth of her baby. Other problems related to her HIV status

included the fact that she was tested without pre- or post-test counselling. An alarming fact was that she refused to disclose her status to her sexual partners and because of unresolved anger wanted to punish men in general by spreading the virus.

Dorcas (Soweto)

Dorcas tested HIV positive and presented with a long history of abuse. She associated her contracting HIV with a sexual relationship that led to a pregnancy and abortion. She tested positive only later on, during treatment for Tuberculosis.

Her financial situation was not good, although her basic needs were met. She stayed with different family members (e.g. her grandmother and her mother). Preparations for her future were based on the assumptions that her mother and grandmother would take care of her when she becomes ill.

Her family provided most of her social support. This support changed from being very supportive to very negative incidents later on. Difficulties resulted from a breach of confidentiality by her family, who disclosed her HIV status to other family members and the police. This resulted in her leaving her family home. Her boyfriend and his family initially supported her. He initially accompanied her to support group meetings. This support then changed in that he started abusing her and even tried to force her to have a baby. The influence of the formal support group however remained stable and they contributed in terms of aspects such as providing information on HIV and on a healthy lifestyle.

Problems related to her HIV status included the fact that she received no pre- or post-test counselling. The test was also done without her consent. She retested after her first test and "still tested positive" (an indication of denial). She also did not want to disclose her status to her partners (because they might leave her), but apparently took care to have safe sex.

Common themes and issues regarding case studies

The absence of pre-and post-test counselling, that are compulsory in South Africa, was alarming. It further seemed that no informed consent was obtained from participants before testing. Testing mostly occurred during interventions for other

heath problems, such as Tuberculosis or after a rape incident. The participants attributed contracting HIV to a traumatic incident that occurred (rape, pregnancy and subsequent abortion), without acknowledging that they might have contracted it earlier on in their relationships in which they were also at risk.

It is clear from the results that the women's social support altered during the time that they were observed for the study. This was partially due to changing needs, but also to stigmatisation and changing attitudes. Two types of social support were evident, formal (external) and informal support. The formal support was provided by various organisations including health care providers, shelters and support groups. Family and friends provided informal support. Both types of support changed according to their HIV status and the disclosure of their status. The formal support was haphazard and no co-ordinated effort existed to help the women regarding their being both HIV positive and abused.

Disclosing their status to sexual partners was a major problem. HIV positive women would not disclose their status to their sexual partners. This was mostly done out of fear of rejection, but also as a punishment method towards "men in general" for contracting HIV. The one participant who did disclose her status to her one partner experienced acceptance and support, but was abused later on in the relationship. Not disclosing their status to sexual partners (and even deliberately trying to infect a partner) not only poses problems for the participants, but also ethical issues for the POWA researchers and counsellors.

Perceived support and planning for the future was mostly based on guesses and blind reliance on support that was in fact not reliable. It seems that their basic survival was more important than planning for the future.

Environmental scan results

Various service providers, including the organisations in the regions where the women who participated in the case studies resided, were investigated.

Unit 1

The unit was established to care for HIV/AIDS positive mothers and their children (irrespective of whether the children were infected or not). Staff try to ensure that the women and children are able to live in an environment of acceptance and understanding. They teach them to care for themselves and their families and they help them learn to cope and live positively with HIV/AIDS.

They provide HIV information, with their main target being pregnant women on their first pre natal visit. They also offer pre-test counselling, with all testing being voluntary. All women tested also received post-test counselling. If they tested HIV negative, HIV education was given and multi vitamins supplied. HIV positive women were given individual counselling and they were referred to support groups, to which their partners were also invited.

Free formula for the baby, up to 6 months of age, was given to unemployed women. Staff also provided cheaper formula to the women who were able to pay. HIV positive women were given Nevirapine to reduce the risk of mother to child transmission. AZT was offered to all women who were ill. A medical practitioner assisted those who were actively ill.

Crisis Centre

The crisis centre's mandate is to assist women and children who have been sexually violated by providing them with immediate emergency health care and ensuring that their cases are recorded and taken up by the police services.

The centre is situated in an inner city hospital. The centre is a stand-alone building, not easily identified. The waiting room is unfriendly and there is no receptionist to guide clients. There are, however, separate counselling rooms, an examination room and nurses' office. The centre offers a 24-hour service with seven full-time workers. None of the workers have undergone Voluntary Counselling and Testing (VCT) training. Training was offered at the time of this investigation, but only to the head of the division.

Upon contact with the centre, if the rape survivor had not already opened a case with the police, he/she was referred to the nearest police station to do so. Once a case was opened, she returned to the centre for a medical examination by the medical practitioner on 24-hour call. The nursing sister on duty carried out the VCT as part of the examination. Any rape survivor who was provided with PEP was requested to attend a three-month follow up HIV test.

Any client who tested positive at the time of intervention was informed of her status. The staff at the centre was not aware of any support groups for HIV positive or survivors of violence. They also did not know where to refer patients.

On average the centre provides services to 98 women a month. Of the women tested (not all women agree to testing), 24 women were already HIV positive at the time of the rape. Due to the number of clients and the inexperience of the counsellors, they did not do in-depth counselling and only spent 20 minutes on average with each woman.

Continuity of service was also a problem. Not all rape survivors who have been provided with PEP actually return for the three-month follow up test. The service and follow-up provided was therefore incomplete.

A high staff turnover also contributed to the poor service delivery. Burnout and staff leaving the service due to better salaries, benefits and more conducive working conditions, were big problems. Burnout and occupational stress can lead to emotional exhaustion and depersonalisation (Peltzer, Mashego & Mabeba, 2003).

The lack of a centralised service impacted greatly on the quality of services, referrals and networks provided to women. The fact that a rape survivor needed to report to the police in order to open a case (police officers were often not available on site) added to the length of time they remained in acute crisis. The medical practitioner was also not on site, so immediate medical assistance was not readily available. The sister who provided testing and counselling was not skilled enough to manage the emotional crisis a client was dealing with. The sister's duty was short-term medical assistance and she had to further refer a client when unable to help. Client referral was not

always available, since the centre was not integrated, or connected to, counselling services available in the area to deal with HIV and/or violence. Considering the number of clients seen in a given month, the staff complement was inadequate. The follow-up procedure for those individuals who had been supplied with PEP was also insufficient. Resources, training and information were limited. Time spent with each client was not sufficient when dealing with issues related to both violence and HIV.

