Select psychosocial risk factors contributing to domestic violence against women in Tshwane, South Africa

by

CHERIE DREYER

submitted in accordance with the requirements

for the degree of

MASTER OF ARTS

In the subject

PSYCHOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF J A NEL

NOVEMBER 2018

TABLE OF CONTENTS

DECLARATION

I, Cherie Dreyer, Student number 41977432, declare that **SELECT PSYCHOSOCIAL RISK FACTORS CONTRIBUTING TO DOMESTIC VIOLENCE AGAINST WOMEN IN TSHWANE, SOUTH AFRICA** is my own work and all the sources I have used or quoted have been indicated and acknowledged by means of complete referencing, and that this work has not been submitted before for any other degree at any other institution.

_____ _____

Mrs. Cherie Dreyer Date

ABSTRACT

South Africa has among the highest rates of physical and sexual violence against women in the world. Research indicates that understanding the causality of domestic violence is very complex and the measurement of risk factors are deemed challenging. Yet, it is important to understand and identify the risk factors associated with domestic violence to effectively prevent it. This phenomenological research study aimed to investigate the lived experiences of female domestic violence victims and sought to identify risk factors (e.g. alcohol and drug abuse, violence in the family of origin, personality factors, cultural differences, socio-economic factors, and the impact of pregnancy) that may have contributed to the occurrence of domestic violence in their intimate relationships .The participants were selected based on purposive and convenience sampling and also their willingness to participate. The sample consisted of six participants between the ages of 18 – 45 years old, residing in Tshwane, South Africa. The data were obtained through semi-structured interviews. A qualitative methodological design was used to collect and explore information about the participants' personal experiences with domestic violence. Hycner's explicitation process was employed to identify the four main themes, namely the participants' experience of domestic violence; socio economic factors; cultural differences, and domestic violence during pregnancy. Each main theme was comprised of sub-themes.

The findings of this study differed slightly in comparison with the existing body of literature that highlight substance abuse as one of the highest risk factors for the occurrence of domestic violence in intimate relationships. In this study, other risk factors such as pregnancy and socio-economic factors played a much bigger role than substance abuse as the key risk factors that contribute to the occurrence of domestic violence.

KEY TERMS:

domestic violence; intimate partner violence; risk factors; psychosocial, substance abuse; violence in the family of origin; personality factors

ISIFINYEZO ESIQUKETHE UMONGO WOCWANINGO

INingizimu Afrika ingenye yamazwe omhlaba anamazinga aphezulu odlame nokuhlukunyezwa kwabesimame ngokocansi. Ucwaningo lubonisa ukuthi ukuqondisisa izimbangela zodlame lwasekhaya yinto eyisixakaxaka ukuyiqondisisa kanti futhi kuyinselele ukukala izinto ezinobungozi kwabesimame. Kodwa ngisho noma kunjalo, kubalulekile ukuqondisisa kanye nokwazi izinto ezinobungozi ezihambisana nodlame lwasekhaya ukuze lukwazi ukuvinjelwa. Lolu cwaningo oluhlaziya ngaphandle kokuthatha uhlangothi, lunenhloso yokuphenyisisa indlela abantu besimame abangamaxhoba odlame abalubona nolubaphatha ngayo udlame lwasekhaya kanye nokubheka izinto ezinobungozi (ezifana nokusetshenziswa kabi kotshwala nezidakamizwa, udlame emakhaya okuqala abahlukumezi, izinto eziqondene nomuntu siqu, umehluko kwezamasiko, eziphathelene nomnotho nabantu kanye nomphumela ekukhulelweni), okungaba yizinto ezinomthelela kudlame lwasekhaya ebudlelwananeni basekhaya. Abantu ababambe iqhaza kucwaningo bakhethwe ngokulandela isampuli enenhloso yokukhetha abathile abazohlangabezana nenhloso yocwaningo kanye nokuzimisela kwabo ukubamba iqhaza kucwaningo. Isampuli ibinababambi-qhaza abayisithupha abaphakathi kweminyaka engu 18 ukuya kwengu 45 ubudala, okwamanje abahlala eTshwane. I-data itholakala ngokwenza ama-interview ahlelekile kodwa angenamkhawulo kakhulu. Kusetshenziswe idizayini yocwaningo esebenzisa i-qualitative method ukuqoqa nokuthola ulwazi maqondana nezipiliyino zababambi-qhaza kudlame lwasekhaya. Kusetshenziswe inqubo ye-Hycner's explicitation ukuphawula izihloko ezine ezinkulu, ukuyizipiliyoni zababambi-qhaza kudlame lwasekhaya, izinto eziphathelene nabantu nomnotho, umehluko kwezamasiko, udlame lwasekhaya ngesikhathi sokukhulelwa. Isihloko nesihloko esikhulu, besihlukaniswe ngezihlokwana ezincane.

Imiphumela yalolu cwaningo yehlukile kancane uma kuqhathaniswa neminye imibhalo ekhona egqamisa ukusetshenziswa kabi kwezidakamizwa njengenye yezinto ezinkulu eziyingozi nembangela yodlame lwasekhaya kanye nakubudlelwane babantu abasondelene kakhulu. Kulolu cwaningo, ezinye izinto eziyizingozi ezifana nokuhlukunyezwa ngesikhathi sokukhulelwa kanye nokuphathelene nabantu nomnotho kunendima enkulu kunokusetshenziswa kabi kwezidakamizwa notshwala njengezinto eziphezulu kakhulu ezinomthelela kudlame lwasekhaya.

AMATHEMU ABALULEKILE:

Udlame lwasekhaya (domestic violence); udlame olwenziwa ngumlingani osondelene naye kakhulu (intimate partner violence); izinto ezinobungozi (risk factors); okuphathelene nokuphilisana kwabantu ngokomqondo (psychosocial), ukusetshenziswa kabi kwezidakamizwa (substance abuse); udlame ekhaya lokuqala lapho umhlukumezi evela khona (violence in the family of origin); izinto ezinomthelela zobunjalo bomuntu siqu (personality factors)

MANWELEDZO

Afrika Tshipembe ḽi vhukati ha phimo ya nṱhesa ya khakhathi dza zwa vhudzekani na dza u huvhadza vhafumakadzi kha ḽifhasi. Ṱhoḓisiso i sumbedza uri u pfesesa vhakwameaho nga khakhathi dza mitani zwi a konḓa nga maanḓa na u elwa ha zwiitisi zwa khombo zwi vhonala zwi khaedu vhukuma. Fhedziha, ndi zwa ndeme u pfesesa na u wana zwiitisi zwa khombo zwine zwa tshimbilelana na khakhathi dza miṱani u itela uri dzi kone u thivhelwa. Iyi ndi ngudo ya ṱhoḓisiso nga tshenzhemo yo livhiswaho kha u ṱhoḓisisa tshenzhemo ye vhafumakadzi vho ṱanganaho na khakhathi dza mitani vha tshenzhema na u ṱoda u wanulusa zwithu zwi vhangaho khombo iyi. (zwine zwa nga vha tshumiso ya zwikambi na zwidzidzivhadzi, khakhathi dza murahu muṱani, vhuvha ha muthu, zwiitisi zwa ikonomi ya matshilisano, phambano ya mvelele, u ḓihwala) zwine zwa nga vha zwo livhisa kha u bvelela ha khakhathi dza miṱani kha vhafunani. Vhadzheneli vho tiwa zwo ḓitika nga ndivho nauri vha tsinisa na lutamo lwa u dzhenelela lwa avho vhathu. Sambula yo vhumbwa nga zwipiḓa zwa rathi zwa vhadzheneli vha miṅwaha ya vhukati ha 18 – 45, vhane zwa zwino vha dzula kha ḽa Tshwane. Data yo kuvhanganywa nga kha mbudziso dzi sa langiho kufhindulele. Nḓila ya u tandula ‘qualitative’ yo shumiswa u kuvhanganya na u ṱhaṱhuvha zwidodombedzwa nga ha tshenzhemo dza vhadzheneli nga ha khakhathi dza miṱani. Kuitele kwa Hycner a songo ḓoweleaho kwo shumiswa u wana ṱhoho dza ndeme nṋa; dzine dza vha tshenzhemo ya vhadzheneli nga ha khakhathi dza miṱani, zwiitisi zwa ikonomi ya matshilisano; phambano ya mvelele, na dzikhakhathi dza miṱani nga tshifhinga vho ḓihwala. Ṱhoho khulwane yo vhumbwa nga ṱhoho ṱhukhu.

Mawanwa a ngudo iyi a fhambana nyana na mbambedzo na tshivhumbeo tsha maṅwalo ane a vha hone ane a ombedzela tshumiso ya zwidzidzivhadzi sa tshiṅwe tsha tshivhangi tshihulwane tsha khakhathi dza miṱani kha vhushaka ha vhafunani. Kha ngudo iyi, dziṅwe khombo dzi fananho na u ḓihwala na zwiitisi zwa ikonomi ya matshilisano zwi vha zwivhangi zwihulwane u fhira tshumiso ya zwidzidzivhadzi na zwiitisi zwa khombo zwa ndeme zwine zwa vhanga khakhathi dza miṱani.

MAIPFI A NDEME:

Khakhathi dza mitani; khakhathi kha vhafunani; zwivhangi zwa khombo; u tambudzwa lwa muhumbulo, tshumiso ya zwidzidzivhadzi; khakhathi dza murahu dza muṱani; vhuvha ha muthu

ACKNOWLEDGEMENTS

I would like to express my sincere appreciation and gratitude to several people:

My supervisor, Prof. Juan Nel, for his professional guidance, consistent encouragement, motivation, patience, and honesty. I would never have been able to this this without your unwavering support and direction.

To my beautiful daughter, you were only a baby when I started on this journey. Thank you for understanding when I had to tell you that mommy had to work and could not play with you. I love you with all my heart.

To my very special mother. If it had not been for all the pain and heartache you have experienced, I would never have studied psychology. I miss you every single day.

To Dr. Caryl Ochse, thank you for your editorial services. Thank you for providing me with your insight and guidance on improving the quality of this dissertation.

To all the participants: I will forever be immensely grateful to all the women who opened their hearts and shared their pain and life stories with me – this study would not have been possible without you.

DEDICATION

This study is dedicated to my beautiful daughter Danaë du Plessis and my late mother, Janey Dreyer.

CHAPTER 1

INTRODUCTION AND ORIENTATION

1.1 Introduction

In this chapter, I provide a general orientation of the study and its context. I include a descriptive statement of the research topic, discuss the rationale of the study, and provide a description of important terms. Last, I provide a brief discussion of the subsequent chapters.

1.2 Contextualising the problem

In South Africa, physical violence is the second leading cause of death and disability (Leburu & Phetlho-Thekisho, 2015). According to research, partner violence accounts for 40% to 70% of the female homicide rate (Abrahams, Mathews, Martin, Lombard & Jewkes, 2013). According to Machisa, Jewkes, Lowe Morna, & Rama, (2010) during 2010, one in five women in Gauteng alone, reported an incident of violence by an intimate partner.

Domestic violence may be known by other terms including, intimate partner violence, domestic abuse, spousal abuse, wife abuse, and battering (Gover, 2009). Domestic violence includes physical, sexual, and psychological abuse (Jackson, 2006; Salkind, 2005). This type of violence can occur between couples in heterosexual relationships as well as between couples in same-sex relationships. I would like to emphasise that this study focused on the occurrence of domestic violence in a heterosexual relationship and in particular directed from men to women. Moreover, several researchers cite that domestic violence is most frequently perpetrated by male intimate partners and the victims are typically female (Department of Social Development, 2009; Gover 2009; Jackson 2006; Miller 2012; Tjaden & Thoennes, 2000).

Domestic violence against women has an extremely deleterious effect on their health and well-being (Gass, Stein, Williams & Seedat, 2010). Physical health outcomes of domestic violence includes injury (e.g. bruises, cuts, fractures), gynaecological problems (e.g. lower abdominal pain, abdominal discomfort, vaginal pain, dysmenorrhoea, dyspareunia, abnormal uterine bleeding), HIV, sexual transmitted diseases, headaches, asthma, irritable bowel syndrome, mental health issues (e.g. depression, fear, anxiety, post-traumatic stress disorder [PTSD], eating disorders) among many other problems (World Health Organisation [WHO], 2013).

The present study aimed to explore some of the risk factors that contribute to the occurrence of domestic violence. Factors such as alcohol and drug abuse, personality factors, violence in the family of origin, socio-economic factors, cultural differences and pregnancy were further discussed. I chose risk factors such as alcohol and drug abuse, personality factors, and violence in the family of origin because they have been identified as some of the highest risk factors for the occurrence of domestic violence. Socio-economic factors, cultural differences and pregnancy abuse were highlighted as high-risk factors of domestic violence during my interviews with the participants.

The understanding of the causality of domestic violence is extremely difficult and the measurement of risk factors such as culture and socioeconomic status are deemed challenging (Jewkes, Levin & Penn-Kekana., 2002). As an example, financial independence of a woman is not always a protective factor against partner violence. Some women who are employed and have partners that are unemployed, are at a great risk for abuse (Jewkes et al., 2002). The partner may feel insecure, threatened, and jealous that his wife or partner is working and therefore subject them to abuse. Another challenging factor may be that some cultures condone the use of physical abuse against women with only certain boundaries and limitations (Jewkes et al, 2002; WHO, 2013).

Having noted the fundamental health concerns as well as the mortality rate of domestic violence victims, it is important to investigate the cause and factors that increase or decrease the risk of such violence. Research can assist us to understand the magnitude and impact of domestic violence on the victims of abuse. Domestic violence can be prevented if we have a better understanding of the risk factors that contribute to the occurrence thereof.

1.3 Aims of the Research

With this research I wish to contribute to the growing body of knowledge of domestic violence against women in Tshwane, South Africa by describing the lived experiences of domestic violence victims and identifying risk factors that may contribute to this type of violence. It is important that domestic violence is minimised or stopped before it occurs rather than rehabilitating perpetrators or treating victims of such violence (WHO, 2013).

1.4 Research Questions

The research questions guiding this study are:

1. What are the demographic characteristics (race, age, education, occupation and marital status) of women who suffer from domestic violence in Tshwane, South Africa?
2. What are the markers that can be used to identify individuals at risk for becoming the victims of domestic violence?
3. How do psychosocial risk factors (e.g. alcohol and drug abuse, violence in family of origin and personality factors, socio-economic factors, cultural differences and the impact of pregnancy) have an influence on the occurrence of domestic violence?

1.5 Definition of terms

The main key terms used in the study are defined and discussed below:

Domestic Violence and Abuse

"Domestic violence is threatening behaviour, violence or abuse (physical, sexual, emotional or financial) between adults who are, or who have been, intimate partners or family members, regardless of gender or sexuality" (Sohal, Feder & Johnson, 2012 p. 750).

Intimate Partner Violence

"Intimate partner violence is actual or threatened physical or sexual violence or psychological and emotional abuse directed toward a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner. Intimate partners may be heterosexual or of the same sex. Terms used to describe intimate partner violence are domestic abuse, spouse abuse, partner violence, rape, and battering, among others." (Swanberg, Logan & Macke 2005, p. 289).

Risk Factors

"A risk factor can be considered a type of correlate. It is associated with an increased probability of an outcome, usually an unpleasant one. It has, however, a major distinguishing characteristic from other correlates, which is it occurs before the outcome. This is one of the two defining characteristics of a risk factor. The measure of the risk factor is taken on each subject before the subject has the outcome of interest. The second defining characteristic of a risk factor is that it can be used to divide a population into high risk and low risk subgroups. The probability of the outcome must be shown to be greater in the high risk compared with the low risk group. Thus, the two defining characteristics of a risk factor are that it precedes

the outcome, and when used it divides a population into high risk and low risk subgroups." (Offord & Kraemer 2000, p. 70).

Psychosocial

"Psychosocial factors are influences that affect a person psychologically or socially. There are multidimensional constructs encompassing several domains such as mood status (anxiety, depression, distress, and positive affect), cognitive behavioural responses (satisfaction, self-efficacy, self-esteem, and locus of control), and social factors (socioeconomic status, education, employment, religion, ethnicity, family, physical attributes, locality, relationships with others, changes in personal roles, and status)" (Gellman & Turner, 2013 p. 1).

Substance Abuse

According to the American Psychiatric Association (2013) "to be diagnosed with a substance abuse disorder, individuals will need to have a problematic pattern of substance use leading to impairment or distress as well as two or more additional factors such as the following: (a) using in larger amounts or over a longer period than intended, (b) unsuccessful efforts to cut down or control use, (c) spending significant amounts of time in activities to obtain the substance or recover from its effects, (d) failure to fulfil role obligations, (e) continued use in spite of social or interpersonal problems associated with use, (f) giving up or reducing important activities, (g) recurrent use in hazardous situations, (h) continued use in spite of physical or psychological problems associated with use, (i) tolerance as indicated by either a need for markedly increased amounts of the substance or diminished effect with continued use of the same amount of the substance, (j) withdrawal when substance use is stopped (or avoidance of withdrawal by continued use), (k) or craving or strong desire for the substance" (Satre & Wolfe, 2015 p. 121).

Violence in the Family of Origin

There are several international studies that have indicated that exposure to violence in childhood can lead to a higher risk of becoming adult perpetrators or victims of domestic violence (Carrigall & Matzopoulos, 2013; Dutton & Hart, 1992; Riggs, O'Leary & Breslin, 1990; Smith & Williams, 1992; Whitefield, Anda, Dube & Felitti, 2003).

Children are said to model the behaviour and response patterns they learn from their parents and family members (Benda & Corwyn, 2002; Camacho, Ehrensaft & Cohen, 2012; Hines & Saudino, 2002, Skuja & Halfrod, 2004). Graham-Bermann et al. (2008) and Sternberg, Lamb, Guterman & Abbott (2006) found that the age at which children are exposed to domestic violence has certain mental development implications, especially for very young children. Younger children are less capable of making enough sense of violent incidents and do not have the coping abilities that older children have (Bell & Wolfe, 2004).

Personality Factors

Hanson, Cadsky, Harris and Lalonde (1997) and Covell, Huss and Langhinrichsen-Rohling (2007) explained that domestic violence perpetrators, tend to score higher on measures of anger, hostility, antisociality and substance abuse. Dutton and Starzomski (1994) and Hamberger, Lohr, Bonge and Tolin (1996) cited that between 50 and 90 % of court-ordered perpetrators of abuse have distinct personality disorder traits. In another international study, Gibbons, Collins and Reid (2011) found that 54% of their sample of male domestic violence perpetrators had a personality disorder and that 37% of the sample had severe personality psychopathology. Ehrensaft, Cohen, and Johanson (2006) cited that personality factors as well as psychopathology are the strongest predictors of partner violence. Antisocial and borderline personality disorders are the most commonly found in partner abusive men (Costa & Babcock, 2008; Ross & Babcock, 2009; Swogger, Walsh & Kosson, 2007).

1.6 Outline of the Dissertation

The content of the chapters in the dissertation will now be discussed.

Chapter 1: Introduction

Chapter 1 serves as a general orientation and context setting for the readers of the dissertation. The chapter includes a descriptive statement of the research topic, a general overview of the research, description of important terms, and a brief discussion of the subsequent chapters.

Chapter 2: Literature review

Chapter 2 provides a literature review on women in South Africa's lived experiences of domestic violence and the risk factors (e.g. alcohol and drug abuse, violence in the family of origin and personality factors) that may have contributed to the occurrence of domestic violence in their intimate relationships. This chapter ends with a discussion of four theories that inform this study: Ecological Theory, Family Systems Theory, Theory of Planned Behaviour, and Feminist Theory.

Chapter 3: Research Methodology

Chapter 3 describes the research process and methodology employed in this study. This chapter includes the research design, population sample, data collection and instrumentation, data analysis, and theoretical framework of the study.

Chapter 4: Analysis and discussion

Chapter 4 begins with a short profile of the participants to orientate the reader towards the current situation of each participant. This is followed by a discussion and analysis of the findings in view of the available literature.

Chapter 5: Summary, conclusion, and recommendations

Chapter 5 provides a summary of this study, conclusion, limitations, and recommendations for future research.

1.7 Conclusion

The following chapter explores the underlying epidemiology of domestic violence against women.

CHAPTER 2

THE EPIDEMIOLOGY OF DOMESTIC VIOLENCE AGAINST WOMEN

Some Kind of love, Some Say;
is it true the ribs can tell
The kick of a beast from a
Lover's fist? The bruised
Bones recorded well
The sudden Shock, the
Hard impact. Then swollen lids,
Sorry eyes, spoke not
Of lost romance, but hurt.
Hate often is confused. Its
Limits are in zones beyond itself
Sadists will not learn that
Love, by nature, exacts a pain
Unequalled on the rack.
~ Maya Angelou
Poet, 1951 - 2014

2.1 Introduction

There is no universally accepted definition for the term violence against women. The definitions of domestic violence vary from narrow to more comprehensive definitions. One of the many definitions of domestic violence is the "…intentional abuse or assault committed by a past or present spouse, intimate partner, family member, or household member regardless of age or gender" (Jackson, 2006, p. 3). The South African Domestic Violence Act, no. 116 of 1998 defines domestic violence as "…physical and sexual abuse (e.g. any behaviour that

humiliates, degrades or violates the sexuality of a person) as well as emotional and psychological abuse (e.g. repeated insults and/or threats, name-calling, obsessive possessiveness and jealousy) that occurs within a domestic relationship. It also includes economic abuse (e.g. unreasonable refusal to share money or selling or giving away household property), intimidation, harassment, stalking, damage to property, and entering a person's home without their consent. Domestic violence is a universal phenomenon that affects all cultures, age groups, ethnicities, income levels, genders, and sexual orientations (Sokoloff & Dupont, 2005). It is important to note that the sexual intimacy factor in a relationship is not a prerequisite for the occurrence of domestic violence (Gover, 2009

Domestic violence is not always a gendered crime (e.g. man to woman); this type of violence can also occur in same-sex relationships as well as from woman to man (Dixon & Browne, 2003; Miller, 2012). Several researchers, however, cite that domestic violence is most frequently perpetrated by male intimate partners and the victims are typically female (Miller, 2012; Tjaden et al., 2000). Studies indicate that female to male violence occurs in only 5% of cases and that men are more likely to seriously injure their female partners than vice versa (Archer, 2000; Bornstein, 2006; Jackson, 2006).

However, as claimed by Bornstein (2006) as well as Buttell and Carney (2004) the prevalence of domestic violence perpetrated by women may be underestimated due to the social stigma that is attached to male abuse. Men are unlikely to speak up about being the victim of domestic violence due to the cultural imperative on men to defend and stand up for themselves. Men are also prone to feel that society will not believe them or even think that they are exaggerating about being the victim of abuse perpetrated by a woman.

According to an international study conducted in the United States, it was found that, within the research population 42% of white females reported being a victim of partner violence whilst 19% of white men reported being abused (Caetano, Schafer & Cunradi, 2001).

2.2 Forms of Domestic Violence

Domestic violence occurs in many forms and perpetrators may use a wide variety of abusive tactics. Literature suggests that there are primarily three types of domestic violence namely, psychological abuse, physical battery, and sexual assault.

2.2.1 Emotional/ Psychological abuse:

Emotional abuse refers to the use of any tone of voice, words, and actions used to control, intimidate, hurt or degrade a person and which results in emotional trauma. Psychologically abusive behaviour includes, but is not limited to, the use of verbal threats, humiliation, limiting or controlling the victim's activities or behaviour, destroying a victim's personal property, abusive behaviour towards a victim's loved ones, intimidation, stalking, economic control, and isolation from friends and/or family (Gover, 2009; Jackson, 2006; Mouradian, 2007). Albeit the fact that most couples frequently argue and say things that they may regret later, emotional abuse refers to *repeated* hurtful exchanges with a blatant disregard for the other person's feelings. This type of behaviour, which is frequently used to gain control and power over the victim, is a common occurrence in relationships where physical abuse also occurs (Bergen 1996; Mauradian 2007).

2.2.2 Physical abuse:

Physical abuse within the domestic domain is also known as partner violence/abuse, physical aggression/abuse, dating violence/abuse, spousal abuse, and conjugal violence. Physical abuse can be described as the act of inflicting or attempting to inflict physical injury or pain to another person (Leburu et al., 2015; Straus & Gelles, 1986). This type of abuse, which is

used to maintain power and control of the victim, includes but is not limited to kicking, punching, choking, throwing of objects, slapping, stabbing, shooting, beating with fists, and biting. Thus, physical abuse involves the use of force that can intentionally or accidentally result in physical harm, disability or death (Gover, 2009; Jackson, 2006). In certain relationships physical abuse may occur as a once off incident but in most abusive relationships it happens repeatedly and escalates in frequency and severity over time (Mouradian, 2007).

2.2.3 Sexual abuse:

Sexual abuse has been defined as "…sex without consent, sexual assault, rape, sexual control of reproductive rights, and all forms of sexual manipulation carried out by the perpetrator with the intention of perceived intention to cause emotional, sexual, and physical degradation to another person" (Abraham, 1999, p. 592). Thus, sexual abuse is any forced sexual act or behaviour that is used to gain power over a victim without their consent. This type of abuse includes rape (including marital and date rape), attempted rape, and forcible sexual acts such as fellatio, oral coitus, and sodomy (Gover, 2009; Jackson, 2006). Sexual abuse also encompasses psychological abuse of a sexual nature such as criticising sexual performance and desirability, and accusations of infidelity (Gover 2009; Jackson, 2006).

2.3 Prevalence of Domestic Violence

The prevalence of domestic violence from a historical perspective, global phenomenon, and local context will now be further discussed.

2.3.1 Domestic Violence: A Historical Perspective

Domestic violence is not a novelty to the modern world. 'Wife beating' was apparently a fairly common occurrence in the ancient world. Early ideas and practices of domestic violence were first documented during Roman times (753 B.C.) and later these practices

escalated and were endorsed by the Catholic Church (England, 2007; Miller, 2012). Romulus, (best known for being one of the founders of Rome) introduced a law that commanded (1) women to surrender themselves entirely to their husband's temper and (2) men to 'rule' their wives (England, 2007). According to the history of laws governing domestic violence, Friar Cherubino (15th century) established the Rules of Marriage in which he defined how a man should control his wife:

> *When you see your wife commit an offense, don't rush at her with insults and violent blows… Scold her sharply, bully and terrify her. And if that doesn't work… take up a stick and beat her soundly, for it is better to punish the body and correct the soul than to damage the soul and spare the body… Then readily beat her, not in rage, but out of charity and concern for her soul, so that the beating will redound to your merit and her good (England, 2007 p. 1).*

The notion of wife beating remained in English law during the 18th Century and was abolished during the 19th Century. In this regard Sir William Blackstone (English judge and Tory politician, 1723-1780) declared that:

> *The husband also (by the old law) might give his wife moderate correction. For, as he is to answer for her misbehaviour, the law thought it reasonable to entrust him with his power of restraining her, by domestic chastisement, in the same moderation that a man is allowed to correct his servants or children; for women the master or parent is also liable in some cases to answer (England, 2007, p. 2).*

The law of chastisement permitted husbands to beat their wives with any implement so long as it was not larger than the husband's thumb. This law later became known as the 'rule of thumb' (Miller, 2012, p. 3). Blackstone declared that women, who were legally bound to their

husbands, had no legal rights and were seen and treated as possessions. A married woman could not file a lawsuit against her husband because it was considered equivalent to having a case against herself (England, 2007; Siegel, 1994).

Chastisement remained in the law until the 19th century. In 1850 Tennessee became the first United States [US] state to pass a law that outlawed wife beating (Brison & Manne, 2013; England 2007). Other US States soon followed suit and the United Kingdom updated their Matrimonial Causes Act in 1878: Women who were victims of violence in marriage were able to obtain a separation order (Foyster, 2005).

2.3.2 Domestic Violence: A Global Phenomenon

Domestic violence is a universal phenomenon that cuts across societal boundaries and persists in all countries of the world (Vos et al., 2009; WHO, 2005).

National and regional variations exist with higher rates of domestic violence in communities that place emphasis on conventional gender roles, heteronormativity, and female chastity (Vos et al., 2009). In an international study, which was conducted by the WHO, it was estimated that over 35% of women globally were victims of physical, and/or sexual abuse by male intimate partners (WHO, 2013). During 2006, a UN survey of 24 000 women in 10 different countries found that the prevalence of intimate partner violence ranged from as low as 15% in urban areas of Japan to as high as 71% in rural Ethiopia (United Nations General Assembly, 2006).

The WHO, in conjunction with the London School of Hygiene and Tropical Medicine and the South African Medical Research Council (MRC), published the first global systematic review of available scientific data on the prevalence and health effects of intimate partner and non-partner sexual violence (Devries et al., 2013; WHO, 2013). According to this report, intimate partner violence (physical or sexual harm by a current or former partner or spouse) is the

most common type of violence worldwide and effects 30% of all women (Devries et al., 2013; WHO, 2013). Other disturbing findings in their study were that globally, of all women who had been a victim of homicide, 38 % had been murdered by their partner and that 42% of women who had been abused by their partners had experienced injuries as a result (Devries et al., 2013; WHO, 2013). Domestic violence victims generally endure a history of violence and brutality by their partner.

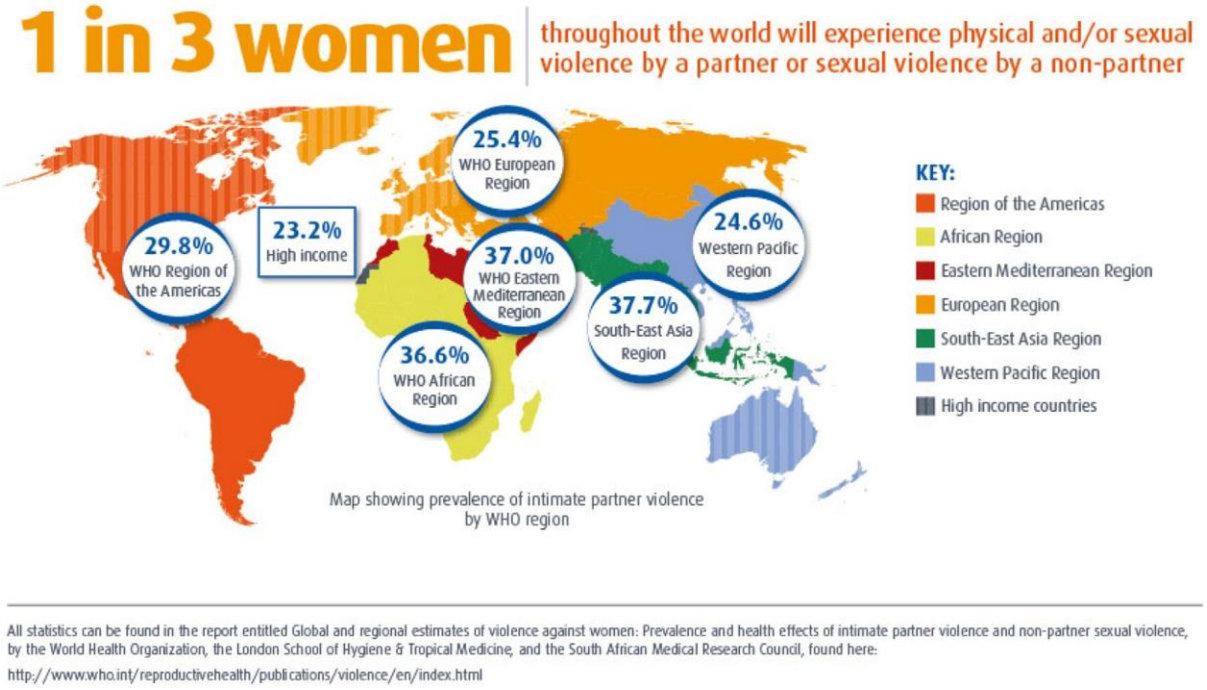

Figure 1. Map showing prevalence of intimate partner violence by WHO region (Devries et al., 2013, p. 2).