Centre in a Hospital

The centre was open 24 hours a day during weekends and for limited hours during the week. A good relationship and networking existed between the centre, the South African Police Services and other service providers in the area.

According to the Centre's statistics, on average, 92 cases were reported in a month, 68 rape cases and the rest domestic violence. Of these, 40-50% of the women were reluctant to open a case with the police. Four of the 68 rape survivors refused the HIV test while 40-45% of the women who decided to test, tested positive.

The centre had a counsellor to provide trauma counselling and also a medical and legal service on site. There was also a police officer and a medical practitioner on call. The medical practitioner employed, had a special interest and training in dealing with trauma cases. There were also four forensic examiners, five social auxiliary workers and six volunteers working at the centre. The clinic also had a specific health department policy and protocol for Voluntary Counselling and Testing (VCT).

HIV positive clients were seen between 3-4 times before they were referred to a support group for long-term support. There were three closed support groups that met weekly. The support even extended to provision of their transport fare to clients when needed.

Although the support provided by the centre was well co-ordinated and encompassed many different aspects in health, social and psychological service provision there were still on average 7-8 points of intervention for the client.

Trauma Unit situated within a Police Station

The unit was situated in a police station and consisted of one room with a desk and two sofas. Clients had to inquire at the police front desk and were frequently misdirected. The fact that there was only one room available made private counselling impossible.

Volunteers headed by a police officer staff the centre. Only the senior staff member has attended VCT training. The police officer still had to undertake other duties and was therefore not available on an ongoing basis. Sometimes male volunteers work alone, with no female to assist with cases.

Common issues in Environmental Scan

Terminology issues and the names used for the different services were misleading. For example, the Trauma Unit was in fact only a receiving agency and provided only a referral service. The Crisis Centre did not provide support, but was an open group that provides information and education.

There was no co-ordinated effort to empower women who were both HIV positive and abused. Better services and better co-ordination of services would also make abused women less financially dependent on the men who abuse them.

It is generally accepted that rapists spread HIV. However, many of the women who were raped were already HIV positive before the incident. As was also clear from the individual studies, sometimes the women themselves were deliberate agents of spreading the virus. This also happened indirectly since many of the women tested after a rape incident were unaware of their status. The rapist could actually become HIV positive through sexual contact with the “victim”. He would then become a secondary agent of spreading the virus. Abused and raped women can also directly be agents who spread the virus in that they are angry and deliberately try to infect other men (their consenting sexual partners).

DISCUSSION

It seemed from the record review that the women often raised issues related to an increased risk of contracting HIV (such as affairs by husbands). These issues were seldom discussed by the counsellors, with all counselling sessions rather focussed on abuse issues alone.

The methods of HIV testing and the absence of pre- and post-test counselling of clients were unacceptable. The clients also experienced problems when disclosing their HIV positive status. Social support and the specific needs around support (both formal and informal) seemed to change with time and circumstances. The participants were so involved in basic survival that they left planning for the future (for themselves when they become sick and for their children) based on assumptions rather than on structured plans. Considering the stress that AIDS orphans are subjected to after the death of their parents it is very important to these women plan for their and their children's futures well in advance (Wild, 2001).

There was no organisation or service found that co-ordinated all the different efforts to help women. Abused women who were HIV positive were therefore sent from one service to the next and due to this lack of co-ordination were lost in the system. One strategy proposed to combat this intersection between HIV and women abuse is better collaboration between different social services and other stakeholders, so that abused and HIV positive women can obtain better care (Elliot, Quinless & Parietti, 2000). Peterson and Swartz (2002) advocated that care should be integrated in South Africa. Campbell and Mzaidume (2002) even suggested that this collaboration should not only be local and national, but also international. Katz *et al.* (2000) and Kilbourne, Herndon, Andersen, Wenzel and Gelberg (2002) proposed intensive case management programmes for HIV and homeless women. This could very well also function to alleviate the problem of women not being comprehensively helped. Because of South Africa's history of apartheid and the influence of other social issues such as poverty it is imperative that co-ordinated efforts for dealing with HIV/AIDS and abuse be made. HIV and the prevention and treatment thereof, and violence against women, are both important social and political issues (Decosas, 2003; Phatlane, 2003; Pronyk *et al.*, 2002).

In conclusion, the results of this study have far reaching implications for POWA as an organisation, in that it was a driving force behind the strategic decision to mainstream HIV into all its activities. It should, however, also inform networks, departments and government about the streamlining of processes and service provision to abused and HIV positive women.

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CHAPTER 5

INTERVENTION STRATEGIES TO COMBAT BURNOUT AMONGST POWA WORKERS

This manuscript has been prepared according to the editorial guidelines of
South African Journal of Psychology.
Tables and figures have been placed in the text.

ABSTRACT

Counsellors dealing with abused women are often exposed to stress and burnout. Support and debriefing are usually given in individual and group sessions to People Opposing Women Abuse (POWA) counsellors. This study aimed to investigate the levels of burnout of POWA staff and the influence of two types of interventions.

A two group repeated measures design was used. The sample consisted of all POWA staff members (n=36). Two intervention strategies were used on a rotation basis: a creative exercise (fabric painting) and structured art sessions. During an eight-month period, bi-weekly sessions of two hours each were conducted. Burnout was measured using the Maslach Burnout inventory that was completed on three occasions (that is before the first intervention and two weeks after each intervention).

The lowest levels of burnout were recorded after staff had completed the first intervention phase with a small increase thereafter. The two groups showed significant differences on two scales, Emotional Exhaustion and Personal Accomplishment. It is concluded that although burnout levels were not high to begin with, work stress can be lessened by creative group activities. An important applied outcome of the study was the introduction of both interventions as part of the counselling strategies used with clients in the POWA shelters.