Figure 1 reveals that in some regions across the world up to nearly 38% of women report violence by an intimate partner (WHO, 2013). However, it is important to note that the precise incidence of domestic violence in any community, or population, is extremely difficult to assess because of the number of incidents that go unreported (Vos et al., 2009). Indeed, it is estimated that less than one in every three incidents of violence is reported (Paradine & Wilkinson, 2004).

2.3.3 Domestic Violence: A South African Overview

South Africa has among the highest rates in the world of violence against women (Boonzaier & de la Harpe, 2011; Jewkes, Levin & Penn-Kekana, 2002; Seedat, van Niekerk, Jewkes, Suffla & Ratele, 2009). During 2010, it was found that one out of every five women in Gauteng reported incidents of domestic violence (Machisa, Jewkes, Lowe Morna & Rama, 2010). Perden, McGee and Sharma (2002) cited that approximately half the homicides in South Africa are caused by partner violence and Jewkes, Levin and Penn-Kekana (2002) mentioned that the homicide figure in South Africa is six times that of the global average.

Since South Africa's political change in 1994, violence against women has begun to receive public awareness and attention (Hamber, 2010; Vetten, 2000). Numerous policies and legislative interventions were introduced to address and help eradicate the violence and injustice committed against women. These interventions included, among others, the Domestic Violence Act (DVA), the Employment Equity Act (EEA), and the Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA).

The transitions (e.g. redistribution of wealth and the tackling of unemployment) that took place after 1994 were not adequate enough to dramatically improve the physical and economic security of all women (Hamber et al., 2006). Overall, many women in South Africa, and more specifically black women, still live in poverty and most are either unemployed or earn much lower salaries than men (Mogale, Burns & Richter, 2012; Reid & Walker, 2005). Research has shown that women who are unemployed, poor, and have low levels of education are vulnerable and at a high risk of being victimised and abused by an intimate partner (Heise & Garcia-Moreno, 2002; Hindin & Adair, 2002; Johnson, 2001).

Poverty, unemployment, and gender inequality are strong social dynamics that contribute to violence in South Africa (Seedat et al., 2009; Vetten, 2014). Individual factors such as

substance abuse and 'toxic' masculinities exacerbate the problem. Seedat et al. (2009) cited that over one third of South Africa's population is unemployed. Poverty and unemployment can result in feelings of humiliation, suffering, shame, loss of self-respect, and depression which in turn can lead to anger and frustration. Violence may escalate and be utilised to gain power and resources that others are perceived to have (Seedat et al., 2009).

Patriarchal social norms, psychosocial risk factors, certain cultural practices, and religious beliefs in South Africa may serve to validate and reinforce the use of violence as a method to control and discipline women (Kim & Motsei, 2002; Naeem, Irfan, Zaidi, Kingdon, & Ayub, 2008; Seedat et al., 2009). In a patriarchal society, women are seen as inferior and men as superior. "Unequal status of women culturally is what underlies a national culture of discrimination against them, reflected in both their economic disenfranchisement and staggering levels of violence" (Bentley, 2004, p. 258).

2.4 Misconceptions about Domestic Violence

The misconceptions about domestic violence and female-initiated violence will now be discussed.

2.4.1 Female-initiated Domestic Violence

An important global debate in the field of domestic violence is centred around female-initiated violence (Carney, Buttell & Dutton, 2006). Domestic violence is traditionally perceived as a crime committed by domineering men against vulnerable women. The prevalence and consequences of domestic violence against women has been well researched and established (Lawson, 2003). There is, however, far less development in the field of female perpetrated violence because a greater proportion of women report partner violence than their male counterparts (Williams, Ghandour & Kub, 2008).

Brown (2004) conducted an American study between the differences in statistics between male and female cases, in the criminal justice system, regarding assault and injury to a partner: Just over 60.02% of females accused of abuse were charged, whereas 91.1% of the males accused of assault were charged. Henning and Renauer (2005) conducted a similar study and found that almost 47% of the cases that involved women as perpetrators of domestic violence against their male counterparts were rejected by prosecutors and another 16% of the cases were dismissed by a judge. That is, only 37% of the women accused of abuse were convicted. Male victimisation is not taken seriously because of cultural beliefs that men should be able to adequately defend themselves against their partners' violence (Carney et al., 2006).

Female perpetrators of domestic violence share, more or less, similar characteristics as male offenders (Carney et al., 2006). These include similar motives for violence and psycho-social characteristics such as aggression, substance abuse, and personality factors. Although male and female perpetrated violence share common characteristics, male violence tends to be more injurious and has more adverse health outcomes than female perpetrated violence (Tjaden et al., 2000). Research on female perpetrated intimate partner violence indicates that women are most likely to engage in emotional violence as opposed to physical forms of violence (Archer, 2004; Xie, Farmer & Cairns, 2003). In a study conducted by the WHO and the London School of Hygiene and Tropical Medicine (2012) statistics revealed that 35% of murdered females were killed by an intimate partner whereas only 5% of male homicides were committed by a female intimate partner.

It is important to note that the limited research on female perpetrated violence suggests that acts of violence are not usually isolated or one-sided but rather bi-directional (both partners participate in some sort of violent behaviour e.g. physical violence, psychological aggression, stalking etc.) in nature (Johnson & Leone, 2005).

2.5 The Public Health Implications of Domestic Violence

Domestic violence is a serious public health issue affecting both women and men and their families. The health consequences of domestic violence on women in particular will now be discussed.

2.5.1 Health Consequences of Domestic Violence

Several researchers have found that there is an astonishing amount of negative health outcomes that have been associated with domestic violence (Black, 2011; Helweg-Larsen & Kruse, 2003; John, Johnson, Kukreja, Found & Lindow, 2004; Plichta, 2004). "The relationship of intimate partner violence to health is complex; the harm may be immediate and direct (such as injury or death), long-term and direct (such as disability), indirect (such as gastrointestinal (GI) disorders), or all three" (Plichta, 2004, p.1300). Most women who have been a victim of domestic violence can suffer from acute injuries ranging from minor to life-threatening injuries, disfigurement, disability, and death (Brown, 2004; Campbell, 2002; Plichta, 2004).

The consequence of domestic violence may have serious implications on a woman's reproductive health and also increases the long-term risk of other health problems due to the physical, emotional, and sexual abuse they have experienced (Helweg-Larsen et al., 2003). Certain health related problems (e.g. anxiety, depression, posttraumatic stress disorder [PTSD], and sleep disorders) were found to not exclusively exist during the period of abuse but may last long after the abuse has ceased (Campbell, 2002; Cox et al., 2006; Dillon, Hussain, Loxton & Rahman, 2013).

There are numerous domestic violence risk factors that may lead to the adverse health outcomes of abuse such as broken bones, miscarriages, emotional harm, broken families and death (Breiding, Black & Ryan, 2005; El-Bassel, Gilbert & Witte, 2003). Women who have

lived with an abusive partner will most likely suffer from psychological symptoms and illnesses such as depression, PTSD, anxiety, suicidality, self-harm, and insomnia (Dillon et al., 2013; Plichta, 2004). Vos et al. (2009) conducted a study in Australia and found that depression, anxiety, and suicide accounts for 73% of the total disease burden that is associated with partner violence. Several researchers found that women who were exposed to domestic violence have a substantially higher lifetime rate of depression than women who have never experienced abuse (Harper & Arias, 2004; Kaplow & Wisdom, 2007; Kendler, Gardner & Prescott, 2002). Studies also indicate that the likelihood of depression in victims of abuse escalates when the frequency and severity of the violent incidents increases (Bonomi, Thompson & Anderson, 2006; Hedtke et al., 2008).

A history of partner violence is also positively associated with the development of PTSD (O'Campo, Kub & Woods, 2006; Pico-Alfonso et al., 2006). O'Campo et al. (2006) cite that it is estimated that abused women were two point three times more likely to develop PTSD than women who have never been abused. According to a study conducted by Pico-Alfonso et al. (2006) PTSD does not exist alone in female victims of partner violence. The authors found that abused women who were diagnosed with PTSD also had comorbid depressive symptoms. In an international study conducted with 44 victims of abuse it was found that 50% had PTSD, 68% had depression and 43% experienced both symptoms of PTSD and depression (Stein & Kennedy, 2001). In another study conducted by Fedovkiy, Higgins and Paranjape (2008) they found that abused women with PTSD were ten times more likely to have high depression scores, than those who had never been abused. Anxiety is another psychological illness that is positively associated with a history of partner abuse (Ansara & Hindin, 2011; Blasco-Ros, Sanchez-Lorente & Martinez, 2010). Pico-Alfonso et al. (2006) found that the severity of anxiety was higher in women who suffered from comorbid

depression. The authors further explain that the more frequent and intense the abuse the women experience the greater the severity of anxiety will be.

Studies suggest a dose-response relationship between domestic violence and the health effects thereof (Coker et al., 2002; Sutherland, Bybee, & Sullivan, 2002). This essentially means that the more severe and/or frequent the incidents of domestic violence the greater the impact on the health of the victim of abuse (Campbell, 2002; Cox et al., 2006 Dillon et al., 2013). Black and Garbutt (2002) emphasise that women who are subjected to more than one form of domestic violence (e.g. sexual and psychological) over a period of time tend to develop more serious health conditions.

A great deal of domestic violence injuries are caused by blunt force trauma to the head, face, and neck and 81% to 94% of women who have been treated for domestic violence have facial injuries (Le, Dierks, Ueeck, Homer & Potter, 2001). One out of every three women have experienced a loss of consciousness at least once as a direct result of domestic violence (Chrisler & Ferugson, 2006; Corrigan, Wolfe, Mysiw, Jackson & Bogner, 2003). In another international study it was estimated that between 54% and 68% of women, subjected to domestic violence have been strangled by their partner (Banks, 2007; Sutherland et al., 2002).

In a Canadian study it was found that women experience longer periods of domestic violence and abuse than men and that women will most likely need medical attention or hospitalisation after an abusive incident (AuCoin, 2005). Ferguson (2006) points out that more than one out every four women who have been injured during domestic violence will require medical attention. Campbell (2002) further explains that women who have been subjected to domestic violence will make use of primary care and outpatient services more often than non-abused women. However, most women who are subjected to violence do not always seek medical attention for injuries because they feel reluctant to disclose the experience of abuse. (John et

al., 2004; Plichta, 2004). Sometimes women refrain from reporting incidents of domestic violence because it is too dangerous to do so. The partner might be monitoring the victim's whereabouts on a regular basis. The women might also refrain from reporting abuse because they feel personally responsible for the occurrence of domestic violence in their relationships. Some women think that if they give their abusive partner another chance he might change over time and refrain from being abusive.

The adverse health consequences and health risk behaviour associated with domestic violence is depicted in table 1 below.

Psychological/ mental health outcomes	**Brain and nervous system**
Dreams Recollections Flashbacks involving traumatic incident Dissociative features Posttraumatic stress disorder Depression Suicidality Self-Harm Anxiety Sleep disturbance Poor mental health Anger Eating disorder	Migraines Headaches Memory problems Seizures Speech difficulties Traumatic brain injury
Stress-mediated health outcomes	**Reproductive system**
High blood pressure Hyper alertness Sleep disorders Backaches	Chronic pelvic pain Genital injuries Hysterectomy Lack of sexual pleasure Sexual dysfunction Painful intercourse Painful menses Pelvic inflammatory disease Poor sexual health Sexually transmitted infections Vaginal bleeding Urinary tract infections
Gastrointestinal system	**Adverse pregnancy outcomes**
Constipation Diarrhoea Frequent indigestion Functional gastrointestinal disorder Gastric reflux Gastrointestinal disturbances Inflammatory bowel syndrome Irritable bowel syndrome Spastic colon Stomach ulcers Stomach problems	Abortion Increased abortion rate Multiple induced abortions Delayed prenatal care Fetal death Interference with contraception Low birth weight Neonatal death Preterm delivery Premature labour Premature rupture of membranes Unintended pregnancy
Musculoskeletal system	**Other**
Activity limitation Arthritis Broken bones Joint disease Physical disability Functional impairment Physical injuries Frequent seizures, convulsions Hearing loss	Alcohol and drug abuse HIV and STI risk factors Smoking Poor general health Poor physical health

Table 1. Some of the health consequences and health risk behaviours associated with experiencing physical, sexual, or psychological partner violence (adapted from Black, 2011 & Coker et al., 2000).

In the next section certain psychosocial risk factors (e.g. alcohol and drug abuse; violence in the family of origin and personality features) that may influence both perpetrators and victims of domestic violence in South Africa are reviewed. According to research, women are more likely to be the victims of domestic violence (Department of Social Development, 2009). Therefore, in this study, my focus is placed on men being the perpetrators of domestic violence

2.6 Psychosocial Risk Factors that may contribute to Domestic Violence

The select psychosocial risk factors e.g. substance abuse, personality factors, and childhood violence will now be discussed.

2.6.1 Substance Abuse

One of the risk factors addressed in this study is the relationship between substance abuse and domestic violence. Substance abuse can refer to alcohol abuse, a variety of illicit drugs, as well as certain medications (Boles & Miotto, 2003). Substances are divided into three major classes: Depressants (alcohol, opiates, sedatives and anxiolytics); stimulants (cocaine, methamphetamine, amphetamine and sympathomimetic) and hallucinogens (LSD, PCP, marijuana and mescaline) (Ellis, Stein, Thomas & Meintjes, 2012).

Substance abuse is one of the most prominent risk factors associated with domestic violence (Corrigall & Matzopoulos, 2013; Corvo & Johnson, 2013). In an international study it was found that 31% of men arrested for domestic violence had a drug use disorder and 53% an alcohol use disorder (Stuart et al., 2008). Many women who are subjected to partner violence are prone to use/abuse alcohol, prescription medication, illegal drugs or tobacco to help them cope with the negative consequences of maltreatment (Black, 2011).

2.6.1.1 Alcohol and drug abuse

South Africa has amongst the world's highest levels of alcohol consumption per capita (Akinboade & Mokwena, 2009; Corrigall et al., 2013; Rataemane S. & Rataemane L, 2006; Rehm & Parry, 2009). "The attractions of intoxication in South Africa are reinforced by alcohol's affordability, availability, and aspirational lifestyle connotations (e.g. through advertising, sponsorship, and product placement)" (Herrick, 2012, p. 1046).

Mental disorders are often associated with alcohol and drug abuse (Herman & Jane-Llopis, 2005). Alcohol, which is a central nervous system depressant, frequently contributes to the development of depression (Petrakis, Gonzalez, Rosenheck & Krystal, 2002). The misuse of alcohol often initially generates an elevated mood, however this is often followed by feelings of drowsiness, irritability, and depression (Ellis et al., 2012).

Frequent alcohol abuse, which results in intoxication, may lead to negative mental health outcomes such as dependence (Corrigall et al., 2013; Ellis et al., 2012). Alcohol abuse, which affects higher order cognitive abilities, may cause disinhibition (e.g. impulsivity, a lack of restraint and judgement, disregard for social conventions, poor risk assessment and social problem-solving skills) (Ellis et al., 2012; Pihl & Hoaken, 2002). The effects of alcohol abuse have been known to cause a perpetrator, who is prone to anger and aggression, to engage in violent behaviour (Giancola, 2000; Klostermann & Fals-Stewart, 2005; Pihl et al., 2002). Boles and Miotto (2003) and Gottfredson, Kearley and Bushway (2008) cited that not all alcohol and drug users and abusers are violent. However, alcohol is usually abused by both perpetrators and victims in many violent situations.

In an international study they found a significant relationship between women's alcohol use and incidents of violence targeted against them (White & Chen, 2002). Alcohol abuse can be the cause or the consequence of violent incidents. Partners (men and women) who both have

a substance abuse problem are at a greater risk to commit domestic violence than only one partner/individual abusing substances (Coker, Smith, Bethea, King & McKeown, 2000).

The most frequently abused substance in treatment centres across South Africa is primarily alcohol (Pluddemann et al., 2009). Several studies have revealed that alcohol abuse is associated with an increased risk of domestic violence (Corrigall et al., 2013; Fals-Stewart, 2003; Gilchrist et al., 2003; Stith, Smith, Penn, Ward & Tritt, 2004). Corrigall et al. (2013) found that alcohol abuse contributed to 25% of all intentional injuries such as interpersonal violence and suicide in South Africa. In a South African study conducted by Abrahams, Jewkes, Laubscher and Hoffman (2006) they found that men who were prone to domestic violence were also more likely to abuse alcohol. Gilchrist et al. (2003) found that 73% of perpetrators consumed alcohol before a domestic violence incident. Fals-Stewart (2003) cite that men were eight times more physical on days they had been drinking and severe violent incidents were 11 times more likely to happen on such days. Also, 60% of patients in treatment facilities for domestic violence were diagnosed with a substance abuse disorder (Kraanen, Emmelkamp & Scholing, 2014; Stuart, Ramsey, Moore & Kahler, 2003).

Associations between drug abuse and partner aggression are less well researched (Cory, Crane, Oberleitner, Devine & Easton, 2014; Klostermann, Kelley, Mignone, Pusateri & Fals-Stewart, 2010). The reason for this may be due to alcohol being a legal substance whereas many other drugs are not. Respondents may be more reluctant to admit to the use of illegal substances (Corvo et al., 2013).

South Africa is emerging as a market for methamphetamine, cocaine and other drugs (Leggett, 2001 & Parry et al, 2006). In this study I am only going to focus on some of the drugs (methamphetamine, cannabis and cocaine) that are most commonly abused in South Africa.

2.6.1.2 Methamphetamine

Methamphetamine (or better known as 'tik' in South Africa), is the fastest growing drug problem and the second most abused illicit drug worldwide (Rawson & Condon, 2007; United Nations Office on Drugs and Crime [UNODC], 2012). Methamphetamine is primarily smoked using glassware such as a 'meth pipe' or a hollowed lightbulb (Peltzer, Ramlagan, Johnson & Phaswana-Mafuya, 2010). The ticking sound whilst smoking the drug gave methamphetamine the South African name 'tik'. The principal effects of methamphetamine are increases in the synaptic levels of dopamine, serotonin, and norepinephrine in the brain, which are responsible for feelings of euphoria (Goodman, Hardman, Limbird & Gilman, 2001; Madras, Miller & Fischman, 2005). Methamphetamine intake produces extremely pleasurable and rewarding states that increase the risk of repeated use of the drug (Sulzer, Sonders, Poulsen & Galli, 2005). Methamphetamine is a highly addictive synthetic psychostimulant that dramatically influences the nervous system and gives the user a false sense of power, energy, and euphoria among other symptoms and effects (Panenka et al., 2013; Romanelli & Smith, 2006). Methamphetamines are extremely neurotoxic and can impair the regulation of aggressive behaviour to a much greater extent than other substances (Baicy & London, 2007).

Due to the drug's effect on the user's response, long term 'tik' abusers often engage in impulsive and risky sexual behaviour (Carrico et al., 2012; Sommers & Baskin, 2006). 'Tik' users may develop mental disorders such as psychosis which is characterised by a loss of contact with reality as well as hallucinations and delusions (Cherner et al., 2010; Meredith, Jaffe, Ang-Lee & Saxon, 2005). Additionally, 'tik' users are at an increased risk of developing mental health problems such as anxiety, depression, and neuropsychological impairment (Cherner et al., 2010; Mehrjerdi, Noroozi, Barr & Ekhtiari, 2012). Deficits in emotional regulation are common in methamphetamine abusers affecting the control of

depressive and anxious moods as well as anger and hostility (Payer et al., 2008). Koob (2009) explains that one of the most defining characteristic of drug abuse is the presence of negative emotions (e.g. depression and anxiety) that occur during the withdrawal phase. Zweben et al. (2004) examined the psychiatric symptoms of 'tik' abusers and found that 68% of all female abusers and 50% of male abusers felt depressed at some stage in their life.

The psychological effects of 'tik' are associated with domestic violence (Boles et al., 2003; Carrico et al., 2012; Sommers et al., 2006). Methamphetamine is the drug that is more strongly associated with violence than any other drug (Baicy & London, 2007). In a study conducted in Cape Town by Watt et al. (2013) it was found that women who were in a relationship with a 'tik' user experienced controlling behaviour and abuse by their partners. The users exhibited anti-social behaviour and unprovoked aggression. In another study conducted by Sommers et al. (2006) they found that 34.9% of methamphetamine abusers committed violent acts while being under the influence of the drug and almost half of these individuals did not demonstrate any aggressive behaviour prior to taking the drug. Zweben et al. (2004) observed methamphetamine abusers and found that 43% had difficulties in controlling violent behaviour.

Methamphetamine abuse is strongly associated with altered functioning in the dorsolateral prefrontal cortex that is responsible for cognition, behaviour, and executive functions (Homer et al., 2008; Sommers et al., 2006). Henry, Mazur and Rendell (2009) found that a specific deficit in social cognitive functioning, which is associated with methamphetamine abuse, is the difficulty of recognising the six basic emotions (anger, fear, disgust, surprise, happiness, sadness) in other people (Henry et al., 2009). Deficits in social cognition and the increase of paranoia in methamphetamine abusers are responsible for the misinterpretation of other people's emotions and hostile intentions (Sommers et al., 2006). Because of poor emotional control, impulsivity, and misinterpretation of social situations the abuser may behave in an

aggressive and violent way without thinking and without regard for the negative consequences of an action (Semple, Zians, Grant & Patterson, 2005).

2.6.1.3 Cocaine

Cocaine, which has been around for centuries, has a history of being used for medicinal as well as work related purposes (Maisto, Galizio & Connors, 2008). Cocaine is derived from the leaves of the coca bush or coca tree (Erythroxylon Coca). During prehistoric times native inhabitants (Inca tribe) of South America chewed on the leaves of the coca plant which they believed had magical powers and used it as part of their religious ceremonies (Streatfeild, 2001). A single coca leaf contains only small amounts of cocaine and during the 1850s scientists became interested in the extraction of cocaine from the leaves. Sigmund Freud (1884) was the leading medical advocate of cocaine and believed that cocaine was a miracle drug that could be used as a treatment of depression, indigestion, morphine addiction, alcoholism, syphilis, neuroses, and asthma (Maisto et al., 2008).

Cocaine, which is a highly addictive drug, produces short-term euphoria and a rush of energy, is usually administered intranasally (sniffing and snorting) or, less frequently, intravenously. Crack cocaine (processed from cocaine), is normally ingested through smoking (SA Health info, 2008). Cocaine, which can cause the pulse rate to increase and blood pressure to rise, generally causes a reduced need for sleep, decreased appetite and heightened sexual arousal.

Cocaine acts as a psychomotor stimulant and is associated with increased irritability, violent and erratic behaviour, restlessness, and psychotic symptoms (Cory et al., 2014; SA Health info, 2008; Walsh, Donny, Nuzzo, Umbricht & Bigelow, 2010). Prolonged use of cocaine can lead to adverse psychological consequences such as psychosis which is marked by paranoia, hallucinations (auditory and visual), delusions, depression, anxiety, impaired memory, and impaired social functioning (SA Health info, 2008; Walters, 2014). Withdrawal symptoms

include agitated and anxious states, which may lead to aggressive behaviour. (Norlander & Eckhardt, 2005). A study conducted by Chermack, Walton, Fuller and Blow (2001) revealed that cocaine use was positively associated with severe partner violence. In an international study it was found that male-to-female partner violence was three times more likely to occur on the day that the male partner used cocaine (Fals-Stewart, Golden & Schumacher, 2003; Moore et al., 2008).

2.6.1.4 Marijuana/Cannabis

Marijuana is the most commonly used drug worldwide (Iverson, 2000). This drug is derived from the dried leaves and flowers of the Cannabis Sativa plant. The term marijuana has its origin in the Portuguese word 'mariguango' which translates as 'intoxicant' (Maisto et al., 2008). 'Dagga' is the South African name for marijuana and this name is inherited from the Khoikhoi word 'Dachab' (Perkel, 2005).

On 18 September 2018, the South African Constitutional Court decriminalized the private use of marijuana in South Africa. However, the law still prohibits the use of marijuana outside of one's private dwelling and the buying and selling thereof.

Marijuana is classified as a hallucinogen and it is believed that the active chemical known as 9-tetrahydrocannabinol (THC), which affects different parts of the brain, is responsible for marijuana's psychological effects (Reid et al., 2005). Furthermore, it is also responsible for structural and functional changes in the brain (Rubino et al., 2009). Chronic cannabis users display impaired neural connectivity in specific parts of the brain that are responsible for executive functions such as memory, learning, and impulse control (Batalla et al., 2013).

Marijuana is the drug of choice in South Africa and our country is among the top four producers of cannabis in the world (Perkel, 2005; South African Community Epidemiology Network on Drug Use, 2015). Marijuana is normally smoked in hand-rolled cigarettes or a

through a pipe (Reid et al., 2005). Smoking marijuana has different effects on different people, some people experience paranoia and hallucinations whilst others become relaxed and mellow (Walters, 2014). Short-term effects of marijuana include: A pervasive sense of well-being, drowsiness, decreased nausea, loss of co-ordination, increased appetite, anxiety and paranoia, memory impairment, increased heart rate, and difficulty thinking and solving problems (University of Washington, 2013; Reid et al., 2005). Marijuana use also has an acute effect on a person's psychomotor functioning. In an international study it was found that cannabis is the most common drug apart from alcohol that is found in drivers who are either stopped for reckless driving or involved in fatal accidents (Ashton, 2001).

Moore and Stuart (2005) and Smith, Homish, Leonard and Cornelius (2012), have found a significant link between marijuana use and intimate partner violence. In an international study conducted by Moore and Stuart (2003) it was found that 53% of 150 men in rehabilitation for spousal abuse reported using marijuana in the past year. In another international study conducted by Chermack et al., (2001) it was found that participants who participated in severe partner violence were frequent marijuana users. Acute marijuana use may decrease a person's ability to process complex stimuli during interpersonal conflict as well as increase a person's disinhibition (Moore et al., 2005; Schumacher, Slep & Heyman, 2001). During interpersonal conflict impulsive responding may increase which may lead to aggressive responses (Moore et al., 2005; Schumacher et al., 2001).

Marijuana withdrawal is another risk factor that may engender violence and longitudinal research has shown a relationship between marijuana use and intimate partner violence (Pihl et al., 2002; Moore et al., 2005). Following long term usage, withdrawal symptoms include: Aggression, anger, restlessness, irritability, mild agitation, insomnia, increased appetite, decreased body weight, sleep disturbance, and anxiety (Budney, Hughes, Moore & Novy, 2001). Heavy marijuana users experience severe mood and behaviour problems (e.g. irritation

and aggression) during the withdrawal phase (Budney & Hughes, 2006). In an international study that involved 49 marijuana users experiencing withdrawal, researchers found that the withdrawal-related outbursts were severely intense and associated with high levels of distress (Allsop, Norberg, Copeland, Fu & Budney, 2011).

In an international study, El-Bassel, Gilbert, Wu, Go and Hill (2005) found that women who had undergone treatment for marijuana abuse were over four times more likely to experience being abused by their drug free partners than non-marijuana using counterparts.

2.6.2 Personality Features and Disorders

Because I am not a clinician, I am unable to diagnose any person with a personality disorder and will therefore focus on personality features that contribute towards domestic violence.

There are numerous physiological factors (e.g. neurological conditions, brain damage associated with loss of impulse control and aggression) that have been found to play a role in violence (Capaldi, Knoble, Short & Kim, 2012; Chermack & Giancola, 1997). Between 40% and 62% of men who are abusive towards their partners have experienced (mostly) frontal lobe head injuries (Cohen et al., 2003; Marsh & Martinovich, 2006).

Risk factors that can activate violent tendencies include: Substance abuse, psychopathy, sociopathic personality disorder, history of violent and criminal behaviour, low socioeconomic status, and being male (Monahan et al, 2001). In an international study conducted by Heru et al., (2006), 90% of psychiatric inpatients (non-psychotic) reported incidents of partner violence within the last year.

Domestic violence perpetrators tend to score higher on measures of anger, hostility, and antisociality (Hanson et al., 1997; Covell et al., 2007). Dutton et al. (1994) and Hamberger et al. (1996) cite that between 50% and 90 % of court-ordered perpetrators of abuse have

distinct personality disorder traits. In another international study, Gibbons et al. (2011) found that 54% of their sample of male domestic violence perpetrators (N = 177) had personality disorder traits and that 37% of the sample had severe personality psychopathology. Personality factors as well as psychopathology are strong predictors of partner violence (Ehrensaft et al., 2006).

Sociopathic and borderline personality disorder traits are the most common personality features found in partner abusive men (Costa et al., 2008; Ross et al., 2009; Swogger et al., 2007). Borderline personality features are closely associated with reactive aggression (unplanned/impulsive, high arousal, expressive and hostile aggression) whereas sociopathic personality features are closely associated with proactive aggression (premeditated, unprovoked, goal-directed and cold-blooded aggression) (Gilbert & Daffern, 2011; Ross et al., 2009).

2.6.2.1 Sociopathic personality disorder

1. The Diagnostic and Statistical Manual for Mental Disorders (APA, 2013, p. 645), describes sociopathic personality disorder as "…a pervasive pattern of disregard for, and violation of the rights of others, occurring since age 15 years as indicated by three (or more) of the following:" Failure to conform to social norms and laws that are created and enforced through social or governmental institutions are grounds for arrest.
2. Deceitfulness, as indicated by repeated lying, using aliases, or conning others for personal profit or pleasure.
3. Impulsivity or failure to plan ahead.
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
5. Reckless disregard for safety of self or others.

6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work or honour financial obligations.
7. Lack of remorse, as indicated by being indifferent to or rationalising their aberrant behavior (e.g. stealing, hurting, mistreating others).

Sociopathic personality disorder is associated with a variety of co-morbid disorders (for instance; depression, anxiety, suicidal tendencies, severe psychosocial impairment, and high rates of substance abuse) (Compton, Thomas, Stinson & Grant, 2007; Goldstein, Dawson & Saha, 2007). Individuals with sociopathic personality disorder characteristically break rules, are reckless, irresponsible, arrogant and deceitful, and often engage in criminal behaviour (Kendall et al., 2009). Sociopathic personality disorder is more common in men and has one of the highest prevalence rates in correctional facilities where it is associated with disorderly and difficult behaviour (Ullrich & Coid, 2009).

Studies have found that sociopathic personality traits have an influence on the occurrence of partner violence (Fowler & Western, 2011; Maurico, Tein & Lopez, 2007). Men with sociopathic personality traits have poor social relationships and may use violence in an attempt to resolve conflict. These individuals control and dominate their partner without showing any remorse or empathy for their spouse's feelings or rights (Babcock, Jacobson, Gottman & Yerrington, 2000; Dutton, 2006). Dominance has been associated with intimate partner violence and the sociopathic individuals will do whatever necessary (e.g. hit, lie, and deceive other people) to get their own way (Straus, 2008).

2.6.2.2 Borderline personality disorder

The Diagnostic and Statistical Manual for Mental Disorders (APA, 2013, p. 658), describes borderline personality disorder as: "…a pervasive pattern of instability of interpersonal

relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:"

1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.
3. Identity disturbance: An unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating).
5. Recurrent suicidal tendencies or self-mutilating behaviour.
6. Emotional instability due to marked fluctuations of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days). Chronic feelings of emptiness may also occur.
7. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights).
8. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Borderline personality disorder was first 'identified' in the 1930s when clinicians encountered troubling groups of patients who did not fit into the usual categorisation of psychoses or neuroses (Bateman & Krawitz, 2013). "The term 'borderline' referred to the belief at the time that this group of people were on the 'border' between 'neurotic' and 'psychotic' (Bateman et al., 2013, p. 2). After the 1950s, borderline personality disorder was used to describe patients who were neither neurotic nor psychotic but rather 'problematic' (Gunderson, 2010). It was only during the 1980s that borderline personality disorder was considered to have sufficient validity as a personality disorder to be included into the DSM manual of psychiatry (Widiger, 2012).

Borderline individuals show high levels of impaired social functioning and experience negative emotions (e.g. episodes of impulsive aggression, self-injury and drug and alcohol abuse) if they are in a relationship in which they perceive that their emotional needs are unrequited. They are extremely sensitive to feelings of rejection, criticism, isolation and perceived failure. The moment borderline individuals sense that they do not get what they need from a relationship they can become angry and frustrated (Hines, 2008). According to the DSM-5, when borderline individuals feel cared for and supported in a relationship signs of depressive features (e.g. loneliness and emptiness) will diminish. As soon as this caring relationship is under threat and there is a fear of losing the relationship the partner is devalued and demonised. The fear of abandonment and loneliness will cause the borderline individual to experience intense anger and rage (Hines, 2008). The borderline individual is said to be 'splitting' objects into two categories namely the good side of a person that they find acceptable and the bad side which they find 'painful'. There is no middle ground for these individuals; according to them a person is either all good or all bad (Hales, Yudofsky & Roberts, 2014).

Borderline personality traits are often associated with functional impairments of which uncontrolled aggression is one of the most commonly seen (Latalova & Prasko, 2010; Leichsenring, Leibing, Kruse, New & Leweke, 2011). When individuals with borderline personality disorder engage in aggressive behaviour it is normally directed towards an intimate partner (Newhill, Eack & Mulvey, 2009; Sansone R., & Sansone L., 2012). "Individuals with borderline traits may have deficits in self-regulation that make them more likely to behave aggressively, and their violence may in turn spark more aggressive responses by their partner" (Maneta, Cohen, Schulz & Waldinger, 2013, p. 240). The findings of two studies (Holtzworth-Munroe, 2000; Costa et al., 2008) revealed that men who abused their partners commonly evidenced borderline personality features.

The borderline individual experiences rapidly changing emotions (e.g. from happiness to sadness and anger to despair) which make them unpredictable and unstable (Widiger, 2012). These individuals show signs of extreme instability which normally lead to impulsive and self-destructive behaviour (e.g. self-harm such as cutting or burning themselves, suicide, substance abuse, and eating disorders) (Hales et al., 2014). More or less 10% of people diagnosed with borderline personality disorder commit suicide before the age of 40 (Black, Blum, Pfohl & Hale, 2004; Oldham 2006).

Little is known about borderline personality disorder and intimate partner violence due to biases in the conceptualisation of borderline personality disorder as a female disorder (Newhill et al., 2009). Individuals with borderline personality disorder are not only at a higher risk of getting hurt but also hurting of others (Drapeau & Perry, 2009). Zanarini, Frankenburg, Reich, Hennen & Silk (2005) found that women with borderline personality disorder are at a higher risk for experiencing domestic violence.

In an international study conducted with 67 university sites from around the world it was confirmed that borderline personality was linked with intimate partner aggression in both men and women (Hines, 2008). The results of the study indicated that borderline personality predicts physical, psychological, and sexual intimate partner aggression in nonclinical samples (Hines, 2008). Borderline personality features which includes self-harming behaviour, fear of abandonment, anger, jealousy, impulsivity, and emotional volatility are risk factors that predict intimate partner aggression (Hines, 2008). I believe that the findings of the study conducted by Hines can be compared to South Africa because the study took place across 67 worldwide universities. This means that a greater variety of the population had been tested for the link between borderline personality features and intimate partner aggression.

Individuals that have been diagnosed with borderline personality disorder often report a history of major family problems, domestic violence in the family of origin as well as violent punishment and abuse during childhood (Kendall et al., 2009).

2.6.3 Violence in the family of origin

The next risk factor I would like to discuss are the effects and relationship between childhood violence and becoming perpetrators or victims of domestic violence. Abrahams and Jewkes (2005) who conducted a local study in Cape Town found a positive association between boys who witnessed abuse against their mothers and perpetration of violence against a partner in adulthood. Due to the paucity of South African studies relating to the relationship between childhood violence and becoming a perpetrator or victim of domestic violence it was necessary to refer to international studies.

Extensive research has shown that exposure to violence and harsh parenting during childhood can lead to a risk of becoming adult perpetrators or victims of domestic violence (Carrigall & Matzopoulos, 2013; Dutton et al., 1992; Riggs et al., 1990; Smith & Williams, 1992; Whitefield et al., 2003). Children exposed to violence have an increased risk of maladaptive development. These include emotional and behavioural problems, social competence, school achievement, cognitive functioning, psychopathology, and general health (Margolin & Vickerman, 2007; Wolfe, Crooks, Vee, McIntyre-Smith & Jaffe, 2003).

Through observational learning children witness and model the behaviour of their parents and family members (Benda et al., 2002, Camacho et al., 2012; Hines & Saudino, 2002, Skuja & Halfrod, 2004). Observational learning explains the behaviour transmission process and describes how children discern the way parents behave and treat each other and then model the same behaviour (Stith et al., 2000). Therefore, children who are exposed to domestic

violence during childhood are at a much greater risk of reproducing the learned behaviour in adulthood than those not exposed to such behaviours (Stith et al., 2000).

The age at which children are exposed to domestic violence has certain mental development implications (Graham-Bermann et al., 2008; Sternberg et al., 2006). Young children are less capable than their older counterparts of making adequate sense of violent incidents because they have underdeveloped cognitive skills (Bell et al., 2004; Dejonghe, von Eye, Bogat & Levendosky, 2011). Children as young as one-year old infants exposed to domestic violence displayed more distress in response to a simulated episode of mild verbal conflict than children who had not been exposed (Bogart, Dejonghe & Levendosky, 2006). Howell, Graham-Bermann, Czyz and Lily (2010) found, in an international study, that 60% - 70% of three to five-year-old children from families with partner violence, displayed behavioural adjustment problems such as aggression, social withdrawal, and anxiety. Similarly, Kernic et al. (2003) found that children exposed to domestic violence had poor social competence and much higher externalising behaviour (e.g. aggression) problems than other children.

Children exposed to domestic violence are more likely to respond to conflict by using aggression and react more violently towards their peers than those not exposed to such behaviours (Ballif-Spanvill, Clayton, Hendrix & Hunsaker, 2004). Some children who are exposed to domestic violence become adults who develop symptoms of instability in their mental and emotional health (Romney, Kennedy & Flynn, 2006). It was also found that children exposed to domestic violence become adults who are likely to be abusive (Wallace, 2002). Such adults are prone to depression and trauma symptoms, instability in mental health, substance abuse, and the use as well as an increased tolerance for violence in adult relationships (Romney et al., 2006; Turner & Kopiec, 2006).

There is a strong relationship between the risk of becoming a victim of intimate partner violence and women who were exposed to childhood family violence (Whitefield et al., 2003). In an international study it was found that women who were physically abused during childhood had a substantially high risk of becoming adult victims of domestic violence (Coin et al., 2001). Another study found a positive relationship between men who were exposed to childhood family violence and the risk of becoming a perpetrator of partner violence (Whitefield et al., 2003).

Boys who witness the abuse of their mothers are more likely than girls to exhibit behavioural problems (Symes, Maddoux, McFarlane, Nava & Gilroy, 2014). In an international study it was found that 40 % of men who were arrested for intimate partner violence had a history of childhood domestic violence (Howard, 2012).

To summarise, is important to note that not all children who are exposed to domestic violence will suffer from immediate and long-term negative effects. Children vary in their responses to domestic violence according to their environmental structure, developmental status and individual circumstances (e.g. gender, age, personality, circumstances of abuse and availability of support system) (Osofsky, 2003). Children who have a support network and a relationship with a caring and competent adult will have fewer behavioural and emotional problems when exposed to domestic violence than those who do not have such a relationship (Romney et al., 2006; Osofsky, 2003). Therefore, not all children who witness or experience domestic abuse in their family of origin will become adult perpetrators or victims of domestic violence (Delsol & Margolin, 2004; Schumacher et al., 2001; Stith et al., 2000).

From the historical background one can conclude that domestic violence has been around since time immemorial. Domestic violence is a global phenomenon that occurs among all socioeconomic, religious and cultural groups, and affects both men and women. The physical

injury resulting from domestic violence can range from minor injuries to serious consequences including death. From the literature studied it is evident that certain psychosocial risk factors (e.g. substance abuse, personality factors and traits, and violence in the family of origin) have an influence on the occurrence of domestic violence. Other risk factors such as low self-esteem, depression, beliefs in strict gender roles, and unhealthy family relationships are only a few examples of risk factors that can also have an influence on the occurrence of domestic violence. Due to the vast number of risk factors, which contribute to the occurrence of domestic violence, it was impossible to address all in this study. However, it is important to note that there is limited research on the psychosocial risk factors that have an influence on the occurrence of domestic violence in South Africa.

In the next section I explore different theories that propose that domestic violence occurs as a result of certain factors.

2.7 Exploring the theories in the context of the current study

Carlson (1984) cited that it is futile to attempt establishing which theories are correct and which are not because there are so many different factors that contribute to the occurrence of domestic violence. However, "theoretical frameworks are of crucial importance in promoting understanding about the origins of behaviour, as they guide professionals in their actions taken to prevent, reduce, or eliminate the problem" (Dixon & Graham-Kevan, 2011 p. 1145; Loseke, Gelles & Cavanaugh, 2005).

2.7.1 Ecological Theory

The Ecological Theory, which was developed by Urie Bronfenbrenner (1970) claims that a person's development and behaviour are influenced and shaped by the interaction between individuals and their physical and social surroundings. Bronfenbrenner (1970) cited that an individual's environment is divided into five different levels: The microsystem, mesosystem,

exosystem, macrosystem, and the chronosystem. In 1984, Bonnie Carlson published an article on the causes and maintenance of domestic violence and relabelled the existing categories to include the individual, family, social-structural, and socio-cultural with specific reference to the analysis of the causes of domestic violence.

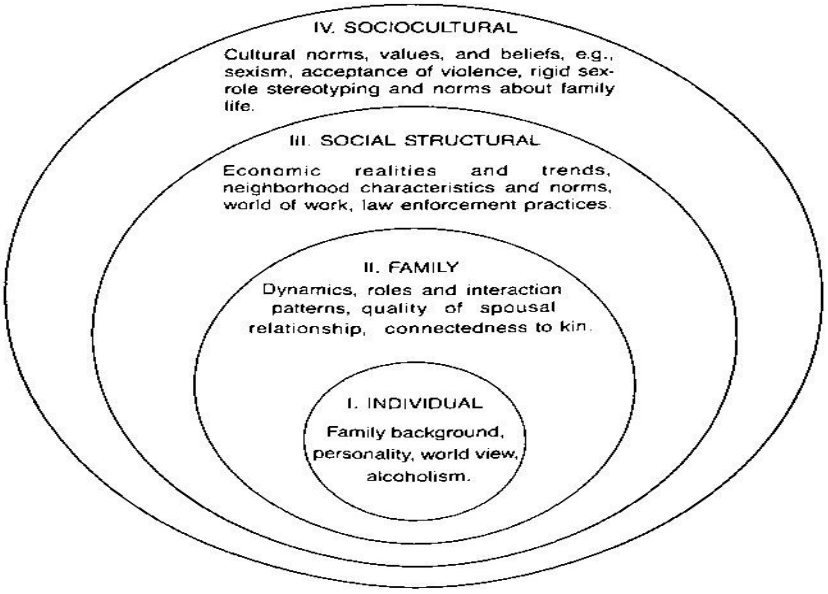

Figure 3. Ecological framework for analysis of causes and maintenance of domestic violence (Carlson, 1984, p. 571).

The overlapping concentric ovals in the Ecological Model depict the interrelationship and interdependence of the various factors (Ali & Naylor, 2013). This model suggests that different factors at divergent levels need to be simultaneously addressed to fully comprehend the problem of domestic violence (Ali & Naylor, 2013).

Level 1: The individual level focusses on what the individual brings with him or her to the relationship. It addresses biological and personal factors that influence human behaviour. These factors consist of demographics (age, gender, education, income etc.); psychological problems and personality disorders (e.g. sociopathic and borderline personality disorder); substance abuse and a history of experiencing, witnessing, or engaging in domestic violence.

This level also includes the attitudes, values, and beliefs that are learned from significant others (Ali & Naylor, 2013; Carlson, 1984).

Level 2: The family level focusses on the nature of family life including the close relationships between the individual and his or her family and friends. Carlson (1984) explained that there are a number of factors (e.g. gender, age and access to resources) that contribute to disagreement and conflict within the family. Other causal factors such as conflict over children, sex, money, housekeeping, and social activities may also have an influence on the occurrence of violence in the family. Carlson (1984) further explained that the more disagreements there are between partners in a relationship or marriage the more likely they are to engage in violence.

Level 3: The social structural level addresses institutions such as schools, workplaces, neighbourhoods, law enforcement, and the criminal justice system. The community level refers to economic factors such as high employment versus low employment, prosperity versus recession, and how these factors can cause or maintain domestic violence (Carlson, 1984). Economic factors, and in particular unemployment and insufficient material resources, can cause deprivation and stress in the family unit which can have an impact on the occurrence of domestic violence (Carlson, 1984).

Level 4: The sociocultural level refers to the societal norms, cultural values and beliefs that affect all of us and differentiates one's particular society from other societies. There is also a focus on how different cultural values and the influence of a patriarchal type of society can encourage the occurrence of domestic violence. We as a society tolerate an enormous amount of violence in the media, public, schools, sports etcetera and therefore, we uphold a precedent for accepting violence in all spheres including intimate situations (Carlson, 1984).

The weaknesses and limitations of the Ecological Model are centred around the fact that, while it is focused on a broad spectrum of causal factors, it does not specifically identify each and every factor that may have an influence on the occurrence of domestic violence (Carlson, 1984).

2.7.2 Family Systems Theory

Family therapy addresses the problems individuals face with relationships, family members, and people in their social network. The Family Systems Theory is based on the notion that each and every family system is unique and that each member may have different personal characteristics and cultural values and beliefs. The Family Systems Theory, which postulates that individuals cannot be understood in isolation from one another, stresses the importance of considering the interactions and relationships within the family rather than focussing on individuals (Gurman & Kniskern, 1981; Murray, 2006). Therefore, to understand the individual we need to understand the dynamics of the family system of that individual. "Individuals within families are intricately connected to one another and experiences in one part of the system affect all other parts of the system as well" (Murray, 2006, p. 234).

Within the Systems Theory/Cybernetics, the concept of linear causality is refuted, and the notion of circular causality is adopted. This essentially means that emphasis is placed on reciprocity, recursion, and shared responsibility (Becvar D. S. & Becvar R. J., 2009; Murray, 2006). For instance; in a relationship where A and B exist, both A and B influence each other equally, and both A and B are the cause and the effect of each other's behaviour (Becvar et al., 2009). In other words, all members interact dynamically in a recursive manner to produce integrated patterns of behaviour. The objective is not to find out who is to blame for creating problems in a family but instead to have all the family members acknowledge that there is an issue and work together to find a solution to the problem (Becvar et al., 2009).

Each and every one of us is part of an interconnected universe and we all share in the destiny of each other (Bronowski, 1978). One system has the ability to influence and be influenced by other systems and an individual can influence and be influenced by other individuals and contribute to the maintenance of certain patterns of behaviour (Becvar et al., 2009; Hyde-Nolan & Juliao, 2012). An important key advantage of the Systems Theory/Cybernetics is that individuals become aware of being part of a bigger whole. Rappaport, (1974, p.59) explains that the ecological systems in which man participates are likely to be so complex that he may never have sufficient comprehension of their content and structure to permit him to predict the outcome of many of his own acts".

When the family system functions satisfactorily it is believed that individuals in the system are able to function and behave in an appropriate and acceptable manner (Moshe, 2013). As soon as an individual in the family feels dissatisfaction or fear concerning the system's integrity (e.g. loss of control, unemployment) the individual will show symptoms of distress. The individual will then try to communicate his/her distress in order to restore control and the homeostasis in the family system.

Domestic violence can be seen as a phenomenon that affects all the members of the family and not only the victims or perpetrators of violence. The causality of domestic violence, according to the Family Systems Theory, is multi-dimensional and there is not one specific factor that is exclusively responsible for family violence (Gelles & Maynard, 1987).

2.7.3 Theory of Planned Behaviour

The Theory of Planned Behaviour, which is a general theory of social behaviour, explains and predicts a wide variety of behavioural intentions (Betts, Heinsz & Heimerdinger, 2011). This theory, which was developed by Ajzen and Fishbein during the 1980s, predicts that behaviour can be deliberate and planned. According to the theory there are three factors that

influence behaviours: Attitudes, subjective norms, and perceived behavioural control (Vallerand, Cuerrier, Pelletier & Mongeau, 1992). These three components of planned behaviour are seen as crucial factors in the prevention and treatment of partner violence (Kernsmith, 2005).

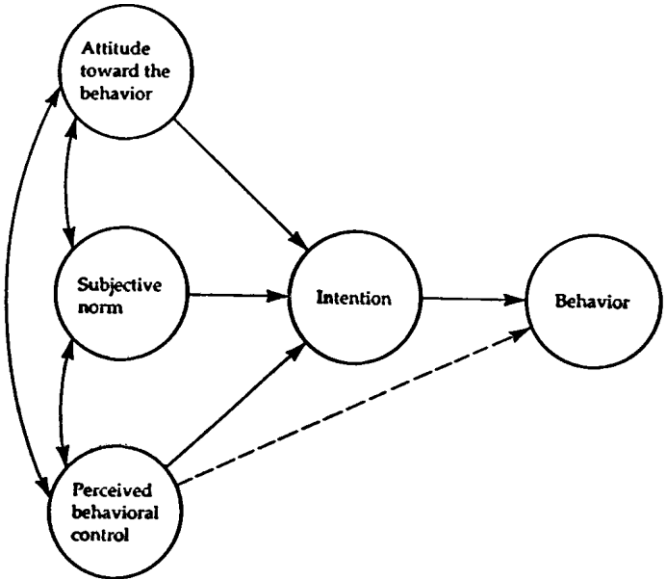

Figure 4. The Theory of Planned Behaviour (Ajzen, 1991, p. 182).

Attitudes are the instrumental evaluations of performing a specific behaviour. A person's attitude towards behaviour is influenced by that person's beliefs about the perceived negative consequences of performing the action (Vallerand et al., 1992). The gain and loss that are associated with the behaviour are measured against one another so that the individual can choose the behaviour with the greatest gain and the least loss (Kernsmith, 2005). Kernsmith (2005) further explains that the attitudes of domestic violence perpetrators may be changed with policies such as no-drop prosecution and mandatory arrest for committing partner abuse. Because of the criminal charges that get laid against perpetrators of violence, victims of abuse are prone to request the drop of all charges before a trial or sometimes become unwilling to participate in the court proceedings. No-drop prosecution will inhibit the prosecutor from dropping any charges laid against a perpetrator of violence. This rule will

force perpetrators to think twice before committing acts of violence knowing that they will be held accountable for their behaviour.

A subjective norm is the perceived social pressure to decide whether, or not to engage in a specific behaviour (Kernsmith, 2005). Subjective norms can be described as how an individual expects people close to him/her to react if he/she behaves in a certain manner (Kernsmith, 2005). Subjective norms, which are related to the prevention of domestic violence, have been addressed in campaigns such as domestic violence billboards as well as education in schools and universities that address the unacceptability of partner violence (Gehz, 2001). Batterer intervention programmes take advantage of peer confrontation to deal with the social and cultural norms, beliefs and myths that endorse abuse (Pence & Paymar, 1986).

The Theory of Planned Behaviour has its origins in the Theory of Reasoned Action. During 1985, Ajzen extended the Theory of Reasoned Action to include perceived behavioural control which predicts both behavioural intention and behaviour. According to Ajzen (1985) perceived behavioural control represents the degree to which an individual believes that he/she has the ability (resources and opportunities) to perform a given behaviour and this in turn influences the likelihood of the behaviour to occur. "The perceived behavioural control is the perceived ease or difficulty of performing a behaviour under different situations when the behaviour may go beyond one's controllable aspects of predicting behaviour directly or through intention" (Ajzen, 1991, p. 186).

Intention is the best predictor of behaviour (Nabi, Southwell & Hornik, 2002). Intention is a motivational factor that influences behaviour - the strongest intention of behaviour usually results in the behaviour being performed. Violent intentions are extremely difficult to gauge for the reason that abusive males are prone to blame their violent behaviour on factors such as

substance abuse, anger or jealousy, and not on their own personal intention (Nabi, Southwell & Hornik, 2002).

2.7.4 The Feminist Theory

Women have been subjected to partner violence perpetrated by men throughout the ages, but it was not until recent decades that violence against women has become recognised as a social problem and a 'real' crime (Hertzog, 2007). Feminist Theory, which originated in the 1970s, has become one of the most predominant theoretical models in the field of domestic violence (Mcphail, Busch, Kulkarni & Rice, 2007; Smith, 1990). With that being said, the Feminist Theory is subjected to countless attacks and criticism by individuals who do not have an adequate understanding of what feminism really denotes (DeKeseredy, 2011). There are certain academics (e.g. Bumiller, 2008; Dutton, 2006), right-wing father's groups, and political counter movements that believe that feminists detest men and are focused on only gaining more power than men in economic, political, and social spheres (DeKeseredy & Schwartz, 1996).

The Feminist Theory postulates that violence against women is not a private family matter but rather a pervasive social problem that calls for the restructuring of society to eradicate the power differences that allow men to abuse women (Gondolf & Fisher, 1988). Feminism can be described as:" a set of theories about women's oppression and a set of strategies for change" (Daly & Chesney-Lind, 1988, p. 6). However, it is important to note that although early feminist studies revolved primarily around women, later feminism extended to include a commitment to achieve gender equality for both men and women (Hooks, 2000).

Feminists attribute the cause of intimate partner violence to the patriarchal structure of society that is responsible for forcing women, through the use of control tactics such as physical, psychological, sexual, and economic abuse, to remain submissive (Yllo & Bograd,

1988; Dobash R. E. & Dobash R. P., 1979; Messerschmidt, 1993). Dobash R. E. & Dobash R. P. (1979), cited that patriarchal domination of women through abuse has its origin in the cultural history of legally sanctioned male subordination of women. Although it is no longer legal to abuse women the history of inequality is still evident in marriage/intimate relationships as traditional gender roles and cultural prescriptions continue to exist (Marciniak, 1998; Sakalh, 2001, Simonson & Subich, 1999).

The feminist perspective maintains that violence against women is not part of the larger whole of family violence but a separate entity that should be studied on its own. Partner abuse has its own causes and properties and cannot be viewed in the same manner as other types of family violence (Dobash et al., 1979). Feminists believe that partner violence is basically a gender issue and thus cannot be understood through any other lens that does not include gender and power as the most important components of analysis (DeKeseredy & Dragiewicz, 2007). The feminist perspective proclaims that the basis of intimate partner violence is male supremacy and not family conflict or conflict of personal interests (Yllo, 1993).

In summary, the preceding section highlighted some of the most prominent theories that offer explanations for the occurrence of domestic violence. It is evident that scientists differ substantially in their delineation of the causes of domestic violence and that all of the above theories have merit and that none of the theories are completely right or wrong.

The current study is primarily based on Ecological Theory as I deem it to be the most appropriate for my research topic. Ecological Theory focusses on variables that can instigate domestic violence at the individual, family, social-structural, and sociocultural levels. It was therefore my aim to take an in-depth evaluation of the psychosocial risk factors that

contribute to domestic violence in Tshwane, South Africa. I furthermore attempted to understand women's reality and lived experiences from their own points of view.

2.8 Conclusion

The review of the literature made it abundantly clear that domestic violence is a universal phenomenon affecting many women all over the world. The literature described some of the most prevalent psychosocial risk factors of domestic violence and the cause and effects thereof. It was also argued that men are primarily found to be the perpetrators and women the victims of domestic violence. However, there is a paucity of research surrounding the psychosocial risk factors that contribute to domestic violence specifically in South Africa. This study therefore attempted to identify select psychosocial risk factors that contribute to the occurrence of domestic violence against women in Tshwane, South Africa.

The following chapter discusses the research design that is used in this study. It also highlights the manner in which the research was approached, the methods of data collection and analysis that were used.

CHAPTER 3

RESEARCH DESIGN

You cannot emerge a
whole human being
when you escape
someone who
constantly beats you
and berates you
physically, emotionally
and spiritually . . .
until that searing
of the soul has been
attended to. . .
There is something that
happens to the psyche.
The wholeness of the
individual must be
looked at. . . They must
begin to understand
what has happened to
them, and why.

~ Survivor of domestic violence

3.1 Introduction

The primary purpose for conducting this research was to describe South African women's, experiences with domestic violence and to identify the psychosocial risk factors that were associated with the occurrence thereof. The aim of the study was to add to the growing body of knowledge of domestic violence against women in Tshwane, South Africa. The research study sought to analyse domestic violence from an angle whereby collected data were explored to find risk factors that contribute to the occurrence of violent incidents.

Before the start of the interview process, it was my initial aspiration to interview women who were victims of domestic violence around risk factors such as alcohol and drug abuse,

exposure to childhood domestic violence, and personality factors. During the interview process additional risk factors such as pregnancy, cultural differences, and socio-economic factors were accentuated as possible additional causes for domestic violence in the participants' intimate relationships.

3.2 Research design that was followed

The research that was followed in the study will now be discussed.

3.2.1 Phenomenological Research Design

We can only know what we experience

~ Edmund Husserl, 1859 – 1938

The history of phenomenology dates back to the 18th century when 'phenomenology' meant the theory of appearances fundamental to empirical knowledge and sensory experiences (Rockmore, 1981). It was only during the 20th century that Edmund Husserl (1900-1901) launched phenomenology as we know it today: 'the science of the essence of consciousness' (Husserl, 1963).

Phenomenological studies are focused on descriptions of individual's experiences and how it is that they experience what they experience (Patton, 1990). Rossman and Rallis (1998, p. 72) cite: "...phenomenology is a tradition in German philosophy with a focus on the essence of lived experience." "Those engaged in phenomenological research focus in-depth on the meaning of a particular aspect of experience assuming that through dialogue and reflection the quintessential meaning of the experience will be revealed" (Rossman et al., 1998, p.72). In phenomenological research participants are asked to recount as accurately as possible a particular phenomenon as their lived experience and the researcher aims to understand and describe the individual's point of view whilst remaining true to the facts (Speziale &

Carpenter, 2007). The lived experience gives meaning to an individual's perception of the specific phenomenon and reflects on what is true and real in his or her life (Giorgi, 2005). The main purpose of phenomenological research is the description, interpretation, and a critical self-reflection of the 'world as world' (Van Manen, 1990). Bringing to the fore the experiences and perceptions of individuals from their own perspective is what makes the phenomenological method remarkably effective.

This research study sought to employ a phenomenological research design. The phenomenological research method was utilised to examine women's experiences of domestic violence in their relationships. The main schools of phenomenology are the descriptive and interpretive approaches (Lopez & Willis, 2004). Both of these approaches reflect insights into the meaning of the phenomena that are being studied. However, this study was focused on the interpretative phenomenological research approach whereby I listened to the lived experiences of the participants and how they made sense of their personal and social world. I gained a better understanding of the women's lives when the victims described their situation and their experience with domestic violence. The women were asked to give subjective descriptions as to which factors or traits in their perpetrator they believed contributed or could have been the cause of their victimisation. I focused exclusively on the perceptions of the victims. This information was organised into patterns and themes to understand the commonalities between the different lived experiences of the women who were subjected to domestic violence. I identified the risk factors that contributed to the occurrence thereof.

3.2.1.1 Qualitative Research

…qualitative research is any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification

~Strauss and Corbin (1990, p. 39)

Qualitative research methods were first used by sociologists and anthropologists during the early twentieth century although an unstructured form of this type of research existed much earlier (Holloway & Wheeler, 2002). During the early times, researchers observed and interviewed different cultural groups, made notes, and told stories of their experiences. The researcher, by that time, was already focused on attaining an insider's view of the lived experiences of the individuals and groups being studied (Holloway et al., 2002).