INTRODUCTION

Counsellors dealing with women who are abused, whether in a shelter environment or in face to face and telephonic counselling are faced with realities of burnout. At People Opposing Women Abuse (POWA) all staff (including administrators and staff other than counsellors) work under these stressful circumstances. Support and debriefing is given in individual supervision sessions and group sessions aiming to alleviate burnout.

LITERATURE REVIEW

Maslach (2003) defined burnout as a prolonged response to chronic emotional and interpersonal stressors on the job. It consists of three dimensions, namely exhaustion, cynicism and a sense of inefficacy.

Stress is an important cause of impaired fulfilment and function at work. Rafferty, Friend and Landsbergis (2001) found that skill discretion and decision authority were associated with burnout even more than high job demands, which only effected emotional exhaustion and not depersonalisation or personal accomplishment (the dimensions measured with the Maslach Burnout Inventory).

Although burnout affects all professionals, it would seem that counsellors working in violence and abuse situations are especially at risk. Counsellors are continually working in the "caring cycle" (including empathic attachments, active involvement and then separations). The counsellor in the abuse setting is repeatedly involved in these cycles, which could easily lead to depletion of caring energies, especially in the absence of sufficient resources and self-caring strategies (Skovholt, Grier & Hanson, 2001). Case workers working with sex offenders reported negative emotional reactions that led to decreased work performance (Thorpe, Righthand & Kubik, 2001).

Gender Based Violence is a very serious problem not only in South Africa, but also world-wide. The seriousness of the problem also explains the reason why the counselling of women who have experienced abuse and domestic violence is psychologically so demanding. Studies have indicated that between 10-50% of

women report lifetime prevalence of physical abuse by an intimate partner. Population based studies have reported that between 12 – 25% of women have experienced attempted or forced sex in their lives. Interpersonal violence was the 10th leading cause of death for women between 15 and 44 years of age in 1998 (World Health Organisation, 2000).

In South Africa a cross sectional study was undertaken in three provinces of South Africa (Mpumalanga, Eastern Cape and Northern Province). The lifetime prevalence of domestic violence was 24.6% (95% CI 21.5-27.6). The prevalence of domestic violence in the past year was 9.5% (95% CI 7.5-11.5) and the prevalence of domestic violence or threats of violence in the past year was 11.6% (95% CI 9.4-13.8). Of the women experiencing violence, 45.9% reported sustaining injury in the past year (Jewkes, 2002; Jewkes, Levin & Penn-Kekana, 2002, 2003). Research done by the Centre for Study of Violence and Reconciliation (CSVR) determined that in South Africa on average one woman is killed every six days by her intimate partner (Mathews, Abrahams, Jewkes, Martin & Vetten, 2003; Vetten, 2003).

People Opposing Women Abuse was established in 1979 as a response to the high levels of violence against women experienced in the community. POWA was primarily initiated by volunteers and offers services to women who have experienced domestic violence, sexual harassment, rape and adult survivors of incest. The organisation has a strong gender sensitive stance and seeks to empower women through the process of counselling, education, advocacy and lobbying.

POWA served 10 000 women during 2002. This number includes 1115 clients seen in face to face interviews, 1600 telephonic counselling sessions and clients supported with regard to legal support. Many more were helped with quick referrals and other information sessions, advocacy and lobbying efforts.

The effects of counselling domestic violence and abuse survivors include changes in schemas such as safety, gender and power issues for counsellors. These counsellors also report difficulty with issues such as confidentiality and feelings of isolation and powerlessness. All these contribute to the high levels of burnout experienced by domestic violence counsellors (Iliffe & Steed, 2000). Preventing burnout leads to

professional longevity, which is ultimately also to the benefit of the clients seeking help (Skovholt, Grier & Hanson, 2001).

Various ways have been researched and proven to aid in decreasing burnout levels in the social services. These include transformative travel, humour and religion (Franzini, 2001; Fuller-Rogers, 2002; Kottler, 2003). Counsellors also use strategies such as debriefing, peer support, self-care and political involvement to combat burnout (Iliffe & Steed, 2000).

Reid *et al.* (1999) found that mental health staff used informal contacts with co-workers, as well as time management strategies, most frequently as ways to cope with burnout. They also found that the main formal support sources were supervision and staff support groups. Group therapy has lately also been extended to using the internet to obtain emotional support, validate feelings, and to obtain information on stress and burnout associated with work and alternative ways of coping (Meier, 2002). The same type of support is also available telephonically and was found to be effective for nurses (Murphy, Stewart, Ritchie, Viscount & Johnson, 2000). Jamuna and Ramamurti (2000) found individual counselling effective in combating symptoms of burnout when measured against a control group who received no intervention.

Another type of group therapy found useful in relieving personal and professional symptoms of burnout, is listening to experienced counsellors, and gaining knowledge from them on how to deal with counselling stress (Coons, 2001). Rafferty, Friend and Landsbergis (2001), however, found that social support from co-workers and supervisors was not associated with lower levels of burnout, which indicates that in addition to supervision or debriefing sessions with peers, other intervention strategies should also be incorporated. Forsgaerde, Westman and Nygren (2000) also found that group discussions on ethics did not reduce burnout levels. It seems that group intervention strategies alone were not sufficient to deal with burnout. In addition, higher levels of self-efficacy were associated with lower levels of stress and interventions developed to enhance self-efficacy were more suitable to combat burnout (Mackenzie & Peragine, 2003).

Maslach (2003) argued that although research has already established the complex nature of job burnout and the causes of stress in the workplace, new and effective intervention strategies have to be developed. One type of therapy that worked for school teachers and was associated with lower levels of burnout than the use of cognitive behavioural interventions was the use of music therapy (Cheek, Bradley, Parr & Lan, 2003). An art therapy group approach was used as an intervention strategy to reduce burnout in mental health workers who deal with domestic violence and sexually assaulted clients. The art therapy was also found to be effective in reducing burnout. This decrease in burnout was attributed to the opportunity for self-discovery, exploring symbolic language and imagery, sparking creativity, developing imagination and increasing knowledge of art therapy (Van der Vennet, 2003).