Qualitative research, which primarily follows the exploratory scientific method and is a form of social inquiry, focuses on the interpretation, description, and understanding of phenomena in their natural settings in which the researcher does not manipulate the phenomenon of interest (Denzin & Lincoln, 1994; Patton, 2001). The researcher uses the qualitative approach to collect and explore information about personal experiences, feelings, attitudes, behaviours, value systems, concerns, motivations, aspirations, culture, and lifestyle (Denzin et al., 1994).

Qualitative research methodology often relies on personal contact over a period of time with research participants in order to conduct in-depth interviews whilst collecting non-numerical data such as words and pictures (Ulin, Robinson & Tolley, 2004). Building a relationship with the research participants, which leads to a better insight and understanding of the world of the participant, adds richness and depth to the data being collected (Ulin et al., 2004). The stories and experiences that are shared by the participants allows the researcher to obtain an 'insider's view' in the life of the participant and is known as the emic perspective (Harris, 1976). An emic perspective essentially means that it is the researcher's aspiration to examine

the feelings and experiences of the research participant and ignore his/her own ideologies and beliefs that may distort the participant's point of view (Holloway et al., 2002).

Qualitative research is not about generating numerical data and thereby supporting or rejecting hypotheses, instead it is about producing factual descriptions and gaining insight into the situations and problems of research participants. Qualitative research is focused on the 'why' rather than the 'what' of social phenomena (Bogdan & Biklen, 1992).

Qualitative research is 'theory generative' which means that there may not be a clear hypothesis or precisely defined variables at the start of a research study, only theoretical notions about the phenomenon being studied (Christensen, Johnson & Turner, 2014). The researcher has the freedom to modify the theoretical notions of the study whilst collecting data and then using what the participants say to develop a theory or pattern of meanings (Christensen et al., 2014; Creswell, 2003). Qualitative methodology is not always completely precise and accurate for the reason that individuals do not usually act in a predictable and rational manner - this forces the researcher to turn to the research participant for direction and guidance throughout the research process (Holloway et al., 2002).

Finally, qualitative methodologies are inductive which means that this approach is concerned with observation and discovery, noticing and describing patterns, and a deeper understanding of the research problem in its own distinctive environment (Ulin et al., 2004). Qualitative research is applied to learn more about a topic or phenomenon of which we may have little or a lack of knowledge (Johnson & Onwuegbuzie, 2004).

After taking the literature pertaining to the psychosocial risk factors that contribute to domestic violence into consideration, as well as the aim of the study, the focus now shifts to defining the framework in which the research was embedded.

3.2.1.2 Research Paradigm

Paradigm: …a loose collection of logically related assumptions, concepts, or propositions that orient thinking and research.

~Bogdan & Biklen, 1998, p.22

The theoretical framework in a study is from time to time referred to as the research paradigm. The theoretical framework has an influence on the way we study and interpret knowledge (Mertens, 2005). The choice of a research paradigm is responsible for the purpose and expectations of a research study (Mertens, 2005). It is vitally important to propose a paradigm at the start of one's research because without it there will be no basis for the choices concerning the literature and research design (Mertens, 2005). "The selection of research methodology depends on the paradigm that guides the research activity, more specifically, beliefs about the nature of reality and humanity (ontology), the theory of knowledge that informs the research (epistemology), and how that knowledge may be gained (methodology)" (Tuli, 2011, p. 99). Every researcher has his/her own particular set of worldviews about what knowledge is, what is knowable, and how we can add to the knowledge of a phenomenon. This set of worldviews assists researchers to clarify their theoretical framework (Guba & Lincoln, 1994).

Ontology

Ontology can be defined as the assumptions and the beliefs that we hold about the nature of existence and reality (Holloway et al., 2002). The ontological question is: What is the nature of reality and what is there that can be known about it? (Guba et al., 1994). The interpretivist researcher believes that reality and the truth are socially constructed by humans and that people make their own sense of what reality is (Mutch, 2005).

Epistemology

Epistemology can be defined as the theory of knowledge and what counts as valid knowledge (Holloway et al., 2002). The question in epistemology is: What is the nature of the relationship between the knower and what can be known? How do we know what we know? (Guba et al., 1994). According to the Interpretivist Approach the researcher and the participants are linked and they explore and construct knowledge together (Mutch, 2005).

Methodology

Methodology can be defined as the principles and ideas on which researchers base their strategies (methods) (Holloway et al., 2002). The question in methodology is: How can the researcher go about finding out what he or she believes can be known? (Guba et al., 1994). Interpretivist researchers immerse themselves in a social group or culture and observe, interview, and interact with participants in order to gain access to the life stories of the people who are being studied.

For the purpose of this research study an interpretivist paradigm was utilised and is now further explained.

3.2.1.3 Interpretivist Paradigm

The Interpretivist Approach which has its roots in philosophy and human sciences, specifically focuses on history, philosophy, phenomenology, and anthropology (Holloway et al., 2002; Mertens, 2005). The Interpretivist Approach which is a theoretical approach that uses qualitative research methods, centres on how research participants view and experience the world around them during their interactions with each other and with society as a whole (Bogdan & Biklen, 1998; Holloway et al., 2002; Maxwell, 2006).

Researchers within the interpretivist approach seeks to understand individuals in their naturalistic environment and tend to be non-manipulative, unobtrusive, and non-controlling (Cohen & Manion, 1994; Holloway et al., 2002).The interpretivist researcher places a strong emphasis on understanding individuals from their own or 'native' or 'actors' point of view and relies on truthful reporting of the facts and quotations of actual conversations with research participants (Merriam, 1995; Weber, 1968). This is known as the 'verstehen' concept which means 'putting yourself into someone else's shoes (Weber, 1968). The 'verstehen' concept emphasises empathetic understanding, however, not in the psychological sense of intuitive and non-conscious feeling. Rather it is viewed as a reflective understanding and interpretation of the thoughts, feelings, and experiences of individuals coping with their condition in a naturalistic environment (Weber, 1968). Weber (1968) gave special importance to the notion of empathy and urged researchers to treat the people they study as 'if they are human beings'.

Reality, according to the Interpretivist Approach is socially constructed and we therefore need to understand the 'world' of human experience (Cohen et al., 1994). Researchers following this worldview believe that the experiences of people are just as important as focusing on explanations, predictions, and control.

I believe that the interpretivist paradigm (as a research paradigm) and phenomenology (as a qualitative research design), which focus on ontological questions of meaning and lived experience, both have the same purpose.

3.2.1.4 Measures of ensuring trustworthiness

In research there is a general consensus that all studies must be open to evaluation and critique. Traditionally, the evaluation of research studies centred on the assessment of the reliability and validity of the study.

Reliability

…the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions.

~Hamersley, 1992, p. 67

Reliability is a concept that is unanimous with quantitative research and is known as the necessary standard by which quality is measured. On the other hand, reliability in qualitative research is a notion that is frequently deceptive (Stenbacka, 2001). In qualitative research the terms consistency, dependability, applicability, and transferability are also the essential criteria for quality measurement (Guba et al., 1994). In qualitative research, researchers strive for consistency and dependability in their research and the findings of their study should reflect the researcher's ability to collect the data (Merriam, 1995).

Brink (1991) proposed a three-test theory of reliability for qualitative research. Each of the theories should be used as the researcher deems suitable for different studies. The first test, which is the stability test, entails the researcher asking participants the same question at different times during the research study. If the same answer is given each time the test is deemed to be stable. The second test, which relates to the consistency of the study, refers to the integrity of issues within an interview so that all the participant's answers on different topics remain consistent. The third and last theory is equivalence, and this is tested by asking the same question, in a single interview, in different terms.

However, there is no benchmark by which one can repeat a study and establish reliability in the traditional sense (Mathison, 1988). For researchers of qualitative studies, the question is not whether different studies of the same phenomena will result in the same findings, but whether the findings of the study are consistent with the collected data (Merriam, 1995).

Validity

… a contingent construct, inescapably grounded in the processes and intentions of particular research methodologies and projects.

~ Winter, 2000, p. 1

For many years several qualitative researchers argued that the term validity is not relevant to qualitative studies (Davies & Dodd, 2012). Nevertheless, qualitative researchers also realised that they did need some kind of qualifying check or measure for their research. This realisation resulted in many qualitative researchers developing their own concept of validity, which they labelled in various terms (e.g. trustworthiness, rigor and quality) (Davies et al., 2012; Stenbacka, 2001).

"Validity in qualitative research means "appropriateness" of the tools, processes, and data. Whether the research question is valid for the desired outcome, the choice of methodology is appropriate for answering the research question, the design is valid for the methodology, the sampling and data analysis is appropriate, and finally the results and conclusions are valid for the sample and context." (Leung, 2015, p. 325).

Validity is not just about establishing the 'truth' anymore therefore the focus has shifted from the 'truth' to the adequacy of the researcher to understand and represent people's meanings (Bannister, Burman, Parker, Taylor & Tindall, 1994). Validity within qualitative research can be viewed from different positions including; culture, ideology, language, and relevance (Altheide & Johnson, 1994).

I ensured validity by meticulous record keeping, demonstrating how I came to my conclusions, and I made certain that my interpretation of the interview data was consistent and transparent. I provide my interpretation of the interview data in Chapter 5.

Credibility and transferability were achieved by describing and understanding the risk factors that influence domestic violence from the participants' point of view. I included direct quotes from the participants' responses to support my findings which increased the confidence in the results. Furthermore, I included short profiles of all the participants to provide the reader with background and in-depth knowledge and understanding of the participant's lives. I further established credibility and trustworthiness through ongoing collaboration with the supervisor. The supervisor guided and provided me with constant feedback regarding my interview schedule, transcripts, and dissertation. This ongoing collaboration created space for alternative interpretation and contributed towards the trustworthiness of the study.

To conclude, there are many divergent opinions about the concepts of reliability and validity in qualitative research. Social scientists differ as to how reliability and validity should be measured in qualitative research. Qualitative researchers mostly agree that a study cannot be repeated by the same investigator because of the highly changeable, personal nature, of each research study (Bannister et al., 1994). In qualitative research the reliability and validity depend on the relationship between the researcher, research process, and the interpretive community (Merrick, 1999

3.2.1.5 Ethical Considerations

The qualitative research approach allows researchers to gain access to intimate details of the perceptions and subjective experiences of individuals. It is therefore vitally important to take note of the ethical considerations whilst doing such research. Due to the sensitive nature of the research topic at hand, the following ethical considerations were an essential part of the planning and execution of this research study.

Informed Consent

Informed consent is a voluntary agreement to partake in research. Prior to giving informed consent the researcher is obliged to provide research participants with clear, adequate, and detailed information concerning the research project, its methods, risks, benefits, and how it will be disseminated (Terre Blanche, Durrheim & Painter, 2006).

Before the start of this research project, participants were provided with a written consent form (participant copy – Appendix A) that extensively explains the purpose of the research study. Participants were requested to sign a consent form (researcher copy – Appendix C). The research participants were informed that participation in the research was voluntary and that they had the freedom to withdraw at any given time.

Confidentiality and Anonymity

Confidentiality refers to the situation in which the researcher knows the identities of the participants but ensures that any disclosures made by them will be protected against unwarranted access. To ensure that the participants remained anonymous, all identifiable information that might expose the participants were removed and pseudonyms were assigned.

All of the information provided by the participants in this study were treated with confidentiality. All individual-level data that were collected were coded in such a manner that personal information could not be readily associated with a specific participant or family member.

It was explained to the participants that the information would only be revealed once permission was received from them.

Respect and Dignity

The participants were treated with respect and dignity at all times and I made an effort to avoid any exploitation or abuse of any participant. Care was taken to avoid and limit emotional and psychological harm to the participants.

In the event of any participant requiring psychological intervention, during or after the research study, I identified appropriate support mechanisms and provided the participants with details of suitable counselling or social services. Arrangements for possible counselling services with Psychologists, at Unisa's Department of Psychology, Psychotherapy Clinic and LifeLine, Pretoria (Mr Malashi Lucky Mabunda – Community Development Coordinator) were made. The contact details of LifeLine Tshwane were made available to all the research participants (participant copy – Appendix C).

According to my knowledge, none of the participants made use of the counselling or social services that was offered to them.

Precautions taken to minimise the risk of interviewing abused women

It is critically important to take the necessary precautions to minimise the risk of women with abusive partners being assaulted as a result of participating in a research study. This involves considering issues such as: How to make first time contact with the participants; how to safely locate women over time in case of longitudinal research; where interviews should take place and how to protect women's safety before, during, and after data collection (Sutherland et al., 2002).

It is crucial to minimise risk when recruiting women through the criminal justice system, the health care system, or after they have exited a domestic violence shelter programme. There should be strategies in place for contacting women in these situations to inform them about a

specific research study without alerting the abuser or violating the participant's privacy (Sutherland et al., 2002). For example, Langford (2000), maximised the safety of his potential research participants by recruiting participants through newspaper advertisements and directing all queries and initial calls to an answering machine. Participants could leave a phone number and a time that would be suitable and safe for them to speak freely.

To ensure that there was not a breach of confidentiality and to minimise the risk of the participant's privacy, I initially planned to send invitations to participate in the research study to relevant community-based and other shelters or institutions with a request to distribute the invitations (e.g. Atteridgeville and Mamelodi). Participants would have been asked to indicate their willingness and desire to participate by contacting me. I would have had a suitable answering machine/service available so that potential participants could direct their calls and leave a message for me to contact them. After serious contemplation, I realised that women who are or had been subjected to domestic violence might be hesitant to contact a complete stranger to schedule an interview. I made the decision to email my research proposal to several different shelters in the Tshwane district and asked them if they would allow me to interview women that have been exposed to domestic violence. Two of the shelters in the Tshwane central business district granted me the opportunity to interview women residing at the shelter.

Furthermore, there is a potential risk of harm to participants if an abusive partner becomes aware of their involvement in the research project. Researchers and evaluators may be under the impression that a woman is safe if she is no longer involved in an abusive relationship (Browne & Bassuk, 1997; Shiu-Thornton, Senturia & Sullivan, 2005). On the contrary, nothing could be further from the truth as it is quite common for batterers to not only continue, but also escalate their violence after an abusive relationship comes to an end. Therefore, when conducting research with abused women the presumption should always be

that each participant could be in danger (Shiu-Thornton et al., 2005). Often battered women are monitored by their partners as to where they go and who enters their home (Fontes, 2004)

Recommendations regarding confidentiality and safety that should be followed during a research study:

- Establish policies and procedures to assure that the participants remain anonymous. For example, aliases/codes can be used to ensure that their names cannot become known.
- Minimise the risk of exposure and ensure the safety of the participants by using a variety of interview sites.
- Terminate or change the subject of discussion should someone intrude on the interview.
- Exercise caution with the message on the answering machine/service. The message must be neutral (e.g. "women's health study") rather than one that reveals the true nature of the study.
- Assure that the abusive partner is unable to track his partner through the study's dissemination. Details such as age and number of children must be disguised.

My initial plan was to follow the above-mentioned recommendations regarding confidentiality and safety. However, because I interviewed women at shelters I did not need to abide by all of the recommendations. I still adhered to changing the subject when we were interrupted by another person and I made sure that the abusive partner could not track down his partner through the study's dissemination by using pseudonyms throughout the dissertation.

Basic safety protocols that should be followed when conducting research:

- In the event of contacting the potential research participant telephonically and a man answers; the researcher should ask for the woman by first name and give as little information as possible.
- If a woman answers the researcher should not assume that she is the participant. The researcher should ask for the woman by first name and assume that the abuser might be listening to the conversation. The researcher should also ask if it is a good time to talk and listen for verbal cues that might indicate that the woman feels unsafe or frightened (e.g. speech hesitations, uncomfortable silences and background noises).
- The interview should be conducted in a safe location that is well-lit and secure. The researcher must always make sure that he/she has a cell phone available.
- The researcher should always be prepared to stop the interview and continue at another time if safety is compromised.
- The researcher ought to have 'story' in place in case the abuser interrupts the interview (e.g. carry cosmetic products and pretend to be selling them).
- The researcher should note times and places that are safe to contact the participant and never assume that they cannot change over time. Participants must be asked each time what the best way is to contact them in future.

Because I interviewed women at shelters I did not need to adhere to all of the above-mentioned safety protocols. Nevertheless, I still made sure that I conducted the interviews in a safe location and I always had my cellular phone with me. I was also prepared to stop the interview in the event that our safety was compromised. Moreover, all of the shelters had security on the premises.

Many abusers use their children as a means to threaten, stalk, or harm their intimate partners and ex-partners (McMahon & Pence, 1995; Shepard, 1992). These abusers might interrogate the children about their mother's whereabouts or manipulate the children without the children realising it. The researcher should avoid leaving messages with children unless the mother specifically indicates that this is acceptable. Children should also not be present during any interview with the participant. To protect the privacy rights of family members, researchers must be careful in determining whether family members should be considered as research participants (McMahon et al., 1995; Shepard, 1992).

During the study, I never contacted any participants telephonically. Before the start of each interview I asked the participants with children if they would be able ask someone at the shelter to look after their children during the interview. I only allowed one participant to keep her infant with her during our interview because of the age of the child.

Certain protocols were followed to ensure the rights of family members/other persons:

- Codes rather than names were used to protect family member's/member's/another person's anonymity.
- Individual-level data were coded and stored so that they could not be readily accessible or associated with a specific participant or family member/other persons.

3.2.2 Participant Selection

Participant selection, which is part of the research design, involves finding appropriate participants for a research study (Terre Blanche et al., 2006). For the qualitative researcher the choice of who will be selected for a particular study is influenced by the research question.

As this is a qualitative study, which aimed at describing the subjective experiences of research participants, the selection of respondents was based on specific considerations that

allowed me to select the participants who met the criteria of the research study. In this study purposive as well as convenience sampling were used. Purposive sampling was chosen as a selection method as it allowed me to select individuals who had first-hand experience of domestic abuse. Convenience sampling (also known as availability sampling), which is a type of non-probability sampling was also used. This method entails selecting participants who are conveniently available to take part in a study.

I sourced women from shelters in the Tshwane district who were victims of domestic violence. Women from diverse racial, cultural, and socioeconomic backgrounds were sought. The target population for this study were women in a heterosexual relationship between the ages of 18 and 45 residing in Tshwane. The average age of the victims of domestic violence that participated in this study was 32.7 years of age. An international study revealed that women between the ages of 25 to 34 received the highest score of domestic disputes per annum and women between the ages of 35 to 44 received the second highest score of domestic disputes per annum (Peters, Shackelford & Buss, 2002).

One of the inclusion criteria for women to participate in this study was that they had to have been a victim of at least one incident of physical, sexual or emotional domestic violence that occurred between 12 months and 36 months ago. A further inclusion criterium was that the victim had reached sufficient closure or distance from the incident so that they could be interviewed and reflect on their experience without being re-traumatised. Respondents were asked whether they felt comfortable in answering personal and sensitive questions that involved thinking about the past or future. The interview only proceeded once the participant acknowledged that she felt comfortable enough to participate in the study.

It was my aim to find women from diverse racial, cultural, and socioeconomic backgrounds. I found this task difficult as most of the women residing at the shelters were from the same

cultural, socioeconomic, and educational background. I was unable to find women from outside the shelter who had been exposed to domestic violence and willing to participate in this study.

During the study I interviewed 13 women who were victims of domestic violence. Unfortunately, some of the first interviews had to be discarded due to thin descriptions. Some of the other interviews I could not properly record because of environmental factors. The interviews were held outside, and we were constantly interrupted by other people who resided at the shelter. Therefore, I could not transcribe the data and had to discard those interviews as well. After the initial interviews I gained enough experience to successfully interview six women.

3.2.3 Data Collection and Instrumentation

It is the qualitative researcher's goal to make sense of others' feelings, experiences, behaviours and social phenomena in their natural environment versus artificially created conditions (Terre Blanche et al., 2006). The researcher should make an effort not to disturb the research environment excessively and aspire to enter the setting with caution and engage with participants in an empathetic and understanding manner. The power of qualitative research is that the researcher can encourage individuals to provide the researcher with a deep understanding and insight into the research topic and question.

Data saturation in qualitative research refers to when further data collection will not add any additional information related to the research question (Saunders, Jim & Jinks, 2018). The researcher will see similar instances in their data and will be unable to find new themes or data. A large sample size will not guarantee saturation but rather what forms part of the data. When the researcher starts hearing the same comments or answers made by others or the participant

provides the same answers over and over again then data saturation has been reached (Saunders et al., 2018)

The primary method of data collection in qualitative studies are interviews. Interviews are understood to be a more natural form of 'interacting' with people than making them complete questionnaires (Terre Blanche et al., 2006). Therefore, interpretive researchers use interviews to understand how participants think and feel about particular phenomena.

A semi-structured interview (see Annexure B) was used to guide and steer the interview without dictating it. Broad open-ended questions were asked to encourage the women to describe their experiences in detail and to answer questions as meaningfully as possible (Lindlof & Taylor, 2002; Smith & Osborn, 2003). During the interview the purpose, goals, and process of the study were extensively explained. The semi-structured interview gave me the opportunity to (a) come face-to-face with victims and ask them a set of questions and (b) have the freedom and flexibility to add to those questions based on the interviewee's responses. With the interviews I gained insight into the lived experiences of the abused women.

The interviews were recorded with the consent of the participants and I noted additional questions and thoughts as they occurred during the interview. I attempted to keep all the interviews within a 60 – 90-minute timeframe to ensure that the participants did not lose their concentration. After the interview I documented all the participants' feelings as well as additional questions that might not have occurred to the women during the interview phase. After all the interviews were completed. I, during the analysis phase, transcribed the recorded interview data.

3.2.4 Data analysis

We should treat the people we study 'as if they are human beings' and try to gain access to their experiences and perceptions by listening to them and observing them.

~Weber, 1864 - 1920.

"Unlike other methodologies, phenomenology cannot be reduced to a 'cookbook' set of instructions, it is more an approach, an attitude, an investigative posture with a certain set of aims" (Keen, 1975, p. 41).

According to Hycner (1999) analysis, which is a term that means 'breaking into parts', means a loss of the whole phenomenon. As Aristotle said: The whole is greater than the sum of its parts. Hycner (1985) therefore preferred using the term 'explicitation', which allows for the examining of data in its whole context. The collected data were explicated according to Groenewald's (2004) simplified version of Hycner's (1985) explicitation process.

The process consists of five steps or phases:

1. Bracketing
2. Delineating units of meaning
3. Clustering of units of meaning to form themes
4. Summarising each interview, validating and modifying it, if necessary.
5. Extracting unique themes from the interviews and making a composite summary.

Bracketing

The phenomenological reduction is a conscious, effortful, opening of ourselves to the phenomenon as a phenomenon… We want not to see this event as an

> *example of this or that theory that we have, we want to see it as a phenomenon in its own right, with its own meaning and structure. Anybody can hear words that were spoken; to listen for the meaning as they eventually emerged from the event as a whole is to have adopted an attitude of openness to the phenomenon in its inherent meaningfulness. It is to have 'bracketed' our response to separate parts of the conversation and to have let the event emerge as a meaningful whole.*
>
> *~Keen, 1975, p. 38.*

Bracketing in phenomenological research means that the researcher should deliberately put aside his/her own beliefs about the phenomenon that is being investigated (Carpenter, 2007; Sadala & Adorno, 2001). I therefore endeavoured to put aside my own experiences, beliefs and values about domestic violence in order to fully understand and describe the life experiences of the participants. Bracketing, which normally occurs prior to conducting the research, allows the participants to express their own experiences without being influenced by the researcher.

My preconceived ideas around the risk factors that contribute to the occurrence of domestic violence changed after I finalised the interviews with the participants. It was my supposition that alcohol and drug abuse would be identified as one of the highest risk factors that contribute to domestic violence in intimate relationships. Most of the articles and journals I reviewed and referenced, highlighted alcohol and drug abuse as a high-risk factor for the occurrence of domestic violence.

I do not believe that my demographics or being a master's student had a major impact on the dynamics with the participants. All the participants felt a need to share their story and for someone to provide them with guidance and advice. Even though I was unable to give them

advice, because I am not a clinician, they were still keen to share their life stories with me. During the interviews I tried to focus solely on the participants' lived experiences and the stories they shared with me. Although I used the method of bracketing which meant I had to enter the field without any preconceived ideas, beliefs, and opinions, I don't believe that bracketing is always possible and is rarely truly achieved. Every researcher has some knowledge, experience, and notion of the investigated phenomenon. Researchers can only attempt to create distance from previously held theories and assumptions. As a researcher, I tried my best to provide detailed and accurate reflections of the participants' life stories without allowing my preconceived ideas to influence the research study.

Delineating units of general meaning

During the transcription and evaluation of the interview the researcher should strive to bracket his/her presuppositions. Every word, sentence and paragraph have to be scrutinised to reveal the essence of the meaning of the participant.

Once the general meaning has been noted and understood the researcher is ready to address the research question and determine whether the participants' disclosures shed light on the research question. Each unit of meaning must be evaluated against the entire context of the interview. Information and statements that have no relevance to the research question should be eliminated.

Clustering units of relevant meaning

With a list of non-redundant units of meaning the researcher again brackets his/her presuppositions in order to remain true to the phenomenon (Groenewald, 2004). Next, the researcher determines whether any of the units of meaning naturally cluster together. This means that a common theme emerges from the clusters of meaning. "Particularly in this step

is the phenomenological researcher engaged in something which cannot be precisely delineated, for here he is involved in that ineffable thing known as creative insight" (Hycner, 1999, p. 150-151).

Summarise each interview, validate and modify

During this step, the researcher revisits the interview transcription data and summarises the interview and the themes that emerged from the data. The researcher proceeds with a validity check by discussing the emergent themes with the research participants. If the researcher, for some reason, did not capture the whole essence of the interview, corrections will need to be made.

General and unique themes for all the interviews and composite summary

After all the previous steps have been completed the researcher looks for themes that are common to most or all of the interviews as well as individual variations (Hycner, 1985). Themes, which are common to all the interviews, are clustered together to indicate a general theme. Care is taken to not cluster themes together that have significant differences. Themes that are unique to a single interview indicate important counterpoints to the phenomena researched (Hycner, 1985).

The researcher concludes the explicitation by writing a composite summary of all the interviews. The summary should reflect the essence of the phenomenon being investigated and describe the world in general as it is experienced by the participants (Hycner, 1985). "The researcher "transforms participants" everyday expressions into expressions appropriate to the scientific discourse supporting the research" (Sadala et al., 2008, p. 289).

3.3 Conclusion

This chapter addressed the phenomenological research design as well as the research method of the study. The qualitative method of inquiry, the concepts of reliability and validity were explained from the qualitative perspective. The research method, the participant selection, data collection, and data analysis were explained.

In the next chapter, I discuss the research findings of this study.

CHAPTER 4

ANALYSIS AND DISCUSSION

4.1 Introduction

In Chapter 3, the research design and the method of data analysis were discussed. The purpose of this chapter is to present and discuss the research findings of this study. This chapter is divided into three sections.

First, I present a brief description of the participants in the form of a short profile so that the reader can be oriented towards the current and historic situation of each participant. Next, the four significant themes are specified. The sub-themes common to the interviews are clustered together to indicate a general theme and individual variations are highlighted. I present a composite summary of the findings for all the interviews which include verbatim extracts and summaries to provide a context within which the themes emerged. This summary reflects on the world in general as it is experienced by the participants. This is followed by a discussion, in relation to the existing literature, of all the themes and sub-themes that emerged from the data analysis.

4.2 Short profile of the participants

In Table 4.1 the personal details of all the participants are presented, as well as the pseudonym used, race, age, relationship status, number of children, highest qualification, and nationality of each participant.

TABLE 4

Personal details of the participants

Participant	Race	Age	Relationship Status	Number of Children	Highest Qualification Completed	Nationality
#1 – Anna	White	45	Divorced after 7 years of marriage	3 (1 child died)	Grade 12	South African
#2 – Nakwasi	Black	24	Separated from partner. 3 Year relationship	1	Grade12	South African
#3 – Dorothy	Black	30	Separated from husband. Married for 4 years	3 (1 child died)	Grade 12	Central African
#4 – Nina	Black	33	Separated from husband. Married for 4 years	1	Grade 12	East African
#5 – Eva	Black	30	Separated from husband. Married for 6 years	3 (pregnant with her fourth child at the time of the interview)	Grade 6	Central African
#6 – Mandisa	Black	45	Separated from 3rd partner. 3 Year relationship	3	Grade 4	South African

4.2.1 Participant #1 – Anna

Anna was a 45-year old, English speaking white female. She grew up in Tshwane, Gauteng with her parents, sister, and two brothers. Anna's father, who was an alcoholic, sold their car and furniture to support his addiction. Anna's mother had to work long hours to take care of the children's needs and this led to Anna taking control of the household when her mother and father were absent. After completing matric Anna attended the University of Pretoria to study financial auditing. She studied financial auditing for two years but never completed her degree. After her brief attendance at university she started working for an auditing firm and

met her future Portuguese husband through the company for which she was working and at the age of 26, Anna married him. Soon after the marriage, Anna realised that her husband was not the same person with whom she fell in love. Her husband, who became extremely jealous and had an uncontrollable temper, accused her of having extramarital affairs with her clients. One of the worst arguments led to her husband throwing Anna down the staircase at their home. Anna was five months pregnant at the time and lost the baby due to the fall. Anna and her husband had two children prior to the incident that led to the death of their unborn child. After the incident, Anna made the decision to divorce her husband and left with their children. The court granted Anna custody of their children but due to the nature of her marriage and childhood, Anna started drinking and had a nervous breakdown. Anna lost her work and could not take care of the children anymore. After her emotional breakdown, she had to ask her ex-husband for assistance with caring for the children. In the end, Anna ended up in a shelter because she did not want to be a burden to her mother or family. Anna was subsequently employed by the shelter as an office manager but found it very difficult to cope with her past.

4.2.2 Participant # 2 – Nakwasi

Nakwasi, a 24-year-old black female, completed matric and two years at university. As a child, Nakwasi, who grew up with her parents, was exposed to domestic violence at a very young age. Her father regularly beat her mother after drinking and called her mother his slave. Nakwasi described her father as a person who had the tendency to behave impulsively and he had the tendency to run away as soon as there were problems at home. One day her father took all the money from their house and left for good. The separation of Nakwasi's parents occurred when she was only 11 years old. Nakwasi went on to explain that her parents were never married because her mother did not want to be 'legally bound' to someone who abused her. After her father left, he met a new woman and moved in with her.

It was only after Nakwasi's father left that her mother made the decision to go to university so that she could be in a better financial position to support her daughter. Years later, Nakwasi met a man who later became the father of her first child. Nakwasi's partner was a drug dealer who often sent her away to visit her family, whenever he had money. It was only after a couple of months that Nakwasi realised he only wanted her to leave so that he could use drugs without her finding out about his addiction. The relationship between Nakwasi and her partner was volatile. Her partner emotionally abused her and prohibited her from showing any emotion during an argument. Nakwasi revealed that the emotional abuse that her partner subjected her to, made her retaliate, and become emotionally abusive towards him. She explained that she felt that she could not express her feelings and emotions in the relationship and felt that she had to suppress these. Nakwasi further explained that she believed that her partner used her as an excuse to steal money. He told his family it was because of the pressure she put on him that made him deal drugs and steal money to support her and the baby. Shortly after the birth of their first child, he was arrested for drug dealing. Nakwasi decided that she did not want to expose her five-month-old child to that kind of situation any further and asked for assistance at a shelter.

4.2.3 Participant # 3 – Dorothy

Dorothy, a 30-year-old black female, was born in Central Africa and moved to South Africa (Tshwane) with her mother, six brothers, and three sisters when she was 10 years old. Dorothy, whose parents divorced when she was a baby, was raised by her mother. At the age of nine, Dorothy was raped by her uncle. During the time of the incident, her mother was looking for work and left Dorothy and her brothers and sisters with family members. After they moved to South Africa they had to sleep outside the United Nations Offices and later moved to a shelter where she had to share a single room with her mother and nine siblings. Dorothy's mother supported the children as best she could, and Dorothy went on to complete

her matric. Years later, Dorothy met her partner whom she married during 2013. She explained that her husband to be started beating her when they were still dating. The first incident of abuse happened because he became jealous about a text message she received from a male friend to wish her a happy new year. She described her husband as a 'violent beater' who physically abused her five days per week. The extremity of the abuse increased during her first pregnancy and this led to Dorothy giving birth to a premature baby who died six days after being born. Dorothy's husband did not work and kept accusing her of having affairs and doing 'things' behind his back. Dorothy gave her entire salary to her husband in the hope that he would become 'okay'. She explained that he started drinking and it was when she fell pregnant with their third child that he tried to force her to get an abortion. He threatened to leave her if she did not oblige. Dorothy explained that she did not want to leave her husband because she was afraid that she might end up like her parents. She believed that God would save their marriage, but the final incident of violence made Dorothy realise that she had to get away from her husband. One day, when he tried to physically abuse her, he hit their one-day old baby, whom Dorothy was holding at the time. She then contacted the police to get help for her herself, her baby, and her daughter.

4.2.4 Participant #4 – Nina

Nina, a 33-year-old black female, relocated with her sisters and brothers from East Africa to South Africa when she was 18 years old. Nina completed her matric and studied law, at the University of Johannesburg, for two years, before discontinuing. Nina described her childhood as a very difficult period in her life. At the age of 10, both her parents were shot dead during a roadblock during the war in East Africa. Nina married her husband in 2013 and fell pregnant with their first child during 2016. Nina explained that the violence in her marriage started when she was four months pregnant. Her husband did not want Nina to work but was also disinclined to support her financially. The violence became worse when she

came to realise the financial issues her husband was facing. He suggested Nina ask for financial assistance from the pastor or her family but would then become enraged when he found out that she had done so. Her husband accused her of gossiping about their financial problems and making fun of him behind his back. After Nina fell pregnant her husband became irritated with the amount of money she spent on food. In the beginning, he was mostly emotionally abusive but shortly afterwards the violence escalated and turned physical. Nina decided to leave her husband and find a place of safety for herself and her child. The baby was only one month old when she left her husband and found a place of safety in a shelter. Nina said she felt like she did not want to raise a child when she was not financially prepared to do so. She felt sorry for her husband because he came from an abusive home and she still believed he had a good heart. Nina further explained that she did not want to divorce her husband but would have liked him to get help for his anger issues. During her time in the shelter she tried to make him realise that he needed to 'work on himself'.

4.2.5 Participant #5 – Eva

Eva, a 30-year old black female, grew up in Central Africa but relocated with her family to South Africa when she was 19-years old. Eva lived in Tshwane since 2008 and described her childhood as problematic. Eva's parents separated when she was a toddler. She explained that her mother never took care of her, her three sisters, and two brothers. Her mother frequently left them with people who were strangers to them. At the age of 14, Eva started sleeping with men to financially support and feed her brothers and sisters. Eva never had the opportunity to finish school because she did not have sufficient finances to pay the school fees. Eva married during her early twenties and described her marriage as good at the time. Eva and her husband already had three daughters when her mother contacted Eva to ask for her assistance with accommodation for her step-sister. Her mother struggled to monetarily support her step-sister and wanted Eva to accommodate her whilst her sister was looking for a job. Eva never

worked, and her husband supported her and their children. After Eva's sister moved in, Eva came to realise that her husband was having an affair with her sister. At that stage, her husband started to physically abuse Eva, which was something that had never happened before. Her husband started lying to her about going to work when in fact he was roaming the streets with her sister. Eventually, he told Eva that he could no longer afford their communal home and that he was looking for an apartment for himself and her sister. During that time Eva's husband still slept with her and her sister and Eva fell pregnant with their fourth child. Without any financial income, Eva was forced to find a place in a shelter. Eva was a broken person who did not know how she was ever going to support three children and a baby without an income or any work experience.

4.2.6 Participant #6 – Mandisa

Mandisa, a 45-year old black female, grew up in Tshwane. Mandisa's parents separated when she was nine months old. During her childhood both her mother and elder sister physically abused her. Mandisa explained that they would punish and beat her for no reason at all. At the age of eight, Mandisa's mother gave her to her aunts to take care of her. During her stay with her aunts she was raped by one of her uncles. Mandisa said that as a child she was taught that if a man beats you it is proof that he loves you. Years later Mandisa had three children with three different men. Two of the relationships were physically and emotionally abusive. Mandisa explained that her second relationship lasted for approximately eight years. She left her abusive partner two years prior to finding help at a shelter. Her partner took her to a Sangoma to get cut because he believed that this would help her to stop being difficult and succumb to him. Mandisa described the cutting as a process whereby men would hold her down and one of them would cut her from her armpits up to her face with a razor blade. Mandisa believed that her partner did this because they owned land together and that he wanted her dead so that he could sell the land. After her second relationship, Mandisa had a

child with her third partner who was also physically abusive. Her third ex-partner was stalking her at the time of the interview and wanted to kill her daughter who was an albino. Mandisa further explained that she believed that her partner's family also wanted to kill her daughter (the albino daughter she had with another man). According to her partner's culture, killing a child with albinism makes one's business prosper. After Mandisa went to court to get a protection order against her partner, the stalking commenced. Mandisa explained that her third partner started beating her because he said she was too beautiful and that no other man would look at her if she were disfigured. Her partner would beat her with a stone in the face, but Mandisa said that she still believed that he loved her because he was still maintaining her and the children. Mandisa explained that she never realised that the things her parents did to her as a child constituted abuse. She only came to realise this after sessions with a social worker at the shelter.

4.3 Presentation of Findings

Next, I discuss the findings of the study. This includes the biographical details of the participants: Their age, gender, race, highest level of education, employment status, relationship status, and number of years they had been residing in Tshwane.

4.3.1 Biographical Information of Participants

To ensure that there was not a breach of confidentiality and to minimise the risk of the participants' privacy being violated, all six participants' biographical details were kept confidential and pseudonyms were used throughout the process. Where a name of a social worker, partner, husband, and/or child was mentioned, a pseudonym was also allocated.

4.3.2 Age of the Participants

At the time of the interview the age of the participants varied from 24 – 45 years of age. Two of the participants were 45 years old, another 33 years old, and three of them were between

24 and 30 years of age. During the time the participants were exposed to domestic violence their age varied from 21 – 41 years of age.

4.3.3 Gender

All the participants were female.

4.3.4. Race of participants

Five of the participants were black females, and one was a white female.

4.3.5 Highest Level of Education

The participants' level of education ranged from attending secondary school but never completing Grade 12 up to some years at tertiary level. Three of the participants pursued tertiary education but never completed their degrees. One of the participants completed Grade 12 and two of the participants left school before they could finish Grade 12.

4.3.6 Employment status

One of the black participants found employment a couple of days prior to our interview, the white participant worked at a shelter, and the rest of the participants were unemployed at the time of the interviews.

4.3.7 Relationship status

Three of the six participants were married, but separated from their husbands, and one was divorced. The two other participants had only been in a relationship with an abusive partner from whom they had since separated due to intimate partner violence.

4.3.8 Number of years that the participants have been residing in Tshwane

The number of years the participants resided in Tshwane ranged from five – 27 years. Two of the participants were born in Tshwane, while one was born elsewhere in Gauteng but

relocated to Tshwane as a child. The rest of the participants relocated, at a young age, from Central and East Africa to Tshwane, South Africa.

4.3.9 Place of residence

All of the participants were residing in shelters in Tshwane, Central Business District, at the time of the interviews.

4.4 Themes

Four themes emerged from the responses of the participants. The themes were divided into sub-themes. Theme 1 is divided into four sub-themes. Themes 2, 3, and 4 respectively have only one sub-theme each. All the sub-themes are divided into different categories as set out in Table 5.

4.4.1 Presentation and discussion of the themes and sub-themes

Table 5 is a presentation of the themes and sub-themes that emerged from the semi-structured interviews with the six participants. This is followed by a discussion of the themes.

TABLE 5

Themes, sub-themes, and categories

Themes	Sub-Themes	Categories
1. The participants' experiences of domestic violence	1.1 Forms of domestic violence	1.1.1 Physical abuse 1.1.2 Emotional abuse
	1.2 Extremely difficult personal circumstances	1.2.1 Traumatic childhood and family disharmony
	1.3 Substance abuse by a partner	1.3.1 Alcohol and drug abuse by a partner
	1.4 Behaviour of partner	1.4.1 Controlling behaviour, jealousy, and false accusations
2. Socio-Economic Factors	2.1 Struggle to make ends meet	2.1.1 Economic neglect
3. Cultural differences	3.1 Cultural differences between partners	3.1.1 Impact of cultural differences on the occurrence of domestic violence
4. Domestic violence during pregnancy	4.1 Occurrence of domestic violence during pregnancy	4.1.1 Impact of pregnancy on the occurrence of domestic violence

The themes, sub-themes, and categories are presented and discussed in detail below. Each section starts with a table of the specific main theme, with its sub-themes, and excerpts from the interviews in which the themes occurred. After each table, the excerpts are analysed and interpreted.

4.4.2 Disclaimer

The excerpts in the following discussions are full of grammatical errors and reflective of the reality that English is a second and or third language for most of the participants. The low educational levels of several of the participants could also be a contributing factor towards the poor grammar.

4.5 Discussion and Findings

Next, I discuss the findings of the study and the themes and verbatim extracts from the interviews.

4.5.1 Theme 1: The participants' experiences of domestic violence

The first theme, *The participants' experiences of domestic violence*, with four sub-themes 'Forms of domestic violence', 'Extremely difficult circumstances', 'Substance abuse by a partner' and 'Behaviour of partner', are discussed and analysed below.

As indicated in the previous chapter, all the participants in this study had to have been a victim of at least one incident of domestic violence and in particular physical, sexual, or emotional abuse between 12 months and 36 months prior to the interviews.

As noted in the literature review chapter, some women who are in a violent relationship experience major obstacles and challenges with respect to health problems and psychological symptoms. Five of the participants in this study indicated that, because of the physical abuse they suffered, they were left with physical injuries as well as feelings of depression and worthlessness. Some of the participants (N = 5) revealed that the physical violence they encountered led to adverse pregnancy outcomes which included preterm delivery and fetal death.

Moreover, although sexual abuse was not discussed as a risk factor in this chapter, two of the participants indicated they were sexually abused by a family member during childhood. The impact of childhood sexual abuse is discussed under the 'Extremely difficult circumstances' theme. Only one of the participants, in this study, revealed that her husband would sometimes force her to have sexual intercourse after they had had an argument. Anna revealed***: "I would go sleep in another bedroom because I was so mad at him and he made me so heart sore and you know, he would just still walk into that room and sort of demand sex."*** I did not further discuss sexual abuse in this research study because none of the other participants mentioned that they were sexually abused by their husband or partner.

4.5.1.1 Theme 1 – Sub-theme 1: Forms of domestic violence

As per the literature review, domestic violence is the intentional abuse or assault committed by a previous or present partner or spouse. The range of abuse women may suffer is extensive and can include physical, emotional, psychological, economical, and pregnancy abuse.

4.5.1.1.1 Physical Abuse

Physical abuse can be defined as the use of physical force, possibly resulting in harm, disability, or death intended to enhance the power and control of the abuser over the partner.

The following table provides excerpts of some of the participants' responses to the physical abuse they experienced in their relationship/marriage. Five of the six participants in this study indicated that they had been a victim of physical abuse, when they were pushed, slapped, beaten and threatened with weapons or objects that could hurt them.

TABLE 6

Forms of domestic violence: Physical abuse

Theme 1: The participants' experience of domestic violence		
Sub-theme1.1	**Category**	**Excerpts from the interview**
Forms of domestic violence	Physical abuse	***Anna: "****And I told him, I am too scared to answer my own door because I do not know who is going to stand outside the door whether it is the police force or the receiver of revenue or whomever. I said to him: I do not know. I, I can't live like this anymore and I told him that he is not the man I fell in love with and I don't love him anymore. And that, that day, was when he threw me down the stairs and I lost the baby."* *"I know he is just gonna come home and beat the crap out of me so I end up phoning all these people, get all the stock delivered, and get all the money collected and then he will still be mad."* ***Dorothy:*** *"I will try to ignore him by all means. Maybe I won't talk. If he will shout at me I will try to ignore. Okay, I won't talk back at him, but if he continues I get angry. I talk back at him and that's when he will snap and start beating me and stuff."* *"Everything that I would do to him it seems wrong. When I go and look for a job for him, it's like okay fine, you want another man. You are going to look for men and everything and he will beat me to a point whereby I gave birth to a premature child."* ***Nina:*** *"Shut up. You've got nothing to say. I'm the man in the house, and I could not bear the pain. That's how I end up here because he start beating me."* *"Every time when he want to beat me I run. He knows that I cannot stand when he's angry. I'm not used to that kind of things".* ***Eva:*** *"Yes, he was beating me and sometimes I call the police. I even needed protection on that day I took him to court."* *"He keeps lying, you know. Lying. Once I'll be asking him, like that we start fighting. He's going to be beating me."* ***Mandisa****:"Then he didn't stop. He started making me the punching bag until to the point whereby the time that he was taking out a gun. Tried to kill me with the gun. Then it's when I said: No. Now no more. Then I said to him: It's over between us and then you go and make your life and I get on with my life and that's it."* *"He was beating me, the whole body with that gun and even here (pointing towards her face) Look at my face somewhere. I can't remember because I got a stitch there."*

Anna explained that her husband started physically abusing by slapping and hitting her soon after they got married. The severity of the abuse escalated to such a point that her husband pushed her down the stairs and she lost her unborn child. During the time of the incident, she was five months pregnant.

Dorothy indicated that her husband started physically abusing her before they got married. He was extremely jealous and often accused her of having extramarital affairs. After they were married, and she fell pregnant with their first child, her husband physically abused her by slapping, hitting, and kicking her to such an extreme that she gave birth to a premature baby who died six days after his birth.

Nina described her marriage as peaceful until she fell pregnant with their first child and her husband started facing financial difficulties. Her husband tried to hide his financial problems from her and promised that he would take care of Nina and their unborn child. Later, Nina found out her husband was lying to her about the extent of his financial problems and she confronted him. It was at the same time that her husband started physically abusing her.

Eva's explained that her relationship with her husband was good until her mother phoned and asked Eva to assist with accommodation for her step-sister. A couple of months later, without her knowing, Eva's husband started having an affair with her step-sister. When she found out that her husband was having an affair with her step-sister, Eva was expecting their third child. Her husband started beating her during her pregnancy and kept having sexual intercourse with both Eva and her sister. When Eva fell pregnant with their fourth child her husband left Eva for her step-sister.

Mandisa described the father of her third child as a lovely person at the beginning of their relationship. However, in their fourth year of marriage he started physically abusing her by

slapping and hitting her. Over time the physical violence became a daily ritual that escalated to her partner punching her, beating her with a stone, and threatening her with a gun.

Physical violence has a tendency to increase in frequency and severity over time and can be potentially life threatening (Gumani & Mudhovozi, 2013; Mouradian, 2007). This corresponds with what Eva experienced: ***"Then he didn't stop. He started making me the punching bag until to the point whereby the time that he was taking out a gun."***

Physical abuse usually occurs in relationships in which there is emotional abuse (Coker et al., 2002). This is similar to the findings of the current study where five out of the six participants indicated that they were both physically and emotionally abused. According to research conducted by Mouradian (2007) physical abuse is an act carried out with the intention or perceived intention to cause physical pain or injury to another person. This type of abuse may occur as a once off incident or happen sporadically but in many relationships, it occurs repetitively. Although both men and women can be victims of violence, research indicates that women are more likely to be physically abused than men (Farrokh-Eslamlou, Oshnouei & Haghighi, 2014; Rakovec-Felser, 2014).

As mentioned previously, physical abuse, which is often accompanied by emotional abuse by the perpetrator, includes deliberate belittling the victim, limiting his/her access to money and other means of support, as well as restricting his/her social interactions and movements (Jewkes, Levin & Penn-Kekana et al., 2002). Literature indicates the impact of domestic violence does not necessarily last just as long as the actual experience of abuse but may continue after the violence has ceased (Dillon et al., 2013).

Another form of domestic violence, namely emotional abuse, is discussed next.

4.5.1.1.2 Emotional Abuse

This sub-theme refers to emotional abuse and the impact thereof on victims. As discussed in the literature review, emotional abuse is also known as psychological abuse, non-physical abuse, or verbal abuse. This type of abuse refers to behaviours of intimidation and the use of verbal and nonverbal acts to threat or control another person, which may result in emotional trauma. Emotional abuse is an ongoing process in which the perpetrator establishes dominance and control over the other person and systematically destroys the character of his/her victim (Ganley, 2002). Emotional abuse tactics are similar to the ones used against prisoners of war or hostage victims. They have the same purpose: The perpetrator wants to gain and maintain power and control over his/her victim (Ganley, 2002).

TABLE 7

Forms of domestic violence: Emotional abuse

Theme 1: The participants' experience of domestic violence		
Sub-theme 1.2	**Category**	**Excerpts from the interview**
Forms of domestic violence	Emotional abuse	***Anna:*** *"I will speak to him: how are you going to explain that, I paid tax my whole life since the day I started working, and he would say: don't start with your shit. The fights were mainly about business, sometimes it was personal; about jealousy."* ***Nakwasi:*** *"So he was very angry and he was saying all sorts of things. Then I was about to cry when he snapped. Like okay, my eyes were getting watery and he just snapped. Tell me that if I cried, he's just going to like, he is just going to make me regret it."* *"You know it's very had to be with someone you can't talk to, especially if they have done something wrong. You can't show him because he normally just going to shut it down. You know if I cry I'll get things like: "I don't want to see those tears again."* ***Dorothy:*** *"He will be accusing me about everything. Oh this and that, or you didn't want me to go because your boyfriend came here, the father of our baby. Maybe this child is not mine and everything".* *"Sometimes he can fight with his boss at work and comes home and take it out on me. I'll be like this is not how it works and he will tell me: you are my wife. You have to take every shit that come from me."* *"Sometimes he will say things that hurt me you know. He will be like saying: okay maybe it's because that's why you were raped. I shouldn't have married you. You are cursed."* *"He would say I am disrespecting him because he is talking to me and I am looking at him as if he is stupid. There was a time I tried to fight him with my silence. I said okay he is going to fight and swear at me and then I will keep quiet because I know that when I talk to him it's like I am adding paraffin on top of fire."* ***Nina:*** *"The worst violence. He used to abuse me whereby the way he talk to me. He would insult me without touching me and that's really painful, knowing a person you are staying in the same place and he just talk without respecting you."* *"He never hurt me in public. Only what he does he abuse me verbally. That's what he does and that's really its torture. He torture me emotionally."* ***Mandisa:*** *"Like we stayed together. Then he introduced himself to marry me within a year. Then I fell pregnant after he paid the labola thing and then we did some ceremonies sort of, and then he started abusing me emotionally, physically he was beating me as well."*

Anna indicated that her husband had a vile temper and often broke the law. She explained that he would hi-jack trucks that transported alcohol and would then force her to phone all her clients and tell them that she was selling alcohol. When Anna declined to assist him with his endeavours he would get extremely angry and emotionally abuse her.

Nakwasi explained that the emotional abuse she experienced started after she gave birth to their first child. Nakwasi's partner constantly belittled her by telling her how much weight she gained during her pregnancy and that she should do something about it. She further explained that her partner prohibited her from showing any emotion during an argument and would threaten her if she started crying. She said that he never took responsibility for his actions and blamed her for everything that went wrong in their relationship.

Nina described her husband's emotional abuse as a painful experience that was worse than the physical abuse. She explained that her husband faced financial problems and could not provide for their child, and this led to arguments. At first, he started to verbally abuse her and told her that she had no right to say anything because he was the man of the house. In time the verbal abuse turned into physical abuse.

Dorothy indicated that her husband emotionally and physically abused her in front of their children. He was extremely jealous and constantly accused her of gossiping behind his back. Even though Dorothy tried to keep quiet during the episodes of emotional abuse her husband took her silence as a sign of disrespect, which infuriated him even more and this escalated the violence.

Mandisa had three children with three different men. Two of the relationships were abusive. The partner of her second child paid labola and wanted to marry Mandisa. Mandisa explained that they held the traditional ceremonies, but they were never officially married. After the ceremonies her partner started emotionally and physically abusing her.

Five of the six participants in the current study indicated that they had been a victim of emotional abuse. Research indicates that emotional abuse occurs at a rate three times higher than physical abuse (Cornelius, Shorey, & Beebe, 2010). According to research the perpetration of emotional abuse typically emerges prior to physical abuse, and may predict its onset (Leonard, 2001).

Emotional abuse varies from shouting, belittling, threatening, and name calling in private and/or in front of children and in public. Verbal attacks against the victim are often intended to deliberately expose the victim's vulnerabilities, for example, being raped as a child, lack of parental skills, or degradation of religious and cultural beliefs (Ganley, 2002). This corresponds with Dorothy's revelation: ***"Sometimes he will say things that hurt me you know. He will be like saying: okay maybe it's because that's why you were raped. I shouldn't have married you. You are cursed."***

Rivara et al. (2009) stated that emotional abuse is a grave form of abuse because women report that it is as harmful as, or worse than, the physical abuse they suffer. This corresponds with Nina's response **"*The worst violence… he used to abuse me whereby the way he talk to me.*"** For Nina, the emotional abuse to which she was exposed, was much worse than the physical abuse.

Research that examined patterns of fighting and physical aggression found that over time elevated levels of verbal abuse often preceded or occurred with physical and/or sexual abuse in a relationship (Mouradian, 2007). This corresponds with Nina's response **"*It's like he wants to depress me until I give up. Yes, that's the kind of way he was abusing me before he decided to beat me*".**

Next, I discuss how a traumatic childhood and family disharmony impacted on the occurrence of domestic violence.

4.5.1.1.3 Traumatic childhood and family disharmony

This sub-theme refers to the effects and relationship between childhood violence and becoming victims or perpetrators of domestic violence. As discussed in the literature review, research has shown that exposure to domestic violence during childhood can lead to a high risk of becoming adult perpetrators or victims of domestic violence (Carrigall & Matzopoulos, 2013; Whitefield et al., 2003).

The summaries in the following table elucidate how a traumatic childhood influenced the participants' trauma. It should be noted that the participants' description of their partners' childhood was purely from the participants' perceptions and/or understandings of the trauma their partners endured during childhood. I did not interview any of the participants' partners and therefore I was unable to verify the information I received.

TABLE 8

Forms of domestic violence: Traumatic childhood

Theme 1: The participants' experience of domestic violence		
Sub-theme 1.2 (A)	**Category**	**Excerpts from the interview**
Forms of domestic violence	Traumatic Childhood	***Anna:*** *"His mother was very abusive. His mother was the hardest person I have ever seen in my life and she is one of those… she never forgives and never forgets. Now that she is getting older she is changing a bit, but before, she was like cold hearted. She used to hit them."* ***Nakwasi:*** *"Yes well. I was quite young you know when my mom went away, but he used to get, especially if he drinks alcohol (participant referring to her own father). You know he used to get abusive and he would slap her around."* *"It doesn't take a lot of drink to get my father really drunk. What people would normally say is: okay if I take this much I will get myself tipsy. For him he just goes into another state."* ***Dorothy:*** *"I was raped you know when I was so young in Zambia by my auntie's husband. When I was still nine years old there. It started when my mom had to leave us in Zambia. We went to visit. It was me, my two elder sisters. I had scars on my body that even my own sisters never knew that I was being raped when I was staying there in Zambia."* *"He would be beating me in front of my children. He doesn't care whether they are looking or what because my daughter she would be screaming, crying,"* *"There was this time he told me that his father once killed a man in front of their very own eyes. That man used to be their mother's lover. He killed that man and told them that this is what a man does."* ***Nina:*** *"He once told me his father won't beat him during the day. He wait until when his sleeping. Imagine that kind of abuse. He will come and throw water on him."* *"So he sat telling me how his father used to beat him and how he used to experience how his father used to fight with his mom. The father was beating the mother."* ***Eva:*** *"My mother is the kind of person she used to leave us. So my mother she would leave us maybe a year or six months. So I am the one that used to take care of my sisters and brothers. Maybe I will go out and sleep with men, get something to feed my sisters and brothers."* ***Mandisa:*** *"Then I just grab that thing with my hands because I feel it was put in, in me, and then he did in between my thighs. Next thing because I saw the dirty there in the blanket I thought they are going to beat me." (Participant talking about her uncle raping her and her family seeing the dirty blankets).*

Anna explained that she was raised in a home with an alcoholic father who could not provide for the family. Anna's mother had to take on three different jobs to support the family. This, in turn, compelled Anna to take care of her siblings as she was the eldest and her mother was seldom home. She further explained that her husband grew up in a violent home where the mother physically abused her children on a regular basis.

Nakwasi described her father as an unreliable person who often disappeared when situations did not sit well with him. When Nakwasi was 11-years old her parents split, and her father moved in with another woman. Nakwasi further explained that her father used to beat her mother especially after he abused alcohol. Moreover, her partner was also raised in an abusive home. Her partner's father was married three times and was physically abusive towards the mother in front of the children.

Dorothy indicated that she had nine siblings and was raised by her mother as a single parent. Her mother did not have any money and they slept outside on the streets until they could find a shelter that was willing to take them in. As a child, Dorothy was raped by her uncle and her mother forced her to keep quiet about it. Dorothy explained that her mother made her feel as though it was a sin to speak about rape. Dorothy further explained that her husband also came from a large family with two boys and eight girls. Her husband's father was a soldier who was extremely abusive and killed his mother's lover in front of their children.

Nina was exposed to a traumatic childhood at a very young age. When she was 10-years old her parents were killed during the war in East Africa. Nina went to live with her aunts in what she described as a good environment. Nina further explained that her husband grew up in an abusive home. Her husband's father maltreated the mother as well as the children.

Eva mentioned that her mother and father separated when she was a toddler. She never knew her father. Her mother had a tendency to leave them with strangers and would sometimes

only return after a year. Eva started sleeping with men at the age of 14 to support her brothers and sisters financially.

Mandisa grew up in a home where she was physically abused by her mother and sister and raped by her uncle. Her father left when she was nine months old. Mandisa said she experienced rejection as a child and to her, it felt as if her mother did not want her. As a child, Mandisa moved in with her aunts who raised her. She revealed that her mother did not contribute financially towards her upbringing. The father of Mandisa's third child also grew up in an abusive home. Her partner's father used to physically abuse the mother in front of the children and would then proceed to beat the children.

Studies have shown that early victimisation, including direct physical or sexual maltreatment of children or indirect victimisation (e.g. children's exposure to domestic violence) can convey the notion that violence and aggression are acceptable interpersonal tactics (Davies & Woitach, 2008; Lieberman & Van Horn, 2008). According to Abrahams et al. (2009) the risk of men becoming perpetrators of intimate partner violence starts in childhood and tends to augment if they are exposed to violence between parents, sexual abuse and physical abuse. The child may internalise the violence as a ‘normal’ occurrence in intimate relationships and as adults may re-enact or subject themselves to these experiences (Waters & Cummings, 2000; Kimber, Adham, Gill, McTavish & MacMillan, 2017).

Heyman and Slep-Smith (2002) cited that women who witness interparental violence and experience physical abuse have a high risk of experiencing domestic violence during adulthood. In a study conducted by Whitefield et al. (2003) it was found that childhood physical abuse increased the risk of domestic victimisation in women by more than twofold. This correlates with the current study where all of the participants indicated that they experienced a traumatic childhood and five of the six participants were exposed to domestic

violence in their family home. Furthermore, two of the six participants were raped by a family member during their childhood. Dorothy explained: ***"I was raped you know when I was so young in Zambia by my auntie's husband. When I was still nine years old)*** and Mandisa divulged**:** ***"my uncle at the time. I didn't know at the time it was rape because he didn't go inside. Like he put his penis between my thighs."*** In a large study conducted by Daigneault, Herbert and McDuff (2009) it was found that childhood sexual abuse was strongly associated with later interpersonal victimisation of women and men, although the relationship was, in fact, stronger for women.

There is evidence that suggests that young boys' exposure to interparental violence significantly predicts the risk of being violent themselves in adolescence and adulthood (Carr & Vandeusen, 2002). In a twenty years study in the United States, by Ehrenshaft et al. (2003) it was revealed that children exposed to intimate partner violence was the second strongest predictor of them becoming adult perpetrators of intimate partner violence. This compares with the current study in which all the male perpetrators were exposed to intimate partner violence as children.

4.5.1.1.4 Alcohol and drug abuse by a partner

This sub-theme refers to the relationship and effect of alcohol and drug abuse on the occurrence of domestic violence. As discussed in the literature review chapter, alcohol and drug abuse are two of the most prominent risk factors in perpetrators and victims of domestic violence (Corrigall et al., 2013; Corvo et al., 2013).

The following table summarises the influence that alcohol and drug abuse had on the intimate relationships of the participants.