Aim of study

The use of different forms of artistic expression, as intervention strategies in burnout among counsellors of domestic violence survivors, stems from the need for alternative strategies to combat burnout in order to complement already existing strategies such as group interventions and individual debriefing. Using less structured creative exercises (such as fabric painting) could be meaningful to staff, since they can also use the exercises with their clients as possible counselling strategies. On the other hand, a more structured approach, such as art sessions focussed on the development of drawing/painting techniques, may be effective in enhancing perceived self-efficacy.

The aims of the study were to 1) determine levels of burnout of POWA staff, 2) measure the change in burnout after two different intervention strategies were applied.

METHODOLOGY

The aims of the study were investigated by using a two group repeated measures design with the two different intervention strategies used on a rotation basis, yielding both between group comparisons and same group comparisons over time (Breakwell, Hammond & Fife-Schaw, 1995).

Measurement instrument

A questionnaire measure consisting of three sections was used in this study. The first section collected biographical data. The second and third sections of the questionnaire contained the Maslach Burnout Inventory (MBI), consisting of the same 25 items each. The second section rated the items on a seven point Lickert scale according to 'frequency experienced' and the third section rated the items on an eight point Lickert scale according to 'intensity experienced' (Maslach, 2003). The MBI consists of four sub scales: Emotional Exhaustion (EE), Personal Accomplishment (PA), Depersonalisation (D), and Involvement (I). Results for each of the sub scales were individually reported and analysed in this study.

A number of studies have reported satisfactory validity and reliability data in using the MBI to assess work-related stress experienced by social service workers (Hatfield, 2000; Schaufeli, Bakker, Hoogduin, Schaap & Kladler, 2001). The factorial validity and construct validity were also statistically investigated and confirmed the factor structure (Bakker, Demerouti & Schaufeli, 2002; Beckstead, 2002; Whitehead, Ryba & O'Driscoll, 2000). Internal consistencies for the subscales ranged between 0.58 to 0.88 (Abu-Hilal & el-Emadi, 2000) and 0.68 to 0.87 (Hastings, Horne & Mitchelle, 2004) for previous studies. The internal consistencies obtained in the present study ranged between 0.64 to 0.81 and compared well with those reported by earlier studies.

Sample

The sample included all POWA staff members (n=36). Two unmatched groups were used on a rotation basis, with one group completing intervention A first and the other group completing intervention A second. The rotation enabled the groups to be used as control groups and also decreased the timing effect and the influence of not using matched groups. However, comparing the biographical data on the groups revealed that they were in fact closely matched. A significant correlation (Pearson r = 0.952, p<0,001, 99% CI 0.73 - 0.98) was obtained when the two groups were compared with regard to age, area of work location and their job descriptions (see Table 1). Not all group members completed the questionnaire on all three occasions, due to resignations and absenteeism. The number of participants therefore varied slightly between measurements.

Table 1: Biographical description of participants

		All	Group A	Group B
Age	**Average**	33.7	35.6	32.7
	Minimum	26	26	27
	Maximum	58	58	42
Area located				
	Berea Office	9	6	3
	Berea Clinical	3	2	1
	Soweto	3	1	2
	Sebokeng	4	2	2
	Katlehong	5	1	4
	West rand shelter	4	3	1
	East rand shelter	4	2	2
Job description				
	Administrative	7	4	3
	Projects	3	2	1
	Social worker	11	7	4
	Social Auxiliary Worker	6		6
	Legal	1		1
	House mother	4	4	

All POWA staff attend monthly individual supervision sessions that include personal debriefing. Group interaction and support is also provided where needed. Discussions of difficult cases also occur on an ad hoc basis. This happens at all staff levels and should not be seen as confounding the results of this study, but is intended to contribute to the experience of lower levels of burnout in general.

Research Design

In employing a two group repeated measures design participants act as their own controls, and this is especially useful in field studies where only small sample sizes are available. It examines change over time and minimises the effects of individual differences (Breakwell, Hammond & Fife-Schaw, 1995). The disadvantage of practice effects was minimised by only measuring the participant responses at intervals of two

months or longer. The groups were also compared for equivalence on critical indicators of work and lifestyle conditions (see results section below).

Interventions

Two intervention strategies were used: informal, creative exercises (fabric painting) and structured art sessions. The different sessions for the fabric painting part included exposure to different techniques, performing small individual projects, doing a project where all participants were asked to paint an interpretation of their work at POWA, and a larger project for personal use (e.g. a tablecloth). The more formally structured art classes included sessions on line, shape and shading, pattern, colour and the expression of emotion. Techniques like drawing (pencil and charcoal), painting, mixed media and sculpting were used.

The groups were housed in different venues and although discussions were allowed between groups and completed products were displayed, the groups did not interact during the sessions.

Time schedule and data collection

The burnout questionnaire was completed on three occasions (that is, before any intervention took place and two weeks after each intervention was completed).

Sessions took place on a rotation basis with each of the groups starting a different type of intervention strategy and rotating after four months. Each block consisted of six two-hour sessions. The sessions followed after each staff meeting (the first Friday of the month) and skills development meeting (the third Friday of the month). Measurements were done on three occasions. The first baseline measurement was done two weeks before the first session started (beginning of April 2003). The second measurement was done two weeks after the groups completed the first intervention strategy (August 2003). The last measurement was taken two weeks after the last session (end of November 2003).

RESULTS AND DISCUSSION

Confounding variables

The following potentially confounding variables were measured to control for group equivalence and to determine the effects, if any, on the levels of burnout of the counsellors: number of clients seen per week, number of years in present work, time since last holiday and relaxation techniques employed. It was found that the two groups were matched for all the variables considered. These variables were important not only for the measurement of matching of groups, but also because a comprehensive understanding of the work and home contexts in which research participants are functioning is essential in studies on the experience of burnout (Angerer, 2003).