TABLE 9

Forms of domestic violence: The impact of alcohol and drug abuse on the occurrence of domestic violence

Theme 1: The participants' experience of domestic violence		
Sub-theme 1.3 (A)	**Category**	**Excerpts from the interview**
Substance abuse by a partner	The impact of alcohol and drug abuse on the occurrence of domestic violence	***Nakwasi:*** *"And I found out he's not really working with his brother anymore. He's just messing up at work, but they didn't tell me that he's now I'll say a full-blown drug addict. They didn't tell me that. They would just be telling me: Ah, he's getting violent. "I wouldn't say his personality changed that much. He was still selfish. He still didn't like emotional confrontations. Even without the drugs he still had to blame everyone, but he just became worse because he became lazy."* ***Dorothy:*** *"The abuse became worse when he was still sober."* *"He was like properly chasing me with a knife and that white guy he came, the security guy, and told him that: how can you hold a knife and chase someone? He said: we can arrest you for drinking and abusing your wife on the street and he didn't even care that they were going to arrest him. He was like: fuck you, man. You can take her and this, and that, and he beat me that day."* ***Mandisa:*** *"He was drinking a lot and even using dagga sometimes. He was using dagga. Like he will just talk to me. See now I don't want the people to look at you or do what-what, and next thing he was going to drink beer. Next thing he will beat me."* *"Alcohol was part of it (contributing to physical violence), but my parents was encouraging. Like according to them, when a man beats you he loves you."* *"I know people who are smoking dagga they obviously, their mind is not… Actually, he was using something apart from dagga, I wouldn't know because he's having that filter part. Like he doesn't have that love or care. If he wants to abuse you he will abuse you. Definitely do what he wants to do."* *"But I know that he was drunk. When he does these things (referring to physically abusing Mandisa) he makes sure he's drunk."*

Nakwasi explained that her partner became a full-blown drug addict when he was in prison. Her partner's brother informed her that he was becoming more violent, and that is how she became aware of his drug addiction. Nakwasi made it clear that she and her partner were together for a long time without him using drugs. She described her partner as a selfish person who blamed everyone else for his problems. It made no difference whether he used drugs or not, Nakwasi felt that he was still the same selfish person who behaved in exactly the same manner as he did before.

Dorothy indicated that her husband abused alcohol on a regular basis and would go out drinking with his friends on weekends. However, Dorothy did not believe that her husband's alcohol abuse made any difference to the occurrence of physical violence in their relationship. Dorothy explained that he also had a tendency to abuse her when he was sober.

Mandisa described her partner as an extremely violent person who would physically maltreat her on a regular basis. She explained that her partner often abused alcohol and became physically violent when he was intoxicated. She further explained that her husband had to be 'drunk' to be able to do the things that he did to her. Moreover, her partner abused drugs, but she did not believe that his drug abuse contributed towards the physical violence in their relationship. She, however, believed that his alcohol abuse was the reason the abuse escalated.

Studies have found that acute alcohol intoxication plays a significant role in almost half of all violent crimes (Beck & Heinz, 2013). Research has found that, in an intimidate relationship, men who abuse alcohol committed violence against women more frequently than non-alcohol-dependent men (Beck & Heinz, 2013). Giancola (2000) pointed out that the psychopharmacological effects of alcohol intoxication cause temporary impairment in executive functioning, such as deficits in social information processing, which has been

linked to an increase in aggressive behaviour. However, the association between alcohol abuse and domestic violence may vary considerably when the characteristics of the person as well as the circumstances under which the intoxication occurs are taken into account (Leonard, 2001).

In this study, three of the six participants' husbands/partners abused alcohol and two of the six participants' husbands/partners abused drugs. However, only one of the participants confirmed that her partner's alcohol abuse contributed to the occurrence of physical violence in their relationship. Mandisa explained: **"*I can't remember properly but I know that he was drunk. When he does these things (slapping and hitting her) he makes sure that he's drunk*."** The other two participants indicated that their husband/partner would physically abuse them irrespective if they had consumed alcohol or not. Dorothy revealed: ***"The abuse became worse when he was still sober."***

As discussed in the literature review chapter, associations between drug abuse and partner aggression are less well researched (Cory et al., 2014; Klostermann et al. 2010). Drugs have varying physiological and behavioural effects on the user as these effects are affected by personal and cultural factors (Moore et al., 2005). One of the participants indicated that she did not believe that the physical abuse in their relationship escalated after her partner had abused drugs. Nakwasi explained: ***"Even with drugs he still had to blame everyone, he just became worse because he became lazy."*** Mandisa indicated that her partner would maltreat her regardless of whether or not he was abusing drugs: **"*If he wants to abuse you he will abuse you. Definitely do what he wants to do."***

4.5.1.1.5 Controlling behaviour, jealousy, and false accusations

This sub-theme refers to the effect of personality features that may contribute to the occurrence of domestic violence in intimate relationships. As discussed in the literature

review chapter; because I am not a clinician, I am unable to diagnose any person with a personality disorder. I, therefore, focused exclusively on the personality features that influenced the occurrence of domestic violence in the participants' lives.

The following table provides summaries of the participants' reflections on how controlling behaviour, jealousy, and false accusations influenced the occurrence of domestic violence in their relationships.

TABLE 10

Forms of domestic violence: Controlling behaviour, jealousy, and false accusations

Theme 1: The participants' experience of domestic violence		
Sub-theme 1.4 (A)	**Category**	**Excerpts from the interview**
Behaviour of partner	Controlling behaviour, jealousy, and false accusations	***Anna:*** *"And so ja, my older brother, after the first time that my ex-husband hit, he uhm, actually went to his work and beat the crap out of him with a baseball bat, and then my husband left me alone for a while. But then, it didn't stop him you know, because he is so uncontrollable, he just has an uncontrollable temper."* *"The people I did books for or whatever would come and sit with me and talk with me. I have known these people for 10-12 years and then he would just go off his rocket because the client was talking to me."* ***Nakwasi:*** *"You know the big mistake because there is a flaw in his personality that I just should have known. He is very self-centred and he doesn't mind making the next person unhappy as long as he is happy."* *"He was threatening me and I could see that he was really mad, and I actually thought, if I did cry he's going to do something to me."* ***Dorothy:*** *"So he saw this message that came from my friend. We used to study together with a friend of mine. Like we were friends since high school. So, it was a guy friend. So, when he saw that message he got angry and then at the park, he had to like beat me up on the street, and then he beat me on my eyes, and I kind of had a blue eye for a week and my eyes were so big and stuff."* *"From the beginning he would never want to see me with even my own cousins. Sometimes he would suspect I am lying. It's your boyfriend, unless my sister or own family confirms that it is our cousin. Then he will calm down."* ***Nina:*** *"He is really a horrible person. You don't wish to see him. He can do crazy things and when he comes back to a normal sense, it's like he's dreaming. It's like I don't know where he come from now."* *"He gets angry very fast. When something happen he react very fast, and when he reacts he go crazy for a couple of hours"* ***Mandisa:*** *"Hey he's not human. He doesn't have humanity inside of him. Eish, I don't know what's inside or maybe it's the bitterness."* *"Like he was beating me and say I am beautiful. Why I'm beautiful? Every man they looking at me and then hitting me with the gun. I have the scars. I show."* *"So at some point he just said to me I don't even have a reason for beating you, but it just happened. Maybe I think I love you too much. Like not allowing anyone to look at you."*

Anna explained that her husband became extremely jealous after they got married and started accusing her of having extra-marital affairs with her clients. Anna further stated that her husband had a vile and uncontrollable temper and would physically abuse her for no reason at all. Her husband's uncontrollable temper led to him assaulting his own brother and members of the public on several occasions.

Nakwasi believed that her partner had a 'flaw' in his personality and described him as a selfish and self-centred individual who easily became angry. Her partner refused Nakwasi to show any signs of emotion during an argument and would 'snap' the moment she began crying. He threatened to make her regret her actions if she dared become emotional.

Dorothy's husband started physically abusing her when they were still dating. Her husband showed signs of extreme jealousy and would physically maltreat Dorothy in public. She further explained that nothing she ever did would meet with her husband's approval. He accused her of having affairs and told her that he did not believe that he was the father of their children. Dorothy explained that her husband had trouble managing his anger. When he experienced a difficult day at work Dorothy would be on the receiving end of his anger, which often escalated into physical violence.

Nina described her husband as someone with an explosive personality. Her partner would get angry very quickly and had the tendency to go 'crazy' for a couple of hours. Nina further explained that her husband became blind with fury and that she was afraid of him when he became enraged. Nina revealed that when her husband's anger escalated she knew that she had to get away, as far as possible, from him.

Mandisa was exposed to an extremely violent relationship. Her third partner showed signs of anger, obsession, and jealousy. Moreover, Mandisa's partner believed that other men were looking at her because she was 'too' beautiful. This led to her partner's jealousy escalating to

such a level that he started to become physically abusive on a regular basis. After he threatened her with a gun, Mandisa decided to end the relationship. Her partner did not accept her decision and started stalking her.

In this study, five of the six participants indicated that their partner had some type of personality feature that contributed to the occurrence of domestic violence.

Consistent with the available literature, personality pathology has been found in a substantial proportion of domestically violent men (Choca, 2004). According to research, individuals with a dissocial personality type have the tendency to become perpetrators of intimate partner violence (Al-Aldawi & Al-Bahlani, 2007). These individuals, who have a habit of being unconcerned about the feelings of others, are prone to blame others for their outbursts (Al-Aldawi & Al-Bahlani, 2007). Furthermore, research indicates that borderline personality disorder and sociopathic traits are often associated with the perpetration of intimate partner violence (Stuart et al., 2008). However, it is important to note that, although individuals with borderline and/or sociopathic disorder traits often display signs of physical and psychological aggression, not all perpetrators of domestic violence have a personality disorder (Holtzworth-Munroe et al., 1994; Lowenstein, 2016).

Borderline personality features are associated with reactive aggression (unplanned/impulsive, high arousal, expressive and hostile aggression) whereas sociopathic personality features are associated with proactive aggression (premeditated, unprovoked, goal-directed and cold-blooded aggression) (Gilbert et al., 2011; Ross et al., 2009). Edwards, Scott, Yarvis, Paizis & Panizzon (2003) cited that both borderline and sociopathic personality disorders include a 'hair-trigger temper' and impulsiveness as defining characteristics. A person with a hair-trigger temper has the tendency to become angry or violent very are easily and is prone to react immediately to the slightest provocation. This corresponds with Nina's response: "***He***

get angry very fast. When something happens he react very fast, and when he react he go crazy for a couple of hours".

According to research extreme jealousy is often a central feature of the personality makeup of men who physically abuse their wives (Dutton et al., 1994; Mechanic, Weaver, & Resick, 2000). Extreme jealousy is also referred to as pathological jealousy. Individuals afflicted with this type of emotion often blame their partners for being unfaithful, without having any evidence. This type of jealousy corresponds with Dorothy's response: "***He will be accusing me about everything. Oh, this and that or (her husband would tell her) you didn't want me to go (to the hospital when Dorothy was in labour) because your boyfriend went there, the father of your baby. Maybe this child is not mine and everything".***

Mechanic et al. (2000) and Rakovec-Felser (2014) further explained that physical abuse of a partner and stalking during periods of separation are extreme forms of the perpetrator's attempt to maintain control over the victim. This coincides with Mandisa's response **"*The thing of him following me it's still happening. It's a pity (referring to her partner) but I'm in a shelter and they have security here, who are taking care of us."***

4.5.2 Theme 2: Socio-economic factors

The following theme, *Struggle to make ends meet* with one sub-theme 'economic neglect' is presented, analysed and discussed below.

According to research low income, being poor, and unemployment have been identified as significant risk factors for the occurrence of domestic violence in intimate relationships (Hindin et al., 2002; Johnson, 2001). Moreover, research indicates that men who have more resources, or earn more, than their female partners are likely to dominate the relationship (Yount, 2005).

4.5.2.1 Theme 2 – Sub-theme 1: Struggle to make ends meet

The following sub-theme emerged from the data. Five of the six participants in this study revealed that financial difficulties had an influence on the occurrence of domestic violence in their intimate relationships.

4.5.2.1.1 Economic Neglect

The next table summarises the influence of low income on the occurrence of domestic violence in the participants' intimate relationships.

TABLE 11

Forms of domestic violence: Economic neglect

Theme 2: Socio-economic factors		
Sub-theme 1.1 (D)	**Category**	**Excerpts from the interview**
Struggle to make ends meet	Economic Neglect	***Nakwasi:*** *"He was really angry. The day I was supposed to get paid I didn't get paid. He was so angry that wow. I'd never seen him like that before because rent was due soon and I had realised that he had apparently been starting relaxing at his own work because he thought no, I'm going to come with the money."* ***Dorothy:*** *"He didn't have a job and he lost his job after I got pregnant and then I'd ask him: Okay, I want to go and look for a job because now you are not working. I have to go and find a job and he had to agree with me to find a job.* *"Every time when I get paid I will give him my salary just to make him okay. He must feel okay that it's okay to lose a job because sometimes people does lose jobs. So, I was pregnant then with my daughter. Still the same thing He would beat me up."* ***Nina:*** *"The violence started the time when I discover he's facing financial problems while from the beginning he didn't even want to tell me the truth, and I was very angry with him."* *"When I buy things he say: Where is the receipt? I give him because I like to keep my receipt. He say: can't you see the money you spending it's a lot and I say: but I need it. What I'm spending I'm finding for good things. I'm not throwing money on the alcohol or doing bad things."* ***Eva:*** *"He would tell me that he went to work, but he's lying to me that he's going to work and he didn't. If he had money for rent he took it, but I didn't know like they were dating."* *"Once the job finish he wouldn't take care of us. Even the children they didn't go to school. He didn't now get any of them to school. So things it was very tough. You know the way he spoke to me it's not fine. He was beating me. So that was it."* *Mandisa: "His mother was forcing me to go and sign (testament that would leave her property to her partner) so that when I die I have to. I said I refused to sign with him because I said if I sign with him then what will my parents do because of you."* *"Yes, he said he wants it (labola money back) and then he'll kill me if I don't and anyway he mean it. If he said he will kill you he will kill you. It wasn't a joke."*

Nakwasi revealed that her partner was a drug addict who became a very different person when he did not have money. Nakwasi explained that when he was going through a good financial period he would send her away to visit family so that he could abuse drugs without her knowledge. After Nakwasi fell pregnant her partner started experiencing financial difficulties and Nakwasi started looking for work. The only job she could find was with a commission-based salary. When she did not receive her first pay cheque her partner became extremely angry. This is when Nakwasi came to realise her partner had lost his job and was depending on Nakwasi's salary which never materialised. This led to more verbal abuse from her partner's side.

Dorothy and her husband went through a difficult financial period when her husband lost his job. Because Dorothy's husband had a tendency to become extremely jealous and physically abusive she had to ask for his permission to search for employment. Dorothy further explained that she was pregnant at the time she was looking for work and could not go back to her family to ask for assistance as they told her that she was married and could not come back home. After Dorothy found a job as a waitress she would give her entire salary to her husband to try and appease him, but Dorothy revealed that the physical violence did not end.

Nina explained that during her first pregnancy her husband hid his financial problems from her. He promised that he would take care of the baby, but Nina soon came to realise that he was lying and that he could not provide for her or the baby. When her husband found out that Nina had asked her family for financial assistance he started beating her. Nina revealed that her husband told her that he was the man of the house and she should not be talking about him behind his back.

At the time of the interview Eva had three daughters and was pregnant with her fourth child. During her last pregnancy, her husband started having an affair with her sister, which led to

Eva experiencing enormous financial strain. Her husband stopped supporting her and the children and became physically abusive. Eva had nowhere to go and could not find a job because she was pregnant and had no previous work experience. In the end, Eva's only option was to ask for assistance at a shelter.

Mandisa explained that her parents, after they found out that she was pregnant with her partner's child, wanted her to marry him. Her partner then proceeded to pay the marriage negotiation fees (labola), but before they were officially married, her partner's mother tried to force Mandisa to sign a new testament that would make her partner the sole trustee of Mandisa's property in the event that something happened to her. Mandisa refused and her partner demanded that she pay back the labola money and threatened to kill her if she did not oblige.

Shiu-Thornton et al. (2005) explained that women who are financially dependent on their partners find it more difficult to end a violent relationship and obtain assistance from family members or friends. The fear of economic hardship, poverty, inadequate housing, and social isolation has an influence on many women's decision to remain in their abusive relationship. This is illustrated by Nakwasi's response: **"*I'm going to leave this guy. I can't, and at that time I was staying with him. Where am I going to go? Where am I going after here? I need to leave him but where am I going. You know I didn't know where I would go."***

Some perpetrators of economic abuse often prevent or forbid their partners from working or even leaving the home (Mouradian, 2007). This corresponds with what Dorothy revealed: **"*Even the time when I get a baby it's like he wants me not to think about getting a job. I must sit at home."*** Financial abuse may also include the following factors: One partner refusing to work and not contributing towards the expenses, forging a partner's signature on financial documents, intimidating a partner to pay all the household expenses, demanding that

a partner hands over his/her pay cheque or denying access to mutual funds, controlling shared resources (e.g. bank accounts) and demanding that a partner has to account exactly for the money that he/she has spent (Mouradian, 2007).

Research has found that financial problems, and especially unemployment, can also be viewed as a risk factor for domestic violence. Because of the stress of struggling to find employment the perpetrator might, as a catharsis, resort to abusing his wife/partner (NACOSA, 2015). This corresponds with Dorothy's narration: ***"Every time when I get paid I will give him my salary just to make him okay. He must feel okay that it's okay to lose a job because sometimes people does lose jobs. So, I was pregnant then with my daughter. Still the same thing, he would beat me up."***

4.5.3 Theme 3: Cultural differences

The next theme *Cultural differences* between partners with one sub-theme 'the impact of cultural differences on the occurrence of domestic violence' is discussed and analysed below.

Culture can be defined as a set of characteristics that includes the beliefs, practices, values, norms, and behaviours that are shared by members of the same group. Culture is inextricably linked amongst individuals in a group and is passed down from generation to generation and might include teachings around a shared heritage, food, dress code and language (Yoshihama, 2000).

4.5.3.1 Theme 3 – Sub-theme 1: Cultural differences between partners

The next sub-theme emerged from the interviews I held with the participants. Five out of the six participants in this study revealed that cultural factors had an effect on the occurrence of domestic violence in their intimate relationship.

4.5.3.1.1 Impact of cultural differences on the occurrence of domestic violence

According to existing literature domestic violence occurs across all cultures and social groups (Pan et al., 2006).

The summaries in the following table orientate the reader towards the impact of cultural differences on the occurrence of domestic violence in the participant's lives.

TABLE 12

Culture: Impact of cultural differences on the occurrence of domestic violence

Theme 3: Cultural differences		
Sub-theme 3.1 (A)	**Category**	**Excerpts from the interview**
Cultural differences between partners	Impact of cultural differences on the occurrence of domestic violence	***Anna:*** *"My husband was just one of those typical Portuguese men, he did not really like children, he had a vile temper and I told him the moment you hit one of my children I will leave you. He never even tried to do it… you know… it was that thing my son use to say: Daddy has snake eyes."* *"We did not really have a reason to argue or fight and that just totally changed once we got married. I was supposed to be this little Portuguese wife."* ***Nakwasi:*** *"I should not have married you (husband to Nina), you are cursed." (Nakwasi's husband believed that she was cursed because she was from another culture).* ***Dorothy:*** *"Me and my husband we are from the same country, but different cultures. Back home we do like he's a, well in Congo we say he's from Kinshasa and I'm from Lubumbashi. So, people from Kinshasa were actually, they usually live their life so wild. Their life's so wild compared to our life you know. So that's why I believe their background is just this kind of background. Yoh. We called them Americans because they lived their lives so wild."* ***Nina:*** *"There is culture (cultural differences). There's a background. Yes, those two things they are crushing, but if he can accept to work on his anger management I don't have a problem with that because I enjoy learning what other people do.* ***Mandisa:*** *"Even now it was something that was supposed to happen because he followed me everywhere we go (referring to ex- partner), and they wanted this daughter of mine because even my family they wanted to kill this one, the second born. Like there is this thing né within the Sotho people that says the business grow by like I don't know, through the blood of somebody. They being cured or what. I can't remember, but I know that there is this kind of thing and the albino. My child is albino. There is this thing that people from Africa they flatter people in saying that the blood of albino or the body of albino makes the business grow."*

Anna, who explained that her husband was “one of those typical Portuguese men”, felt that there were huge cultural differences between herself, as an Afrikaner woman, and her husband. Anna described her husband as a loud and obnoxious person who was raised in a home where tempers were forever flaring, and family members were constantly fighting with one other. She believed that Portuguese men wanted their wives to be submissive and she had trouble abiding by his rules. Anna explained that because she questioned her husband and refrained from keeping quiet during an argument, the physical abuse increased and became more severe.

Nakwasi explained that her partner, who was from West Africa and thus a ‘foreigner’ in South Africa, found it difficult to find work and make a living. Whenever they faced financial problems it was always Nakwasi’s fault and she explained that her partner believed that she was cursed because of her culture and the bearer of bad luck. Her partner blamed her for everything that went wrong in their relationship and this led to continuous emotional abuse.

Dorothy disclosed that she and her husband were from the same part of Africa but were raised within different cultures. Dorothy described her husband’s culture as ‘wild’ compared to her own and revealed that her husband enjoyed life, going out to bars, and drinking. When Dorothy fell pregnant for the third time, her husband wanted her to go for an abortion, but she refused as, according to her culture and beliefs, it would be murder. Dorothy further explained that because she did not listen to her husband and kept the baby this contributed to further physical abuse.

Nina revealed that her husband’s culture differed very much from her own. Nina was born in East Africa, which she described as a “war country.” Her husband, on the other hand, was from West Africa. Nina said she saw “lots of things” and experienced how a human being could become “crazy” within a second. She described the people from West Africa as

individuals with anger management problems. She believed their cultural differences had an influence on the way her husband behaved, but she was willing to accept his behaviour if he managed to work on his anger.

Mandisa's partner started abusing her shortly after her parents began negotiating the terms and agreements (lobola) of their impending marriage. Her partner beat her with a stone in the face because he believed she was too beautiful and that other men were looking at her. Mandisa explained that her partner decided to take her to a traditional healer (Sangoma) to help get rid of Mandisa's reluctance of succumbing to her husband's demands. Mandisa was convinced that her partner wanted to kill her. She described how she was held down by men who cut her and afterwards applied some sort of ointment to the cuts. Furthermore, Mandisa revealed that her partner wanted her daughter with Albinism from a previous marriage. According to Mandisa, her husband's culture believed that shedding the blood of a person with Albinism could make their business grow.

Vandello and Cohen (2003) explained that the events that trigger episodes of domestic violence may vary across different cultures and there is a tremendous cultural variation in patterns of domestic violence. Many cultures have their own legal traditions, and what is acceptable behaviour in one culture may be frowned upon by another. Traditional cultural beliefs and attitudes can also be viewed by society as a risk factor for the occurrence of domestic violence. Traditional cultural beliefs endorse that a man has the right to beat his wife/partner every so often. (NACOSA, 2015).

Women's perceptions of gender and marital roles also differ. Women who are raised with more traditional ideas around a woman's role have a different outlook on gender and marital roles as opposed to women who are raised with more liberal ideas (Jewkes et al., 2002). This corresponds with Anna's response: ***"We did not really have a reason to argue or fight and***

that just totally changed once we got married. I was supposed to be this little Portuguese wife."

Attitudes towards domestic violence have also been identified as a risk factor for spousal abuse. In a study conducted by Johnson and Das (2009) it was found that a supportive attitude towards wife-beating was the strongest predictor of intimate partner violence. Another study, in Egypt, found that 60% of women who were physically abused in the past accepted the abuse as a normal part of marriage (Diop-Sidibe, Cambell & Becker, 2006). Wang (2016) mentioned that the rate of acceptance towards intimate partner violence was lower in western/developed countries as opposed to poor and developing countries such as Asia or Africa. Women are at a greater risk of becoming victims of intimate partner violence if they accept that they should be subservient to men. Research indicates that this often occurs when women are exposed to childhood violence and witness their mothers being physically abused by their fathers (Abrahams et al., 2009).

4.5.4 Theme 4: Domestic violence during pregnancy

The fourth and last theme, domestic violence during pregnancy, with one sub-theme 'The occurrence of domestic violence during pregnancy' will now be discussed.

4.5.4.1 Theme 4 – Sub-theme 1: The occurrence of domestic violence during pregnancy

The next sub-theme emerged from the interviews when it was noted that five of the six participants indicated that they were physically abused during pregnancy.

4.5.4.1.1 Impact of pregnancy on the occurrence of domestic violence

Domestic violence during pregnancy is a common, chronic, and complex social problem that occurs cross-culturally (Devries et al., 2010).

The following summary provides examples of the influence of pregnancy on the occurrence of domestic violence in the participants' intimate relationships

TABLE 13

Domestic violence during pregnancy: Impact of pregnancy on the occurrence of domestic violence

Theme 4: Domestic violence during pregnancy		
Sub-theme 4.1 (A)	**Category**	**Excerpts from the interview**
Domestic Violence during Pregnancy	Impact of pregnancy on the occurrence of Domestic Violence	***Anna:*** *" And uhm, well my ex-husband was abusive not just emotional but also physically as well and in that period of being with him, I lost a baby when he threw my down the stairs and ja, I still, I don't know, had like a nervous breakdown after what happened with the stairs.* ***Dorothy:*** *"When I go and look for a job for him, it's like okay fine you want another man. You are going to look for men and everything, he'll beat me to a point whereby I gave birth to a premature child."* ***"****That's when I found that I was pregnant with this my second one, but in January it started again 2016 (participant referring to physical abuse). I was like maybe because sometimes there's this needs that goes around that when you are pregnant sometimes you and your partner you won't. You will be fighting each other like cat and dog and I believed that. I thought okay let me. Let this phase of pregnancy pass and then I will see what will happen."* ***"****When I told him that I'm pregnant that when he was like: how can you be pregnant while you know that we don't have enough money? I'm working as a car guard. You just have your job now because I mean we cannot take care of this baby. You have to take out this pregnancy, and I told him: it's already four months old. I can't. Even if it was not, I wouldn't do that."* ***Nina:*** *"The time when he started (referring to physically abuse) that was the last year I was four months pregnant. I did come here (referring to the shelter) and when I came here, when I look around I say no."* ***Eva:*** *"Right now it's been a year (referring to the physical abuse). Yes, one year now. This probably started when I was with this, my baby (referring to pregnancy). She's one year four months now."* ***Mandisa:*** *After I fell pregnant and my parents knew him. This when that started (referring to physical abuse) Then after a while he started punching me, hitting me every day.*

Anna's husband started physically abusing her before she fell pregnant with their first child. However, the physical violence escalated to such a degree that when she fell pregnant with their third child her husband pushed her down the stairs of their home and she lost the baby.

Dorothy confirmed that the physical abuse in her marriage started before she fell pregnant and that her husband continued the abuse during her pregnancy. Dorothy explained that because her husband was jealous and believed that she was seeing other men, he physically abused her to such an extent that she gave birth to a premature baby who died six days after birth.

Nina's husband started physically abusing her when she was four months pregnant. Nina explained that because of her husband's explosive personality she had to get away from him after their son was born. According to Nina, her husband did not care whether she was holding the baby or not, if he wanted to abuse her nothing could stop him. The evening Nina left their communal home, her husband accidentally hit the baby when he tried to abuse her.

Eva's husband started physically abusing her during her fourth pregnancy and only after this incident did Eva find out that her husband was having an affair with her sister. Eva explained that in the end he left her for her sister.

Mandisa's partner started physically abusing her after her parents found out Mandisa was pregnant and introduced themselves to her partner. They wanted her partner to pay labola and marry Mandisa because she was with child. Her parents also told her partner that if he wanted to marry Mandisa he would have to visit the Sangomas (traditional healers) to ensure everything was good in their relationship. Mandisa's parents told her that if a man beats a woman it means he loves her.

Pregnancy abuse has been recognised as an important risk factor for adverse health outcomes for both mother and child (Devries et al., 2010). A study conducted in South Africa found that 36%-40% of pregnant women had been victims of physical violence (Joyner, Reese & Honikman, 2015). The effects of physical abuse on a pregnant mother include the risk of miscarriage, premature delivery, fetal trauma, low birthweight, high levels of depression, and injury to the mother and/or child (Devries et al., 2010). This coincides with Anna's response: ***"My husband was very abusive, not just emotionally, but physically as well, and in that period of being with him I lost a baby because he threw me down the stairs."***

Research indicates that domestic violence may commence during pregnancy notwithstanding that in some cases the violence is a continuation of abuse that preceded the pregnancy and is likely to continue after the birth of the child (Campbell, Oliver & Bullock, 1998; Edin, Dahlgren, Lalos & Hogberg, 2010). However, one of the six participants in this study revealed that the physical abuse started when she fell pregnant for the first time. Nina divulged the following: **"*The time when he started (hitting her) that was the last year, I was four months pregnant."***

Research proposed five explanations for the occurrence of domestic violence during pregnancy: Male sexual frustration, hormone-induced mood swings in women, the stress of imminent parenthood, the woman's increased physical vulnerability and helplessness, and a conscious or subconscious desire to terminate the pregnancy (Calder, 2000). This corresponds with Dorothy's response: **"*I'm working as a car guard (husband). You just have your job now because I mean we cannot take care of this baby. You have to take out this pregnancy (referring to an abortion) If you want this baby when we have to go our separate ways.*"**

Moreover, research indicates that women's exposure to intimate violence during pregnancy may increase the chance of the child exhibiting behavioural problems in future (Silva, Lemos, Andrade & Ludermir, 2018).

4.6 Conclusion

The current chapter presented the findings, analyses, and related discussions of the research findings. The themes and sub-themes that emerged from the interviews, which I held with the participants, were substantiated with extracts from the interviews and previous literature studies.

The next and final chapter summarises the preceding chapters and also the research findings. During the final chapter, I also discuss the conclusions and limitations of the study as well as suggestions for future research.

CHAPTER 5

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

Today another woman died
and not on a foreign field
and not with a rifle strapped to her back,
and not with a large defence of tanks
rumbling and rolling behind her.

She died without CNN covering her war.
She died without talk of intelligent bombs
and strategic targets
The target was simply her face, her back
her pregnant belly.

The target was her precious flesh
that was once composed like music
in her mother's body and sung
in the anthem of birth.

The target was this life
that had lived its own dear wildness,
had been loved and not loved,
had danced and not danced.

A life like yours or mine
that had stumbled up
from a beginning
and had learned to walk
and had learned to read.
and had learned to sing.

Another woman died today.
not far from where you live;
Just there, next door where the tall light
falls across the pavement.