The number of clients seen respectively by the two groups over the 3 phase period did not differ significantly between groups (n = 70, 68, 61 for group A and n = 85, 72, 92 for group B). Only for group B did the number of clients increase somewhat during the third phase of the study. A subjective measure of perceived workload was also included in the questionnaire. There was no statistically significant difference for perceived workload between group A and Group B for any of the phases. When comparing groups for the same type of intervention strategy, no statistically significant differences for the fabric painting or art sessions were found.

The number of years in the present work was also determined and no statistically significant difference was found between the different groups for each phase or for the same group at different stages.

The average time since their last vacation for the two groups over the three phases of the study did not differ significantly, but the time since the last vacation differed for the sample group as a whole over the last phase of the study (n = 14.5 weeks, 11.8 weeks, 24.4 weeks ago).

Participants were asked in an open-ended question to list what they did to relax. The answers were content analysed to determine the frequency experienced of each type of strategy for each phase (Table 2). The strategies used most during phase 1 (pre-intervention) included watching television and reading; during phase 2 they included

reading, listening to music and watching television and during phase 3 included reading and listening to music. The strategies were mostly of a passive nature. Few participants used creative strategies and informal discussions with participants revealed that they felt being creative was expensive and time consuming. No differences were found between the reported strategies used by the two groups. This result strengthened the researcher's confidence that the measurement of changes in the experience of burnout can therefore with some assurance be attributed to the intervention strategies used in the study.

The two groups were compared for each sub scale of the MBI for each phase (see Table 3). Statistically significant differences were only seen for the sub scales Personal accomplishment for both frequency (t = 1.93, p = 0.03, *df* = 22; $\bar{x}_1 - \bar{x}_2$ = 1.3, 95% CI 0.37 - 2.22) and intensity experienced (t = 2.22, p = 0.01, *df* = 22; $\bar{x}_1 - \bar{x}_2$ = 1.67, 95% CI 0.38 - 2.96), for Emotional Exhaustion intensity experienced (t = 1.88, p = 0.03, *df* = 22; $\bar{x}_1 - \bar{x}_2$ = 1.13, 95% CI 0.10 - 2.14) and for Depersonalisation intensity experienced (t = 1.70, p = 0.05, *df* = 22; $\bar{x}_1 - \bar{x}_2$ = 0,56, 95% CI 0.005 - 1.13). These differences were also only evident for the third phase (after both groups completed both intervention strategies). This seems to indicate that the only times that differences were present were after both groups completed both intervention strategies.

To determine the influence of each of the intervention strategies, the fabric painting and art technique sessions for Group A and Group B were compared. The only sub scale that yielded statistically significant differences between the groups was the measure of the intensity experienced of Involvement in the art classes rather than the fabric painting sessions for group A whereas group B showed no differences (t = 2.65, p = 0.00, *df* = 16; $\bar{x}_1 - \bar{x}_2$ = 0,77, 95% CI 0.45 - 2.20).

The differences for each intervention strategy compared to baseline measurements (phase 1 before the interventions) were also examined. For frequencies the only statistically significant difference was for Personal Accomplishment between phases one and three (t = 1.75, p = 0.04, *df* = 18; $\bar{x}_1 - \bar{x}_2$ = 0,23, 95% CI 0.01 - 2.27). For intensity experienced, differences were found to be statistically significant for Emotional Exhaustion between phases one and three (t = 2.46, p = 0.01, *df* = 18; $\bar{x}_1$ -

$\bar{x}_2$ = 0,52, 95% CI 0.42 - 2.39), Personal Accomplishment between phases one and three (t = 2.04, p = 0.02, *df* = 18; $\bar{x}_1 - \bar{x}_2$ = 0,24, 95% CI 0.22 - 2.80) and between phases two and three (t = 1.76, p = 0.04, *df* = 19; $\bar{x}_1 - \bar{x}_2$ = 0,16, 95% CI 0.03 - 2.71).

Table 2: Relaxation strategies used by the sample group as a whole

Relaxation method		**Phase 1**	**Phase 2**	**Phase 3**
Creative	**Art**	3	3	2
	Sew	1		1
	Study		1	
Substances	**Smoke**		1	1
	Drink	1		
Socialise	**Joke**	1		
	Shop		3	1
	Friends	3	4	3
	Travel		1	1
	Party	1		4
	Church	1	1	1
Passive	**Music**	3	7	6
	Read	10	12	9
	PC games	1		
	TV	11	6	5
	Movies	1	3	2
	Bath	1		2
	Sleep	5	5	4
Physical	**Exercise**	4	1	2
	Walk	3	1	1
	Swim	1		
	Talk		1	
	Eat			1
	Sit in park			1

Table 3: Comparison of groups scores on the Maslach Burnout Inventory sub scales

	Phase 1 (Base line)			Phase 2			Phase 3		
	All	**Gr A**	**Gr B**	**All**	**Gr A**	**Gr B**	**All**	**Gr A**	**Gr B**
EE Frequency	2.07	2.10	2.03	2.19	2.28	2.08	2.27	2.20	2.33
EE Intensity	2.30	2.49	2.05	2.48	2.44	2.53	2.82	2.25	3.38
PA Frequency	4.08	4.11	4.03	4.01	3.75	4.33	3.85	3.20	4.50
PA Intensity	4.51	4.55	4.45	4.52	4.58	4.46	4.27	3.43	5.10
D Frequency	0.79	0.92	0.61	0.77	0.82	0.70	1.12	1.49	0.76
D Intensity	0.87	1.06	0.63	0.98	1.04	0.91	1.08	1.36	0.80
I Frequency	1.61	1.75	1.44	1.13	1.15	1.10	1.47	1.63	1.32
I Intensity	1.59	1.50	1.71	0.93	0.76	1.15	1.50	1.53	1.47

Legend: EE: Emotional exhaustion, PA: Personal accomplishment, D: Depersonalisation, I: Involvement
Group B, phase 2: Formal art classes, phase 3: Informal fabric painting
Group A, phase 2: Informal fabric painting, phase 3: Formal art classes

CONCLUSION

For group B an increase was evident for Personal Accomplishment as well as Emotional Exhaustion. This group was first exposed to the art sessions (formal) and then did the fabric painting sessions. Group A first participated in the fabric painting sessions. This type of intervention strategy was generally regarded as taking part in acquiring a craft. Group A took the art classes after the fabric painting sessions and therefore could not include the information and knowledge gained from the art classes in their fabric painting expressions.

Although the project initially set out to determine the usefulness of each intervention strategy, it appeared that a specific sequence combination of the strategies has worked best. Although additional control groups were not used in this study, clear indications were obtained that the interventions are most effective in reducing the experience of burnout amongst mental health workers when the more technical formal art sessions preceded the more expressive (fabric) painting sessions. First gaining information and technical skills (e.g. the use of colour) appeared to have aided participants in relating to the use of expressive strategies that contribute to the relief of stress and burnout.

The participants first obtained information about and validation of the usefulness of the exercise for themselves (and implicitly also for their clients), which added meaning to taking part in a seemingly time consuming exercise. This is consistent with Mackenzie and Peragine (2003) and Van der Vennet (2003), who advocated that intervention strategies aimed at combating burnout first have to address self-efficacy before they are deemed important and beneficial.

Combinations of strategies with active behavioural coping strategies were found to be more effective in combating stress than avoidance strategies or cognitive strategies. It seems that in the present study the specific order of the intervention strategies brought in a level of cognitive readiness for the active behavioural strategies to be fully operational. To see the intervention strategies as avoidance behavioural coping (seeking alternative rewards, venting emotions and engaging in tension reducing behaviours) alone could not explain the already low burnout levels at baseline measurement. A combination of active behavioural coping strategies (including seeking guidance and support) and active cognitive strategies (relying on logical analysis, positive reappraisal and mental rehearsal of alternatives and consequences) seems to be an effective way to avoid burnout in POWA staff members. A combination of the group and individual debriefing sessions with creative exercises proved to be the most effective (Billings & Moos, 1981; Folkman & Lazarus, 1980; Lazarus, 1966).

It is interesting to note that the participants' relaxation strategies, during the time they were involved in this study, did not change to include creative activities, yet they prescribed these to their clients and requested more sessions for themselves at work. This could be due to the possibility that they had not yet fully internalised the strategies as part of their personal lifestyles, but still separated stress and burnout at work from that experienced at home. It seems likely that they disregarded the cumulative effect of stress and also saw the management of burnout as a "work" problem and considered that the remedy should therefore be found and addressed within the work context. This issue should be further investigated by a follow-up longitudinal study, since it is also possible that over time a stronger internalisation process will take place.

The skills learned through the fabric painting exercises were used, even before the termination of the project, as a tool for the economic empowerment of POWA shelter clients. A qualified art therapist also started sessions with the sheltered women. These two applied outcomes of this study indicated that the burnout interventions with staff members were indeed deemed important by staff. The staff recognised the benefits of the sessions within the context of working with their clients, before recognising the benefits for themselves. The meaningful use of the interventions as an extension of their counselling skills appears to have resulted in at least a partial internalisation that could have contributed to the expression of decreased burnout levels. The intervention strategy first had to be relevant to their work, along with an increase in the experience of self-efficacy, to be effective (Mackenzie & Peragine 2003; Van der Vennet 2003).

In conclusion, it seems that effective strategies to combat burnout in counsellors should consist of combinations of different approaches. In this study the debriefing and group sessions (and discussion of cases amongst colleagues) already alleviated high stress and burnout levels (as was evident from the baseline measurement results). In addition, the importance of group therapy and individual debriefing session should not be underestimated (Jamuna & Ramamurti, 2000; Meier, 2002; Reid *et al.*, 1999).

One weakness of the study that could be useful in planning future research in the same field is the absence of additional control groups. In replication studies these could consist of workers in the trauma field, yet not involved in women abuse, or/and a group with similar sample characteristics that is not offered debriefing sessions, but only the intervention strategies as introduced here.

A slight timing effect could have been present in this study, since the workload during the last stages of the intervention did increase. This increase is not evident from the measured "perceived workload" since only the number of clients seen was measured, and not other duties such as delivering presentations and other administrative duties that increase annually during August, internationally declared as the month where extra thought and consideration is given to women's issues. Ideally, future studies should include more differentiated measures of stress and coping.

However, within the emotionally challenging work environment of POWA, this specific group of trauma counsellors underscored the beneficial role of art and creative strategies in assisting them to remain meaningfully engaged with both colleagues and clients.

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CHAPTER 6

GENERAL CONCLUSIONS

Violence against women is a multifaceted problem, not only in South Africa, but also worldwide. Although it seems that it affects some portions of the population more, it actually cuts across all groups and should be addressed in all sectors of the population.

OVERVIEW

There are many factors influencing relationships, ranging from attraction, to developing abuse, to the different strategies used by abused partners to end the abuse. These strategies are aided by factors from all the different levels, as described by ecological approaches. Some studies focus on individual factors (for victim and perpetrator), while others focus on the microsystem (immediate relationship), mesosystem (other relationships and the interplay between aspects of the socio-cultural environment), exosystem (context of social relations within the socio-physical environment) or the macrosystem (culture at large) (Heise, 1998). None of these approaches is necessarily wrong, but a multilevel approach, incorporating all the different levels, is needed for future research (Schoeman & Ferreira, 2000).

This very complex interaction should further be seen as a continuum in time in which the abused women function. Not only is the abusive part of the relationship important, but also the time before the abuse started. The same is relevant for the time after women decide to leave. The influence of all the different levels is also crucial in determining the reasons why women finally decide to leave and stick to this decision. This makes research involving women who have already moved on to a new life without the abuser important. Aspects important during one phase of the relationship might change and be completely different during a new phase. A diagrammatical representation of this interaction is provided in figure 1.