Just there, a few steps away
where you've often heard shouting,
Another woman died today.

She was the same girl
her mother used to kiss;
the same child you dreamed
beside in school.
The same baby her parents
walked in the night with

and listened and listened and listened
For her cries even while they slept.

And someone has confused his rage
with this woman's only life.

~ Carol Geneya Kaplan, 1970

5.1 Introduction

In this final chapter of the research study, a summary, differences and similarities (compared to other studies), limitations of the study, recommendations for further research, and conclusion are presented.

The present study explored Tshwane based women's' lived experiences of domestic violence and identified how certain psychosocial risk factors (e.g. alcohol and drug abuse, violence in the family of origin, personality factors, socio-economic factors, cultural differences and pregnancy) can be associated with, and may contribute to, the occurrence of domestic violence.

What follows is a summary of each chapter in the research study.

5.2 Summary of chapters

In chapter one, I presented the research problem that inspired this research study. In addition, I discussed the aim of the research study: I was interested in gaining a better understanding of how psychosocial risk factors may influence both perpetrators and victims of domestic violence in Tshwane.

Furthermore, this study aspired to address the following research questions:

1. What are the demographic characteristics (race, age, education, occupation and marital status) of women who suffer from domestic violence in Tshwane, South Africa?
2. What are the markers that can be used to identify individuals at risk for becoming the victims of domestic violence?
3. How do psychosocial risk factors (e.g. alcohol and drug abuse, violence in family of origin and personality factors, socio-economic factors, cultural differences and the impact of pregnancy) have an influence on the occurrence of domestic violence?

This research study reviewed selected psychosocial risk factors that may contribute to the occurrence of domestic violence in intimate relationships. One of the risk factors discussed was the influence of substance abuse on the occurrence of domestic violence. Substance abuse includes alcohol abuse, a variety of illicit drugs, and medication. Research has shown that substance abuse is one of the most prominent risk factors that lead to violence in an intimate relationship (Corrigall et al., 2013: Corvo et al., 2013).

Another risk factor I discussed was how certain personality features may contribute to the occurrence of domestic violence in intimate relationships. Sociopathy and borderline personality disorder traits are the most common personality features found in abusive men (Costa et al., 2008; Ross et al., 2009; Swogger et al., 2007).

Furthermore, I discussed violence in the family of origin as a risk factor that could have an influence on the occurrence of domestic violence. Research indicates that exposure to violence and harsh parenting during childhood can lead to a high risk of becoming adult perpetrators or victims of domestic violence (Carrigall & Matzopoulos, 2013; Dutton et al., 1992; Riggs et al., 1990; Smith & Williams, 1992; Whitefield et al., 2003).

Chapter two concluded with a discussion on Ecological Theory, Family Systems Theory, the Theory of Planned Behaviour, and the Feminist Theory which served as a reference to the different theoretical frameworks of domestic violence. I chose to employ the Ecological Theory as I deemed it to be the most suitable for my research study.

In Chapter three, the research methodology was discussed. The primary purpose for conducting this research was to describe Tshwane based women's experiences of domestic violence and to identify how psychosocial risk factors are associated with the occurrence of domestic violence. The research study sought to analyse domestic violence from an angle whereby collected data were explored to find risk factors that contributed to the occurrence of domestic violence incidents.

A qualitative research method was applied to collect and explore information around women's personal experience, feelings, and attitudes about the risk factors that contribute to domestic violence.

I chose to use a phenomenological research design. This type of research design gave the participants the opportunity, during the interview process, to recount their experiences as accurately as possible by describing their lived experiences of domestic violence.

Furthermore, the research study focused on the interpretive phenomenological analysis [IPA]. This type of analysis gave me insight into how the participants, in a specific context, made sense of their world, how they experienced events, and their attributions regarding the causes of domestic violence. This type of analysis produced an account of the lived experiences of the women who participated in the study.

Reliability in qualitative research is concerned about being thorough and honest when conducting research. In qualitative research a researcher is not able to replicate work because

human behaviour is never static. Therefore, in qualitative research it is not about the findings being replicated.

Validity in qualitative research refers to the trustworthiness and credibility of the data. I accomplished credibility and trustworthiness by including rich verbatim extracts and direct quotations of the participants' responses. I further established credibility and trustworthiness through the involvement of my supervisor who guided me and provided me with constant feedback regarding my interview schedule, transcripts, and dissertation.

Data saturation is the point in data collection when additional information does not lead to any new insights or themes. During the interview process I asked all the participants similar questions and explored their answers and life stories until saturation was reached. I also asked the participants at the end of the interview if they had anything else they would like to share.

I was constantly aware of the sensitivity of the topic as well as the qualitative nature of the study and therefore used both purposive and convenience sampling. Purposive sampling gave me the opportunity to select six women who had been victims of domestic violence. According to research, women between the ages of 25 to 34 have the highest number of domestic disputes per annum (Peters et al., 2002). The second highest number of domestic disputes per annum occur between the ages of 35 to 44 (Peters et al., 2002). I therefore decided to interview women, who were victims of domestic violence, between the ages of 18 to 45. I approached different shelters in the Tshwane district and asked for permission to interview women residing at the shelters. Convenience sampling enabled me to select women (who were willing to participate in the research study) residing in shelters in Tshwane.

Data were collected through semi-structured interviews that lasted 60 – 90 minutes per interview. The interviews, which were conducted in English, were audio recorded with the consent of the participants. The recording of the interviews ensured that I could limit possible

errors when transcribing the interview data. Finally, the data were analysed using Groenewald's (2004) simplified version of Hycner's (1985) explicitation process.

Chapter four presented a discussion and analysis of the findings in relation to the available literature. This was followed by a discussion of the themes that were supported by verbatim extracts from the interviews and substantiated by relevant literature. During the data analysis, four main themes and six sub-themes emerged. The findings were divided into the following four main themes:

- Theme 1: The participants' experience of domestic violence.
- Theme 2: Socio-economic factors
- Theme 3: Cultural differences
- Theme 4: Domestic violence during pregnancy

5.2.1 Theme 1: The participants' experience of domestic violence

This theme discussed the experience of domestic violence and was divided into the following sub-themes: Forms of domestic violence (physical and emotional abuse), traumatic childhood and family disharmony, alcohol and drug abuse, controlling behaviour, jealousy, and false accusations.

Sub-theme 1.1: Forms of domestic violence

Next, I discuss physical abuse and emotional abuse as forms of domestic violence.

Physical abuse

Comparable to other studies this study found that the frequency and severity of physical abuse escalated over time (Gumani et al., 2013; Mouradian, 2007). Five out of the six participants in this study indicated that they were victims of physical abuse, which started as emotional abuse and became increasingly worse over time. Research has indicated that

physical abuse may occur as a once off incident and sometimes happens sporadically but in most abusive relationships the abuse occurs frequently and repetitively (Farrokh-Eslamlou et al., 2014; Rakovec-Felser, 2014). The current study found that physical abuse in the participants' intimate relationships occurred often and recurrently as opposed to once off or sporadically. The adverse health outcomes of physical abuse in the study included physical injuries, depression, anxiety and poor general health.

Emotional abuse

The current study, similar to other studies, found that the participants who were exposed to physical abuse were also subjected to emotional abuse (Coker et al., 2002). All the participants in the current study indicated that they had been victims of emotional abuse. This abuse varied from shouting, belittling, threatening, name-calling, shaming, degrading, and stalking. Research indicates that emotional abuse occurs at a higher rate than physical abuse (Cornelius et al., 2010). This study found, similar to other studies, that emotional abuse was often worse for the victims than physical abuse (Rivara et al., 2009).

Sub-theme 1.2: Extremely difficult circumstances: Traumatic childhood and family disharmony

Research indicates that domestic violence during childhood leads to a high risk of becoming adult perpetrators or victims of domestic violence (Corrigall et al., 2013). A child who is exposed to domestic violence may experience social, emotional and behavioural problems which, in turn, increase the odds of perpetrating domestic violence in adulthood (Margolin & Vickerman, 2007). Some children who witness domestic violence become adults who develop symptoms of instability in their mental and emotional health (Romney et al., 2006). Moreover, research found that women who are exposed to inter-parental violence during childhood were in jeopardy of experiencing domestic violence during adulthood (Whitefield

et al., 2003). This corresponds with the current study where all of the participants indicated that they had experienced a traumatic childhood and five out of the six participants were exposed to domestic violence in their family home. Furthermore, two of the participants were exposed to sexual violence as children when they were raped by a family member. According to Jewkes et al. (2002) women raised in violent homes learn certain attitudes that place them at risk for becoming adult victims of violence. These women may start viewing domestic violence as normative and may display tolerance for this kind of behaviour by men. (Jewkes et al., 2002).

The Ecological Theory, at the individual level, focuses on the factors that a person brings into the relationship, these include a history of witnessing marital violence, being abused as a child, or previously engaging in domestic violence. Domestic violence at this level may occur because women and/or her partner was/were exposed to childhood violence or abuse. The current study found that all of the women's male partners were exposed to inter-parental violence during their childhood.

Sub-theme 1.3: Substance abuse by a partner: Alcohol and drug abuse by a partner

The findings of the current study concur with previous studies that the association between alcohol abuse and domestic violence vary considerably when the characteristics of the person, as well as the circumstances, under which the intoxication occurs are taken into account (Leonard, 2001). Alcohol abuse, which affects a person's higher cognitive abilities, tends to influence a person's lack of restraint and judgement. People who are prone to anger may engage in violent behaviour when they are under the influence of alcohol. The current study found that alcohol abuse contributed to the occurrence of physical violence in one of the participants' intimate relationship. The participant explained that her partner had to be intoxicated to physically abuse her to the extent to which he was accustomed. Two of the

participants explained that their partners also abused alcohol but were also inclined to become physically abusive irrespective of being sober or intoxicated.

When I questioned the women about their own alcohol consumption and drug use, none of them admitted to ever having used drugs. Some of the women revealed that they consumed alcohol only on social occasions and the rest of the women refrained from using alcohol altogether. Only one participant revealed that she became an alcoholic after she divorced her husband. She claimed that she consumed alcohol because it helped her to obliterate all of her problems. She further mentioned that the frequency of her alcohol consumption led to her becoming an alcoholic.

The current study, akin to other studies, concurs that illicit drugs have varying psychological and behavioural effects on partner aggression. Only two participants in the current study, who revealed that their partners abused drugs (marijuana), indicated that their partner's drug abuse did not contribute to the occurrence of domestic violence in their relationship. One of the participants stated that her partner, in fact became more passive after abusing drugs, although, his brothers believed that he was becoming more violent. The other participant explained that her partner would physically abuse her regardless of whether or not he was using illicit drugs. What was noteworthy was that this participant's partner had a tendency to abuse alcohol before he physically abused her. Although the participant explained that she did not believe his drug abuse had any impact on the occurrence of physical violence in their relationship, it might be due to the partner abusing alcohol and drugs simultaneously. There was no way of being certain that it was the alcohol and/or illicit drug abuse that contributed to the physical violence in their relationship. A research study conducted by Kraanen et al. (2014) found that alcohol abuse with marijuana/cannabis abuse was positively associated with severe intimate partner violence incidents compared to other patients who only abused alcohol.

However, because of the social stigma, guilt, and shame attached to illicit drug abuse, it is possible that some participants may refrain from admitting that they and/or their partners abuse illicit drugs.

The Ecological Theory, at the individual level, focuses on personal factors, such as alcohol and drug abuse that may influence the occurrence of domestic violence. Alcohol and drug abuse at this level can be explained by the dynamic interplay of genetic and environmental factors (Bogg & Finn, 2009). Environmental factors include the availability and affordability of substances. Drugs (specifically marijuana) and alcohol seem to be easily available and affordable to anyone. The link between the family and substance abuse can be highlighted as prominent factors that influence the formation of a child's identity (Mudavanhu & Schenck, 2015). If children are not raised in a healthy socio-economic environment, they are at a high risk for using substances later in life.

Sub-theme 1.4: Behaviour of partner: Controlling behaviour, jealousy and false accusations

Because I am not a clinician, I am unable to diagnose any person with a personality disorder and therefore focused on participants' accounts regarding personality features that they believed contributed towards their partners' domestic violence. Five of the six participants in this study revealed that their partner had some type of personality feature that they believe contributed to the occurrence of domestic violence in their intimate relationships.

Research suggests that sociopathy and borderline personality disorder traits are often found in abusive men (Stuart et al., 2008). "Borderline personality disorder is characterized by affective instability, impulsivity, identity diffusion, and interpersonal dysfunction. Perceived rejection and loss often serve as triggers to impulsive, suicidal, and self-injurious behavior, affective reactivity, and angry outbursts, suggesting that the attachment and affiliative system

may be implicated in the disorder" (Stanley & Siever, 2010, p.24). According to research borderline personality disorder is associated with difficulties such as impulse-control and self-regulation (Mosquera, Gonzalez & Leeds, 2014). The borderline individual has a tendency towards angry outbursts, self-mutilating behaviour and a fear of loneliness (Mosquera et al., 2014). One of the participants confirmed that her partner became angry very quickly and would react (by physically abusing the victim) immediately after he lost his temper. The current study found, similar to other studies, that extreme jealousy was a prominent feature of physically abusive partners (Dutton et al., 1994; Mechanic et al., 2000). Most of the participants (N = 5) revealed that their abusive partners had a tendency to become extremely jealous and would either emotionally and or physically abuse them. Some (N = 2) of the participants in this research study explained that when their partners became angry they showed signs of obsession.

The Ecological Theory at individual level takes into account personal history as well as biological factors that influence how a person behaves. Adolescent antisocial behaviour has been linked to a set of risk factors across the multiple systems in the ecology of youth. Individual factors include temperament, poor social skills, poor verbal skills, and difficulty learning prosocial behaviour from experience (Hoffman & Tompson, 2002). Family factors include parenting and discipline problems, lack of monitoring the child, marital discord and family disorganisation. Peer characteristics include association with the 'wrong' group of individuals. School factors include a chaotic school environment and low achievement rates at school. Neighbourhood factors include a criminal subculture (Hoffman et al., 2002).

5.2.2 Theme 2: Socio-economic factors

The following sub-theme, which emerged from the interviews, addresses the effects of economic neglect as a risk factor for the occurrence of domestic violence in intimate relationships.

Sub-theme 2.1 Struggle to make ends meet: Economic Neglect

Comparable to other studies (Hindin et al., 2002; Johnson, 2001), this research study found that low income, being poor, and unemployment contributed to the occurrence of domestic violence in the participants' intimate relationships. Five of the six participants in this study revealed that disputes around low income and poverty had an impact on the occurrence of domestic violence in their relationships. Most of the violent incidents occurred when the participants and their partners faced economic hardship which led to arguments about money. Two of the participants in the current study, akin to other studies, disclosed that their partners prohibited them from working or leaving their communal home even though they (male partners) neglected to provide for them financially (Mouradian, 2007). One of the participants explained that although her partner solely relied on her income he controlled all their finances. Restricting women's movements or controlling all the income is yet another form of power and control that men may exhibit.

According to the Ecological Theory and specifically the relationship level, factors such as conflict around male control, wealth, and decision making may have an influence on the occurrence of domestic violence. An international study conducted by Hindin et al. (2002) found that when men dominated household decision making the risk for domestic abuse was 2.7% greater than in households in which mutual decisions were made. Poor, unemployed women, with a low level of education are most vulnerable to domestic violence as they are dependent on their partner and have no resources to leave the situation (Sitaker, 2007). Many

battered women stay in abusive relationships because they do not know where they will live and how they will be able to support themselves and their children. Poverty and unemployment can result in feelings of suffering and humiliation, which in turn may lead to anger and frustration. In this study, most of the women (N = 5) were unemployed and were from a similar socio-economic background. Five of the women in this study's individual's or family's economic and social position in relation to others, based on income, education, and occupation were more or less similar. All of the women (N = 6) in this study confirmed that they stayed in an abusive relationship for several years before they made a decision to leave the relationship. Poverty and unemployment were found to be one of the main reasons why most of the women (N = 5) found it difficult to leave their abusive partners.

5.2.3 Theme 3: Cultural differences

The next sub-theme, which emerged from the interviews, relates to the cultural differences between partners and how culture can impact on the occurrence of domestic violence. Five of the six participants in the current study revealed that cultural factors had an effect on the occurrence of domestic violence in their intimate relationships.

Sub-theme 3.1: Cultural differences between partners: Impact of cultural differences on the occurrence of domestic violence

The research findings of the current study concur with previous studies that have shown that domestic violence occurs across all cultures and social groups (Yoshihama, 2000). The current study, comparable to other studies, identified cultural differences as a risk factor for the occurrence of domestic violence. It has been found that perpetrators of domestic violence often misuse their cultural and religious beliefs to justify their behaviour (Ganley & Hobart, 2010). Some of the women (N = 5) in the current study came from different cultural backgrounds than their partner/husband. The participants' perceptions of gender and marital

roles, akin to other studies, also differed (Jewkes et al., 2002). Several participants (N = 5) in the current study did not believe that women should have to be submissive in intimate relationships. They alleged that in a healthy adult relationship neither party has the right to discipline or control the other person. Therefore, some of the participants found it difficult to understand their partner's cultural beliefs and norms.

The Ecological Theory at socio-cultural level explains that different cultural values and the influence of a patriarchal type of society can encourage the occurrence of domestic violence. In a patriarchal society, men are seen as superior and women as inferior. A man's use of domestic violence in a relationship may be a direct expression of male authority.

Beliefs around successful masculinity have been linked to a man's ability to provide for his family financially (Boonzaier & de la Rey, 2004). In the present study, half of the women (N = 3) and their abusive partners were foreigners in South Africa. According to Black et al. (2006) the rejection and hostility against foreigners in South Africa is due to limited resources such as education, housing, health care, and employment. Foreigners who immigrate to South Africa frequently find shelter in informal settlements that are characterised by high levels of poverty, unemployment, and a shortage of housing. Black foreign nationals are often seen as opportunists who are found to be the scapegoat for increasing poverty and unemployment in South Africa (McKnight, 2008).

5.2.4 Theme 4: Domestic violence during pregnancy

The following sub-theme, domestic violence during pregnancy also emerged from the interviews I held with the participants. The current study found that a number of the participants (N = 5) indicated that they had been abused during one or all of their pregnancies.

Sub-theme 4.1: Occurrence of domestic violence during pregnancy: Impact of pregnancy on the occurrence of domestic violence

Similar to other studies, this research identified domestic violence during pregnancy as a common, chronic, and complex social problem that occurs cross-culturally. Comparable to other studies, this research found that domestic violence may commence during pregnancy but in some cases, it was a continuation of abuse that preceded the pregnancy (Campbell et al., 1998; Edin et al., 2010). Five out of the six participants in the current study revealed that they were physically abused during pregnancy. One of the participants revealed that the physical abuse started when she fell pregnant for the first time. The other four participants were exposed to domestic violence prior to their pregnancies and the abuse was simply a continuance of what happened prior to their falling pregnant. The research findings of the current study, which are in agreement with previous studies, revealed that a number of domestic violence assault cases involve pregnant women (Calder, 2000). Two of the participants in this study were abused to such an extent during their pregnancies that they lost their unborn babies. The adverse health outcomes of pregnancy abuse in the study included; fetal death and premature labour.

5.3 Applying the Ecological Theory to the phenomenon of domestic violence

As discussed in the literature review chapter, theoretical explanations can be used to shed light on the phenomenon of domestic violence. The Ecological Theory provided me with a web of factors which maximised my understanding of the many facets which contribute to the occurrence of domestic violence against women.

From an ecological perspective, people and their environment are viewed as interdependent. Theorists maintain that domestic violence must be conceptualised as a multifaceted phenomenon which are grounded in the interplay among personal, situational, and socio-

cultural factors (Crowell & Burgess, 1996). According to the theory, domestic violence is not caused by one factor but are more likely to occur as several factors interact at different levels of the ecology (Crowell et al., 1996). This study is in agreement with the Ecological Theory that several factors, which interacted at different levels, were responsible for the occurrence of domestic violence in the participants' lives. All the women in the study (N = 6) were exposed to various factors, at various levels in their family, community, and society that contributed to the phenomenon of violence in their marital or intimate relationships.

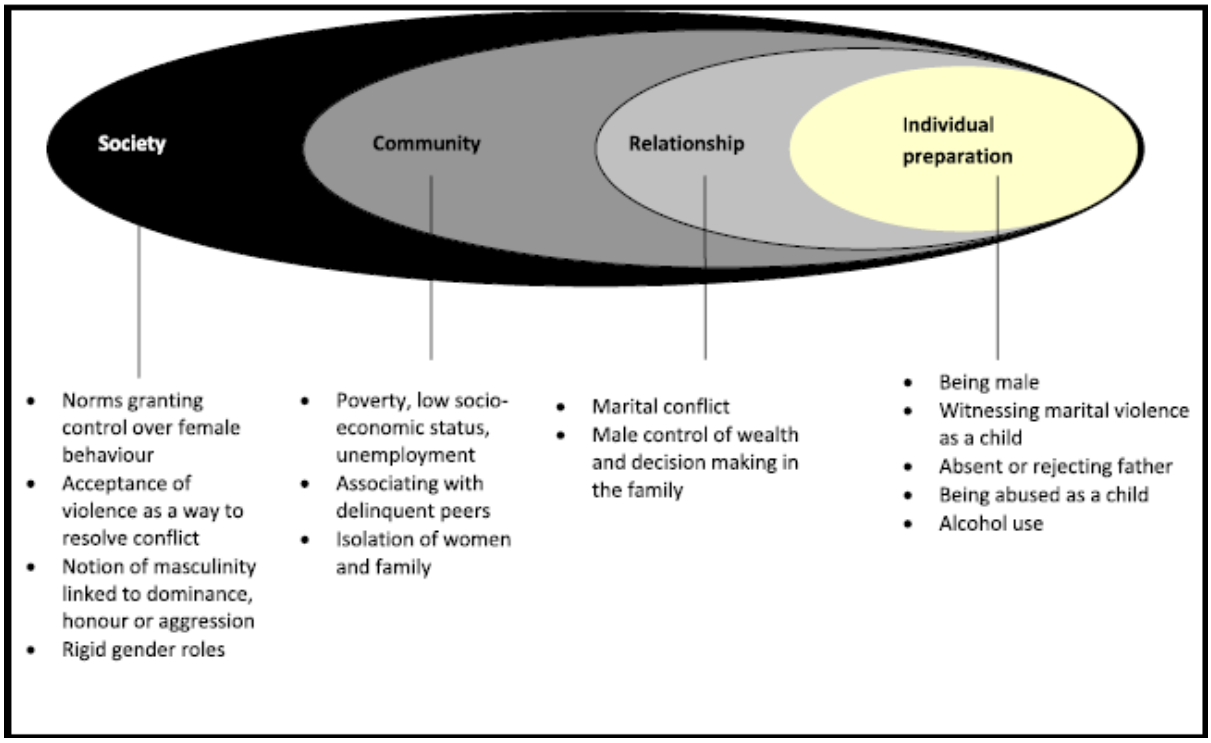

Figure 5. Ecological model of factors associated with partner abuse (Heise, 1998, p. 262).

The first layer of the ecological theory is focused on the individual level which represents biological, demographic, and personal history factors that each victim of intimate partner violence brings to her behaviour in the relationship. These factors include age, gender, education, income, psychological problems, personality disorders, aggressive tendencies, and substance abuse.

As discussed in the literature review chapter, gender has been found to be one of the predictors of intimate partner violence. Males have a higher perpetration rate for interpersonal violence of all types. Furthermore, as discussed in the literature review chapter, and under the themes section of this chapter; education, income, personality disorders and aggressive tendencies were found to be risk factors that increased the likelihood of the occurrence of domestic violence incidents in several participants' intimate relationships. Moreover, this study found similar to other studies, that experiencing or witnessing domestic abuse as a child, increases the likelihood of violence in adulthood. Sons of battered women have a higher rate of becoming adults who abuse their partners. This was confirmed in the study when all of the women revealed that their partners were allegedly exposed to domestic violence during childhood. This study is in agreement with previous studies that daughters who have been exposed to domestic violence were more likely to become victims of intimate partner violence. Five out of the six women who participated in this study were exposed to childhood domestic violence and later became the victims of intimate partner violence.

The next layer is focused on interpersonal relationship that describes the immediate context in which intimate partner violence takes place and the influence of relationships with family and friends. The relations level also explains how different relationships with family, intimate partners, friends, and workplace situations can contribute to conflict and disagreement in the family. This study found, akin to previous studies, that women were at a higher risk of becoming victims of intimate partner violence in families where men considered themselves to be the head of the household with primary decision-making authority. As discussed under the struggle to make ends meet theme, battered women are often found to be more isolated from interaction with family, friends and neighbours. Women who live in cultures where high-violence is tolerated are more isolated and intimate partner violence are considered outside public scrutiny.

The third layer represents the community, workplace, neighbourhood, justice system, peer groups, and social groups in which the abusive relationship is embedded. This level looks at factors such as poverty, unemployment, and low socio-economic status that can contribute to a victim of domestic violences' vulnerability of sustaining violent acts. As discussed earlier in this chapter, this study found that unemployment and living at or below the poverty line increased the risk of domestic violence in the participants' intimate relationships. Most of the women (N = 5) were from a similar socio-economic background and were at a higher risk of domestic abuse when they faced financial tribulation in their intimate relationships. Living in poverty, is likely to generate frustration and stress which increases marital conflict and domestic violence incidents.

The fourth layer is the social and economic environment that highlights the general views and attitudes around culture. This level also looks at factors such as parental roles and responsibilities, societal norms, larger economic, social, and health structures affecting the victims of domestic violence's lives. As discussed in the literature review chapter, religious and historical traditions permitted physical punishment of women under certain circumstances. Currently several cultures still adhere to more traditional and rigid gender roles. Some of the women in the study (N = 5) found it difficult to understand their partners' cultural background and beliefs. The women did not want to be in a submissive relationship where men had a sense of ownership or entitlement over women.

The overlapping rings of the Ecological model depict the interrelationship and interdependence of the factors to one another. According to Ecological theory, to deal with the problem of domestic violence in intimate relationships, various factors at different levels need to be dealt with simultaneously. If we understand the interaction between the levels, we will be able to put factors in place to prevent domestic violence.

5.4 Summary

This study aimed to gain a better understanding of the demographic characteristics of the women who suffer from domestic violence in Tshwane, South Africa. Furthermore, I attempted to determine which markers could be used to identify individuals at risk for becoming victims of domestic violence. Lastly, the study was focused on how psychosocial risk factors contribute to the occurrence of domestic violence in intimate relationships.

The demographic characteristics of the women who participated in this study differed to some degree. At the time of the interview the age of the participants varied from 24 – 45 years of age. During the time the participants were exposed to domestic violence their age varied from 21 – 41 years of age. Five of the six participants were black females, and one was a white female. The level of education of the participants ranged from attending secondary school but never completing Grade 12 up to some years at tertiary level. One of the participants found employment a couple of days prior to our interview and the white participant worked at the shelter. The other participants were unemployed and were looking for employment at the time of the interview. Five out of the six participants were separated from their partners at the time of the interview and one participant was divorced.

One of the markers that can be used to identify individuals at risk for becoming victims of domestic violence is that of age. Peters et al. (2002) found that women between the ages of 25 to 34 received the highest score of domestic disputes per annum. The second highest score of domestic disputes per annum were women between the ages of 35 to 44. In this study, the victims of domestic violence were between 21 – 41 years of age at the time of abuse in their intimate relationships. Therefore, all of the participants (N = 6) in the study were between the age that received the highest and second highest score of domestic disputes per annum.

A second marker that can be used to identify individuals at risk for becoming victims of domestic violence are unemployment and income under the poverty level at baseline. As per my discussion under the theme: socio-economic factors; employment instability and financial strain increases the likelihood of violence against women in intimate relationships.

Additional markers that have been discussed and can be used to identify individuals at risk for becoming victims of domestic violence includes exposure to violence in the family of origin, personality factors, socio-economic factors, cultural differences, and pregnancy.

The literature review and research findings provided insights into the psychosocial risk factors (e.g. alcohol and drug abuse, violence in the family of origin, personality factors) that may have an impact on the occurrence of domestic violence in intimate relationships. This study further identified risk factors such as: Socio-economic factors, cultural differences and abuse during pregnancy that also had an influence on the occurrence of domestic violence in the participants' intimate relationships. Additional risk factors such as depression, low self-esteem, beliefs in strict gender roles, and unhealthy family relationships are only a few examples of other risk factors that may also contribute to the occurrence of domestic violence. The aforementioned risk factors were not discussed as it is impossible to address each and every risk factor that contributes to the occurrence of domestic violence in a single study.

During the research study I could not identify alcohol and drug abuse as one of the most prominent risk factors for the occurrence of domestic violence. Only one out of the six participants revealed that alcohol abuse had an influence on the occurrence of domestic violence in her intimate relationship.

In conclusion, I have answered all the research questions and met the study objectives.

5.5 Differences and similarities to other studies

A study by Dixon et al. (2011) led them to conclude that when women are the perpetrators of violence it should be understood in terms of self-defence or retaliation. Although none of the women in this study admitted being the instigator of violence towards a non-violent male partner, two of the participants confessed that they became violent during arguments with their abusive partners. One of the participants revealed that she became so enraged that she thought she was going to faint. The other participant admitted to throwing boiling water over her partner during one of their arguments. In conclusion, similar to previous research the two participants in this study justified their behaviour by claiming it was done in self-defence. This is an area that could have been further investigated if it were possible to interview both partners.

Substance abuse is seen as one of the most prominent risk factors relating to domestic violence (Corrigall et al., 2013; Corvo et al., 2013). However, in this study only two participants confirmed that their partner abused alcohol and two admitted that their partner abused illicit drugs (marijuana). One participant admitted that her partner's alcohol abuse contributed to the extremity of the physical violence in their relationship. The other participant did not believe that her partner's alcohol abuse made any difference as he would still mistreat her when he was sober. This corresponds with the research findings of Ganley (2002): Some perpetrators who consume alcohol or illicit drugs, are violent irrespective of having or not having any chemicals in their bodies. None of the participants believed that their partner's alleged illicit drug abuse contributed directly to the occurrence of domestic violence in their relationships. The participants also refrained from talking about their own alcohol and drug abuse, if any. When I questioned the participants around their own alcohol use, some of them (N = 3) revealed that they only consumed alcohol on social occasions and the others (N = 3) refrained from using alcohol altogether. There was only one participant in

this research study that admitted that she became an alcoholic after she divorced her abusive partner. In conclusion, different from other studies, substance abuse was not found to be a prominent risk factor for the occurrence of domestic violence in the participants' lives. Socio-economic factors, cultural differences, and pregnancy played a much greater role.