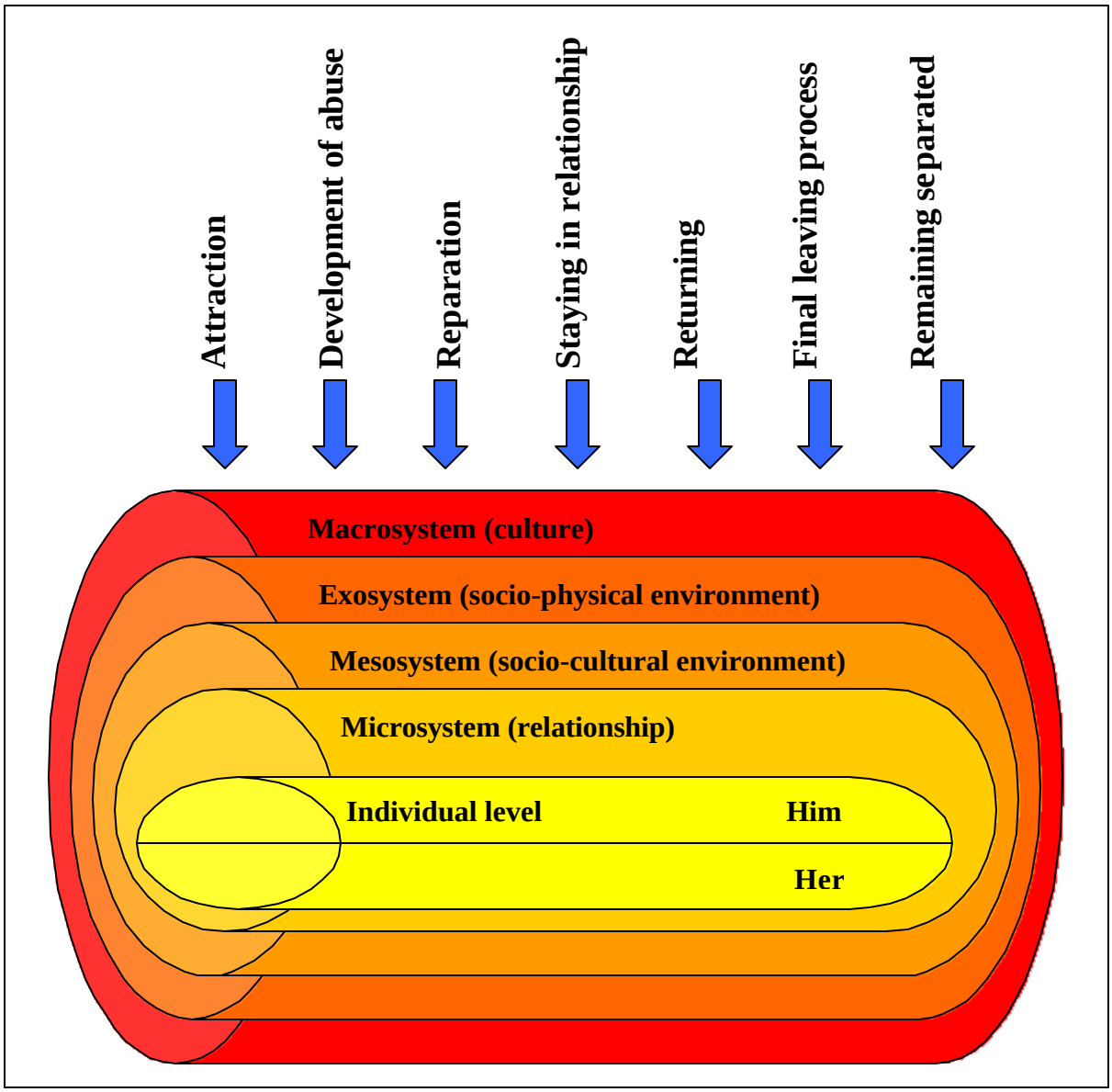

Figure 1: Temporal distribution of the influence of different systems

This thesis has documented different studies performed to investigate the experiences of and support received by abused women during their experiences, including describing the experiences of women who decided to leave an abusive partner, involvement of medical professionals, social support of abused women who are living with HIV and burnout amongst workers in the field of violence against women. The following diagram aims to describe the links between the different studies (Figure 2).

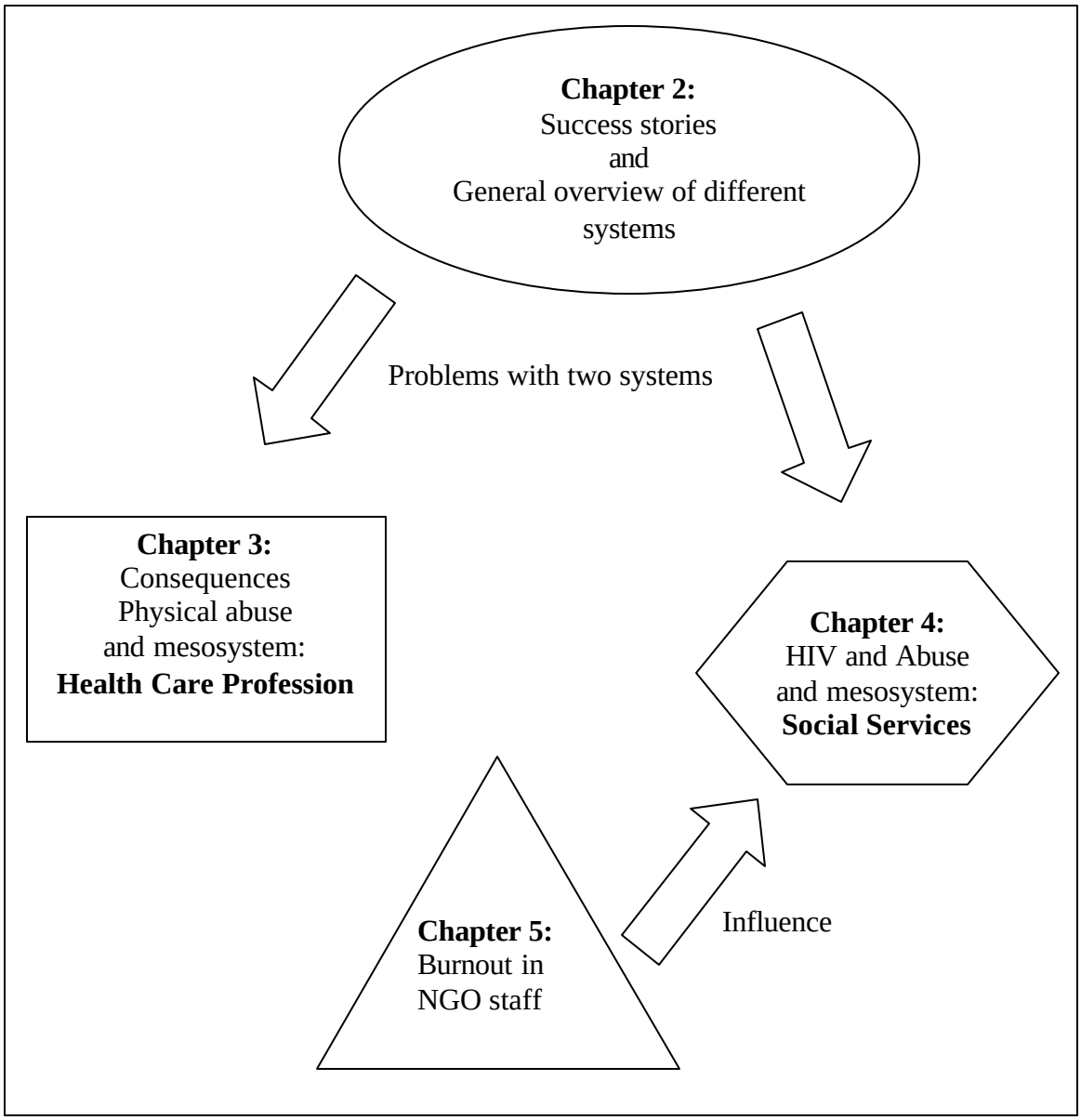

Figure 2: Diagrammatic representation of chapters

CONCLUSIONS

The following is a brief description of the main conclusions found for each individual study as well as of the combined effect of the studies.

Success Stories of Women Who Decided to Leave Their Abusive Partners: A Temporal, Ecological Approach

This study explored the experiences of abused women who decided to leave their abusive partners. Not only was the importance of investigating all the different levels relevant in an ecological approach emphasised, but also the importance of

incorporating the different stages of the relationship or the timing in the women's decision making process. The resilience of the women participating in the study was admirable, yet their inability to forgive the perpetrator surprising (Humphreys, 2003). The study further provided a broad overview of the literature and the current situation of abuse research.

Physically Abused Women's Experiences and Expectations of Medical Practitioners

The anatomical location of the physical injuries sustained by women revealed that most of the injuries were caused by unpremeditated violence by the abuser or in defensive actions by the women. The women expressed a need to be recognised as victims of abuse and treated and referred correctly and early by medical practitioners.

HIV and Women Abuse: Case Management

Because of the growing importance of dealing with a special group of abused women who also tested positively for HIV, the study investigating the intersection of HIV and women abuse was conducted. This study did not consider the risk factors but rather the experiences and the support that these women receive from social services. Due to a lack of understanding of the specific needs of these women they often do not access the relevant services or are shifted from one social service to another. This topic will become increasingly important for organisations dealing with abused women.

Intervention Strategies to Combat Burnout amongst POWA Workers

Due to the heavy workload experienced by People Opposing Women Abuse (POWA) and the commitment and personal involvement of staff members with their clients, burnout is a serious negative effect on these individuals that can in turn affect the service delivery to clients. The well-being of the workers is therefore of importance and although debriefing and supervision sessions are held regularly, additional intervention strategies are needed. The use of creative exercises in combination with formal art sessions seemed to be the correct intervention for this group of workers.

General conclusions

The importance of social support organisations was emphasised in all four different articles included in this thesis. The role of Non Governmental Organisations (NGOs) such as People Opposing Women Abuse (POWA), faith based organisations and the government is crucial in developing intervention strategies on all the different levels.

The involvement of an organisation such as POWA spans all aspects covered in the ecological approach and also the timing of the events. Although it might seem that their involvement is based at the individual level, the training, advocacy and lobbying role played by these organisations can never be underestimated. But the contribution of research and the newly established research department at POWA can address problems at various levels. In-house research on the NGO level can also play an important educational role not only for internal use (e.g. taking care of counsellors well-being) or for use in the sector of violence against women, but also a broader role in educating other stakeholders (e.g. medical professionals). The intersection of HIV and any other health or social science is of crucial importance in the South African context. Investigating aspects of the intersection between women abuse and HIV will be of increased importance in future. It seems that research into all aspects of women abuse should not be left to academics, but should also be addressed by organisations working at grass root levels.

LIMITATIONS

The following aspects limited the generalisability of the findings, especially to other regions:

- Some studies, due to the restrictions in funding and staffing (limited fieldworkers), could only be conducted with limited numbers of participants. This, however, does not detract from the importance of the findings for the specific organisation and its clients.
- Participants are all vulnerable due to the fact that they were abused and recruitment is therefore hampered, especially in cases where other factors (such as being HIV positive) play a role.

RECOMMENDATIONS

The main recommendations of this thesis include:

- In-house research departments such as the one established at POWA should be developed and supported.
- Findings of research studies should be disseminated so as to educate not only academics and people in the sector (including stakeholders such as the police service and medical professionals), but also the clients of NGO's and the general public.
- All aspects of an abused women's relationship should be considered and more research is needed that examines the interaction of all the different aspects in an individual's experiences.
- Abused women should be approached in a way that reflects the acceptance of the timing aspects and the differences in women in different phases of the abusive relationship. For example, women preparing to leave should be treated in a different way from women who have not yet come to this decision and for whom remaining in the relationship is the best way of dealing with the abuse.
- Networking amongst academic institutions and new NGO research departments is crucial, as is the networking between NGOs in the sector. This will also result in more accurate statistics that can in turn serve an important role in advocacy, lobbying and education.

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