Similar to other studies, this research study found that pregnancy was a high-risk factor for the occurrence of domestic violence in the participants' intimate relationships. According to research, abuse during pregnancy has been found to be an especially high-risk period for the occurrence of domestic violence (Rakovec-Felser, 2014). Pregnancy abuse is also one of the leading causes of infant mortality in the United States, Australia and the United Kingdom (Rakovec-Felser, 2014). Five out of the six participants in this study revealed that they had been a victim of pregnancy abuse.

Sexual abuse, similar to physical abuse, includes a wide range of different behaviours. Sexual abuse includes coercive sex, when the victim does not want sex, and violent sex or forced sex (Ganley, 2002). In an international study conducted in the US: "An estimated 13% of women and 6% of men have experienced sexual coercion in their lifetime (e.g. unwanted sexual penetration after being pressured in a nonphysical way); and 27.2% of women and 11.7% of men have experienced unwanted sexual contact" (Black et al., 2010, p 2). In this research study, only one participant indicated that she was occasionally coerced into sex with her partner after an argument. Two participants revealed that they were sexually abused by a family member when they were still minors. In conclusion, different from other studies, sexual abuse was not found to occur in most the participants' intimate relationships.

5.6 Limitations of the study

Although this study provided insights into the lived experiences of women who were exposed to domestic violence, it had certain limitations:

- The small size of the participant group. I attempted to recruit women from diverse racial, cultural, and socioeconomic backgrounds. However, this was impossible as I could not source abused women, within the general population, who were willing to share their story with me.
- The notion of generalisability: Most of the women residing at the shelters had similar educational and socioeconomic backgrounds. Women living outside of a shelter might have a different perception on the psychosocial risk factors that contribute to domestic violence in their intimate relationships.
- Another limitation of this study is that purposive and convenience sampling were used to select the participants. These methods do not allow for everyone within a defined population to have an equal chance of being selected. A biased sample can lead to incorrect conclusions regarding the larger population. Therefore, broad inferences and generalisations about the selected population cannot be made.
- Phenomenological research focusses on the meaning of particular experiences that are revealed through dialogue and reflection. The level of education of the participants and the language barrier may have contributed to the women struggling to understand the meaning of my questions. This could have made it difficult for the participants to effectively communicate their feelings and beliefs around the risk factors that contributed to domestic violence in their intimate relationships. The use of an interpreter would have made it easier for the women to understand my questions more effectively.
- The partners/spouses of the abused women were not part of the research study and they were not interviewed. I therefore, solely relied on the women's perceptions and lived experiences of domestic violence in their intimate relationships. In essence, this means I did not hear the 'other side of the story'. It would have been beneficial to

include all members of the family as this would assist in understanding the phenomena considerably better.

- Another factor that may have had an influence on the limitations of this study is that of response bias. Because of the sensitivity of the research topic the participants might have felt overwhelmed and pressurised to provide me with answers that were socially acceptable and therefore did not answer all the questions accurately and truthfully. This means for instance, that some of the participants may have refrained from telling the truth about their own, or their partner's, illicit drug abuse because of the legal consequences of using drugs.
- The Ecological Theory is focused on the interaction of many factors at four levels and no single factor can explain why some people are at a higher risk of interpersonal violence. Therefore, the Ecological Theory does not specifically and exhaustively identify every possible factor at each level that might contribute to the occurrence of domestic violence in intimate relationships.

5.7 Recommendations for further research

Research into the risk factors that may contribute to the occurrence of domestic violence is limited and there is, therefore, a substantial scope for further investigation in this area. The following recommendations for future research are made:

- Research that examines the similarities and differences regarding men's and women's experiences of domestic violence is limited. Since men are also the victims of domestic violence, insight into these experiences might be useful to identify risk factors that contribute to domestic violence.
- Before I started the interview process, I planned on sourcing participants by delivering invitations to community-based organisations with a request to distribute them. In the end I decided to contact shelters in and around Tshwane (telephonically

and via email) to ask them if they would be willing to allow me the opportunity to interview some of the women residing at the shelters. Two shelters in the Tshwane Central Business District gave me permission to interview women residing at the different shelters. Therefore, this research study was focused on women's experiences with domestic violence, residing in shelters around Tshwane. I would recommend including women from other regions who do not reside in a shelter, as this may provide a better general understanding of domestic violence in intimate relationships.

- Due to the shortage of qualitative research into the risk factors that contribute to domestic violence, it would be advisable to use other alternative methods of qualitative research that include case studies and participant observations. This could add to the knowledge of which risk factors may contribute to domestic violence in intimate relationships.

5.8 Critical self-reflection

Over the course of five years I completed the research study. This proved to be an extremely difficult journey because I chose to write about something that hit close to home. I believed that I could only write about a topic if I had first-hand experience and knowledge thereof. My own lived experiences made me choose domestic violence as a research topic because I wanted to better understand the reason behind women being emotionally and physically abused. What caused this type of abuse? Why are women being abused on a daily basis? What are the risk factors of domestic violence?

When I finished my literature review and research design chapter my initial idea was to distribute interview invitations to organisations and institutions based in Tshwane. However, I realised that battered women would be unlikely to voluntarily contact me to participate in the research study. I made the decision to contact shelters. I emailed my research proposal to several different shelters in Tshwane and asked them if they would allow me the opportunity

to interview female victims of domestic abuse. Two shelters in Tshwane central business district gave me permission to interview resident women but I was given limited time. The head of the shelters wanted me to complete the interviews as soon as possible. Moreover, the head of the shelters did not indicate which of the women had been exposed to domestic violence. I had to randomly ask women residing at the shelter if they had a victim of domestic violence.

My first couple of interviews did not go well. I became extremely nervous and had no experience on how to properly interview participants. This made me question my ability and therefore I struggled to ask the right follow-up questions. At times I allowed the women to deviate from the subject of domestic violence which caused the interviews to go on for more than an hour and a half. The first three interviews were not information rich and I had to interview more women. One of the women who I interviewed at the first shelter took me to a second shelter. The second shelter did not have a shelter head. The shelter was an old factory where homeless men, women, and children took refuge for short periods of time. This was devastating to experience, I saw children eating stale bread from a bag sitting on the factory floor. There were more than fifty people at the shelter and they lived in extremely poor conditions. I had to interview the women outside and we were constantly interrupted which resulted in my recordings being of such poor quality that I struggled to transcribe the interviews. Ultimately, I was unable to rewrite any of the interviews. I made the decision to visit another shelter. At the third shelter I gained enough confidence to effectively interview women. I made sure that we had a quiet place to talk so that I could record the interviews accurately.

In the end I interviewed 13 women at three different shelters. It was only after I gained more experience that I succeeded to interview six women adequately. I knew that I could not go back to the shelters for follow up interviews. The women were only allowed to stay at the

shelters for three months at a time and most of the women that I interviewed had to leave the shelters and find another place to stay. I made numerous mistakes during my first interviews, but I also learned from them. After I transcribed the data I found areas that I felt could have been explored further. I would have preferred to be able to do follow up interviews with the abused women.

The stories the women told me affected me to such an extent that I remember struggling to sleep at night because I did not know how to help them. I drove home crying after I interviewed some of the women and I found it difficult to motivate myself to finish all of the interviews. Some of the women wanted my advice and this caused me to feel helpless because I am not a clinician and could not provide them with advice or counselling. After some time, I realised that it was physically impossible to help the women and I had to just walk away after the interview. I could not let their stories affect me any further. With that being said, it was an incredible journey, I did not only learn more about the risk factors of domestic violence, I also learned more about myself. I hope that someday I will be able to study further and assist victims of domestic violence.

5.9 Conclusion

In conclusion, the present study explored the psychosocial risk factors that contribute to the occurrence of domestic violence in the participants' intimate relationships. The findings of this study highlighted issues of alcohol and illicit drug abuse, violence in the family of origin, personality factors, socio-economic factors, cultural differences, and pregnancy. It can therefore be concluded, that these are some of the several psychosocial risk factors that contribute to the occurrence of domestic violence in intimate relationships. Other risk factors such as low self-esteem, depression, beliefs in strict gender roles, and unhealthy family relationships are only a few examples of risk factors that can also influence the occurrence of domestic violence. Due to the vast number of risk factors that exist, and contribute to the

occurrence of domestic violence, it was physically impossible to address each and every one in this study.

Finally, it is my hope that the findings in this research study will assist in educating the public on some of the risk factors that contribute to the occurrence of domestic violence and also add to the body of research on the phenomenon.

REFERENCE LIST

Abrahams, N., Mathews, S., Martin, L. J., Lombard, C., & Jewkes, R. (2013). Intimate partner femicide in South Africa in 1999 and 2009. *PLOS Medicine, 10*(4), 1–8.

Abrahams, N., Jewkes, R., Laubscher, R., & Hoffman, M. (2006). Intimate partner violence: Prevalence and risk factors for men in Cape Town, South Africa. *Violence and Victimisation, 21*(2), 247-264.

Abrahams, N., & Jewkes, R. (2005). Effects of South African men's having witnessed abuse of their mothers during childhood on their levels of violence in adulthood. *American Journal of Public Health, 95*(10), 1811-1816.

Abraham, M. (1999). Sexual abuse in South Asian immigrant marriages. *Violence Against Women, 5*(6), 591-618.

Ajzen, I. (1991). The theory of planned behaviour. *Organisational Behaviour and Human Decision Processes, 50*(2), 179-211.

Ajzen, I. (1985). *From intentions to actions: A Theory of planned behaviour*. Action-control: From cognition to behaviour. Heidelberg: Springer.

Akinboade, O. A., & Mokwena, M. P. (2009). The problem and awareness of liquor abuse in South Africa. *International Journal of Social Economics, 37*(1), 54-74.

Al-Aldawi, S., & Al-Bahlani, S. (2007). What's love got to do with it? *Sultan Qaboos University Medical Journal, 7*(1), 1–10.

Allsop, D. J., Norberg, M. M., Copeland, J., Fu, S., & Budney, A. J. (2011). The cannabis withdrawal scale development: Patterns and predictors of cannabis withdrawal and distress. *Drug and Alcohol Dependence, 119,* 123–129.

Ali, P. A., & Naylor P. B. (2013). Intimate partner violence: A narrative review of the feminist, social and ecological explanations for its causation. *Aggression and Violent Behaviour, 18*(6), 611-619.

Altheide, D. L., & Johnson, J. M. (1994). Criteria for assessing interpretive validity in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 485–499). Newbury Park, CA: Sage.

Ansara, D. L., & Hindin, M. J. (2011). Psychosocial consequences of intimate partner violence for women and men in Canada. *Journal of Interpersonal Violence, 26*(8), 1628-1645.

Archer, J. (2004). Sex differences in aggression in real-world settings: A meta-analytic review. *Review of General Psychology, 8*(4), 291-322.

Archer, J. (2000). Sex differences in aggression between heterosexual partners: A meta-analytic review. *Psychological Bulletin, 126*(5), 651-680.

Ashton, C. H. (2001). Pharmacology and effects of cannabis: A brief review. *British Journal of Psychiatry, 178,* 123-128.

AuCoin, K. (2005). *Family violence in Canada: A statistical profile.* Statistics Canada 89.

Babcock, J. C., Jacobson, N. S., Gottman, J. M., & Yerrington, T. P. (2000). Attachment, emotional regulation and the function of marital violence: Differences between secure, preoccupied, and dismissing violent and nonviolent husbands. *Journal of Family Violence, 15*(4), 391-409.

Baicy, K., & London, E. D. (2007). Corticolimbic dysregulation and chronic methamphetamine abuse. *Addiction, 102*(1), 5-15.

Ballif-Spanvill, B., Clayton, J. C., Hendrix, M., & Hunsaker, M. (2004). Individual differences in the use of violent and peaceful behaviour in peer conflicts among children who have and have not witnessed interparental violence. *Journal of Emotional Abuse, 4*(2), 101-123.

Banks, M. E. (2007). Overlooked but critical: Traumatic brain injury as a consequence of interpersonal violence. *Trauma Violence Abuse, 8*(3), 290-298.

Bannister, P., Burman, E., Taylor, M., & Tindall, C. (1994*). Qualitative methods in psychology: A Research guide.* Bristol University.

Batalla, A., Bhattacharya, S., Yucel, M., Fusar-Poli, P., Crippa, J. A., Noque, S. Torrens, M., Pujol, J., Farre, M., & Martin-Santos, R. (2013). Structural and functional imaging studies in chronic cannabis users: A systematic review of adolescent and adult findings. *PLOS One, 8*(2).

Bateman, A. W., & Krawitz, R. (2013). Borderline personality disorder. An evidence-based guide for generalist mental health professionals. *Psychiatry Bulletin, 38*(4), 256.

Becvar, D. S., & Becvar, R. J. (2009). *Family therapy. A systemic integration.* Seventh Edition: Pearson Education.

Bell, M. A., & Wolfe, C. S. (2004). Emotion and cognition: An intricately bound developmental process. *Child Development, 75*(2), 366-370.

Benda, B. B., & Corwyn, K. F. (2002). The effect of abuse in childhood and in adolescence on violence among adolescents. *Youth and Society, 33*(3), 339-365.

Bentley, K. (2004). Women's rights and the feminisation of poverty in South Africa. *Review of African Political Economy, 100*(31), 247-261.

Bergen, R. K. (1996). *Wife rape: Understanding the response of survivors and service providers.* Thousand Oaks: Sage Publications.

Betts, K. R., Heinsz, V. B., & Heimerdinger, S. R. (2011). Predicting intentions of romantic partner abuse with the theory of planned behaviour. *Springer Science Business Media, 30*(2), 130-147.

Black, M. (2011). Intimate partner violence and adverse health consequences: Implications for clinicians. *Centres for Disease Control and Prevention, 5*(5), 428-439.

Black, D. W., Blum, N., Pfohl, B., & Hale, N. (2004). Suicidal behaviour in borderline personality disorder: Prevalence, risk factors, prediction and prevention. *Journal of Personality Disorder, 18*(3), 226-239.

Black, P. H., & Garbutt, L. D. (2002). Stress, inflammation and cardiovascular disease. *Journal Psychosomatic Research, 52*(1), 1-23.

Blasco-Ros, C., Sanchez-Lorente, S., & Martinez, M. (2010). Recovery from depressive symptoms, state anxiety and posttraumatic stress disorder in women exposed to physical and psychological, but not to psychological intimate partner violence alone: A Longitudinal study. *BMC Psychiatry, 10*(98).

Bogart, G. A., Dejonghe, E., & Levendosky, A. A. (2006). Trauma symptoms among infants exposed to intimate partner violence. *Child Abuse and Neglect, 30*(2), 109-125.

Bogdan, R. C., & Biklen, S. K. (1998). *Qualitative research for education: An introduction to theory and methods.* Boston: Allyn & Bacon.

Bogdan, R. C., & Biklen, S. K. (1992). *Eight common questions about qualitative research.* In qualitative research for education: An introduction to theory and methods. Allyn & Bacon.

Bogg, T., & Finn, P. R. (2009). An ecologically based model of alcohol consumption decision making: Evidence for the discriminative and predictive role of contextual reward and punishment information. *Journal of Studies on Alcohol and Drugs, 70*(3), 446 – 457.

Boles, S.M., & Miotto, K. (2003). Substance abuse and violence: A review of the literature. *Aggression and Violent Behaviour, 8*(2), 155-174.

Bonomi, A. E., Thompson, R. S., & Anderson, M. (2006). Intimate partner violence and women's physical, mental and social functioning. *American Journal of Preventative Medicine, 30*(6), 458-466.

Boonzaier, F., & de la Harpe, K. (2011). Women's experience of an intervention for violent men. *Psychological Society of South Africa, 41*(2), 147-156.

Boonzaier, F., & de la Rey, C. (2004). Woman abuse: The construction of gender in women and men's narratives of violence. *South African Journal of Psychology, 34(*3), 443 - 463.

Bornstein, R. F. (2006). The complex relationship between dependency and domestic violence: Converging psychological factors and social forces. *American Psychologist, 61*(6), 595-606.

Breiding, M. J., Black, M. C., & Ryan, G. W. (2005). Chronic disease and health risk behaviours associated with intimate partner violence – 18 U.S. states/territories, 2005. *Annals of Epidemiology, 18*(7), 538-544.

Brink, H. I. L. (1991). Validity and reliability in qualitative research. *Curationis, 16*(2).

Brison, S. J., & Manne, D. (2013). *Domestic violence*. The International Encyclopedia of Ethics, 1454-1462.

Bronowski, J. (1978). *The origins of knowledge and imagination.* New Haven: Yale University Press.

Brown, G. R. (2004). Gender as a factor in the response of the law-enforcement system to violence against partners. *Sexuality and Culture, 8*(3-4), 3-139

Browne, A., & Bassuk, S. S. (1997). Intimate violence in the lives of homeless and poor housed women: Prevalence and patterns in an ethnically diverse sample. *American Journal of Orthopsychiatry, 67*(2), 261-278.

Budney, A. J., & Hughes, J. R. (2006). The cannabis withdrawal syndrome. *Current Opinion Psychiatry, 19*(3), 233-238.

Budney, A. J., Hughes, J. R., Moore, B. A., & Novy, P. L. (2001). Marijuana abstinence effects in marijuana smokers maintained in their home environment. *General Psychiatry, 58*(10), 917-924.

Bumiller, K (2008). *In an abusive state: How neoliberalism appropriated the feminist movement against sexual violence*. Durham. Duke University Press.

Buttell, F. P., & Carney, M. M. (2004). A multidimensional assessment of a batterer treatment program: An alert to a problem? *Research on Social Work Practice, 14*(2), 93-101.

Caetano, R., Schafer, J., & Cunradi, C. B. (2001). Alcohol-related intimate partner violence among white, black and Hispanic couples in the Unites States. *Alcohol Research and Health, 25*(1), 58-65.

Calder, M. C. (2000*).* Towards a framework for conducting pre-birth risk assessment. *Child Care in Practice, 6*(1), 53-72.

Camacho, K., Ehrensaft, M. K., & Cohen, P. (2012). Exposure to intimate partner violence, peer relations, and risk for internalising behaviours: A prospective longitudinal study. *Journal of Interpersonal Violence, 27*(1), 125-141.

Campbell, J. C. (2002). Health consequences of intimate partner violence. *Lancet, 359*(9314), 1331-1336.

Campbell, J. C., Oliver, C. E., & Bullock, L. F. (1998). The dynamics of battering during pregnancy: Women's explanations of why. *Empowering Survivors of Abuse, 81*-89. Thousand Oaks, CA: Sage.

Capaldi, D. M., Knoble, N. B., Short, J. W., & Kim, H. K. (2012). A systematic review of risk factors for intimate partner violence. *Partner Abuse, 3*(2), 231-280.

Carlson, B. (1984). Causes and maintenance of domestic violence: An ecological analysis. *Social Service Review, 58*(4), 569-587. The University of Chicago Press.

Carney, M., Buttell, F., & Dutton, D. (2006). Women who perpetrate intimate partner violence: A review of literature with recommendations for treatment. *Aggression and Violence Behaviour, 12*(1), 108-115.

Carr, A. (2014). The evidence base for couple therapy, family therapy and systemic interventions for adult-focused problems. *Journal of Family Therapy, 36*(2), 158-194.

Carr, J. L., & Vandeusen, K. M. (2002). The relationship between family of origin violence and dating violence in college men. *Journal of Interpersonal Violence 17*(6), 640-646.

Carrico, A.W., Pollack, L. M., Stall, R. D., Shade, S. B., Neilands, T. B., & Rice, T. M. (2012). Psychological processes and stimulant use among men who have sex with men. *Drug and Alcohol Dependence, 123*(1-3), 79-83.

Chermack, S. T., Walton, M. A., Fuller, B. E., & Blow, F. C. (2001). Correlates of expressed and received violence across relationship types among men and women substance abusers. *Psychology of Addictive Behaviours, 15*(2), 140-151.

Chermack, S. T., & Giancola, P. R. (1997). The relation between alcohol and aggression: An integrated bio psychosocial conceptualization. *Clinical Psychology Review, 17*(6), 621-649.

Cherner, M., Suarez, P., Casey, C., Deiss, R., Letendre, S., & Marcotte, T. D. (2010). Methamphetamine use parameters do not predict neuropsychological impairment in current abstinent dependent adults. *Drug and Alcohol Dependence, 106*(2), 154-163.

Choca, J. P. (2004). *Interpretive guide to the Millon Clinical Multiaxial Inventory*. Third Edition. American Psychological Association.

Chrisler, J., & Ferguson S. (2006). Violence against women as a public health issue. *Annals of the New York Academy of Sciences, 1087*, 235-249.

Christensen, L. B., Johnson, R. B., & Turner, L.A. (2014). *Research methods, design and analysis*. 12th Edition. Pearson.

Cohen, R. A., Brumm, V., Zawacki, T. M., Paul, R., Sweet, L., & Rosenbaum, A. (2003). Impulsivity and verbal deficits associated with domestic violence. *Journal of the International Neuropsychological Society, 9*(5), 760-770.

Cohen, L., & Manion, L. (1994). *Research methods in education*. London: Routledge.

Coker, A.L., Davis, K.E., Arias, I., Desai, S., Sanderson, M., Brandt, H.M., & Smith, P.H. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventative Medicine, 23*(4), 260-268.

Coker, A. L., Smith, P. H., Bethea, L., King, M. R., & Mckeown, R. E. (2000). Physical health consequences of physical and psychological intimate partner violence. *Archives of Family Medicine, 9*(5), 451-457.

Coid, J., Petruckevitch, A., Feder, G., Chung, W., Richardson, J., & Morrey, S. (2001). Relation between childhood sexual and physical abuse and risk of re-victimisation in women: A cross-sectional survey. *The Lancet, 358,* (9280), 450-454.

Compton, W. M., Thomas, Y. F., Stinson, F. S., & Grant, B. F. (2007). Prevalence, correlates, disability and comorbidity of DSM-IV drug abuse and dependence in the United States: Results from the national epidemiologic survey on alcohol and related conditions. *Archives of General Psychiatry, 64*(5), 566-576.

Cornelius, T.L., Shorey, R.C., & Beebe, S. M., (2010). Self-reported communication variables and dating violence: Using Gottman's marital communication conceptualization. *Journal of Family Violence, 25*(4), 439-448.

Corrigall, J., & Matzopoulos, R. (2013). Violence, alcohol misuse and mental health: Gaps in the health system response. *South African Health Review 2012-2013,* 103-114.

Cory, A., Crane, L., Oberleitner, M. S., Devine, S., & Easton, C. J. (2014). Substance use disorder and intimate partner violence perpetration among male and female offenders. *Psychology of Violence, 4*(3), 322-333.

Corrigan, J. D. P., Wolfe, M. L., Mysiw, W. J. M. D., Jackson, R. D. M. D., & Bogner, J. A. P. (2003). Early identification of mild traumatic brain injury in female victims of domestic violence. *American Journal of Obstetrics and Gynaecology, 188,* S71-S76.

Costa, D., & Babcock, J. (2008). Articulated thoughts of intimate partner abusive men during anger arousal: Correlates with personality disorder features. *Journal of Family Violence, 23*(6), 395-402.

Corvo, K., & Johnson, P. (2013). Sharpening Ockham's razor: The role of psychopathology and neuropsychopathology in the perpetration of domestic violence. *Aggression and Violent Behaviour, 18*(1), 175 -182.

Covell, C. N., Huss, M. T., & Langhinrichsen-Rohling, J. (2007). Empathic deficits among male batterers: A multidimensional approach. *Journal of Family Violence, 22,* 165-174.

Cox, A. L., Coles, A. J., Nortje, J., Bradley, P. G., Chatfield, D. A., Thomson, S. J., & Menon, D. K. (2006). An investigation of auto-reactivity after head-injury. *Journal of Neuroimmunology, 174*(1-2), 180-186.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches.* Thousand Oaks: Sage Publication.

Crowell, N. A., & Burgess, A. W. (1996). *Understanding violence against women*. Washington: National Academy Press.

Daigneault, L., Herbert, M., & McDuff, P. (2009). Men's and women's childhood sexual abuse and victimization in adult partner relationships: A study of the risk. *Journal of Family Violence, 17*(4), 377-389.

Daly, K., & Chesney-Lind, M. (1988). Feminism and criminology. *Justice Quarterly, 5*(4), 497-538.

Davies, D., & Dodd, J. (2012). *Qualitative research and the question of rigor*. School of Social Inquiry. Murdoch University, Perth, Western Australia.

Davies, P. T., & Woitach, M. J. (2008). Children's emotional security in the interparental relationship. *Current Directions in Psychological Science, 17*(4), 269-274.

Dejonghe, E. S., von Eye, A., Bogat, G. A., & Levendosky, A. A. (2011). Does witnessing intimate partner violence contribute to toddlers internalising and externalising behaviours? *Applied Developmental Science, 15*(3), 129-139.

DeKeseredy, W. S. (2011). Feminist contributions to understanding woman abuse: Myths, controversies, and realities. Faculty of Social Science and Humanities. *Aggression and Violent Behaviour, 16*(4), 297-302

DeKeseredy, W. S., & Dragiewicz, M. (2007). Understanding the complexities of feminist perspectives on woman abuse: A commentary on Donald G. Dutton's rethinking domestic violence. *Violence Against Women, 12*(8), 874-884.

DeKeseredy, W. S., & Schwartz, M. D. (1996). *Contemporary criminology.* Belmont: Wadsworth.

Delsol, C., & Margolin, G. (2004). The role of family-of-origin violence in men's marital violence perpetration. *Clinical Psychology Review, 24*(1), 99-122.

Denzin, N. K., & Lincoln, Y. S. (1994). *Handbook of qualitative research.* Newbury Park: Sage Publications.

Department of Social Development (2009). *National policy guidelines for victim empowerment. Pretoria.* Department of Social Development.

Devries, K. M., Mak J. Y T., Garcia-Morenco, C., Petzold, M., Child, J. C., Falder, G., Lim, S., Bacchus, L. J., Engell, R. E., Rosenfeld, L., Pallitto, C., Vos, T., Abrahams, N., & Watts, C. H. (2013). The global prevalence of intimate partner violence against women. *Science, 340*(6140), 1527-1528.

Devries, K. M., Kishor, S., Johnson, H., Stockl, H., Bacchus, L. J., Garcia-Moreno, C., & Watts, C. (2010). Intimate partner violence during pregnancy: Analysis of prevalence data from 19 countries. *Reproductive Health Matters, 18*(36), 158-170.

Diop-Sidibe, N., Cambell, J. C., & Becker, S. (2006). Domestic violence against women in Egypt – wife beating and health outcomes. *Social Science and Medicine, 62*(5), 1260–1277.

Dillon, G., Hussain, R., Loxton, D., & Rahman, S. (2013). Mental and physical health and intimate partner violence against women: A review of the literature. *International Journal of Family Medicine, 2013*:313909.

Dixon, L., & Browne, K. (2003). The heterogeneity of spouse abuse: A review. *Aggression and Violent Behaviour, 8*(1), 107-130.

Dixon, L., & Graham-Kevan, N. (2011). Understanding the nature and etiology of intimate partner violence and implications for practice and policy. *Clinical Psychology Review, 31*(7), 1145-1155.

Dobash, R. E., & Dobash, R. P. (1979*). Violence against wives: A case against the patriarchy.* New York: Free Press.

Drapeau, M., & Perry, J. C. (2009). The core conflictual relationship themes (CCRT) in borderline personality disorder. *Journal of Personality Disorders, 23*(4), 415-431.

Dutton, D. G. (2006). *Rethinking domestic violence.* Vancouver: University of British Colombia.

Dutton, D. G., & Starzomski, A. J. (1994). Psychological differences between court-ordered and self-referred wife assaulters. *Criminal Justice and Behaviour: An Intentional Journal, 21*(2), 203-222.

Dutton, D. G., & Hart, S. D. (1992). Evidence for long-term specific effects of childhood abuse and neglect on criminal behaviour in men. *International Journal of Offender Therapy, 36*(2), 161-171.

Edin, K. E., Dahlgren. L., Lalos, A., & Hogberg. U. (2010). Keeping up a front: Narratives about IPV, pregnancy, and antenatal care. *Violence Against Women, 16*(2), 189-206.

Edwards, D. W., Scott, C. L., Yarvis, R. M., Paizis, C. L., & Panizzon, M. S. (2003). Impulsiveness, impulsive aggression, personality disorder, and spousal violence. *Violence and Victims,* 18*(1),* 3–14.

Ehrensaft, M. K., Cohen, P., & Johanson, J. G. (2006). Development of personality disorder symptoms and the risk for partner violence. *Journal of Abnormal Psychology, 115*(3), 474-483.

Ehrensaft, M. K., Cohen, P., Brown, J., Smailes, E., Chen, H. N., & Johnson, J. G. (2003). Intergenerational transmission of partner violence: A 20-year prospective study. *Journal of Consulting and Clinical Psychology, 71*(4), 741–753.

El-Bassel, N., Gilbert, L., Wu, E., Go, H., & Hill, J. (2005). Relationship between drug abuse and intimate partner violence: A longitudinal study among women receiving methadone. *American Journal of Public Health, 95*(3), 465-470.

El-Bassel, N., Gilbert, L., & Witte, S. (2003). Intimate partner violence and substance abuse among minority women receiving care from an inner-city emergency department. *Women's Health Issues, 13*(1), 16-22.

Ellis, G. F. R., Stein, D. J., Thomas, K. G. F., & Meintjes, E. M. (2012). *Substance use and abuse in South Africa*: *Insights from brain and behavioural sciences.* Cape Town: UCT Press.

England, C. (2007). The battered women's syndrome: A history and interpretation of the law of self-defence as it pertains to battered women who kill their husbands. *Humanities and Social Sciences, 3*(1).

Fals-Stewart, W. (2003). The occurrence of partner physical aggression on days of alcohol consumption. *Journal of Consulting and Clinical Psychology, 71,* 41-52.

Fals-Stewart, W., Golden, J., & Schumacher, J. A. (2003). Intimate partner violence and substance use: A longitudinal day-to-day examination. *Addictive Behaviours, 28*(9), 1555-1574.

Farrokh-Eslamlou, H., Oshnouei, S., & Haghighi, N. (2014). Intimate partner violence during pregnancy in Urmia, Iran in 2012. *Journal of Forensic and Legal Medicine, 24*, 28-32.

Ferguson, C. J. (2006). *Violence against women as a public health issue, 1087,* 235-249. New York.

Fontes, L. A., (2004). Ethics in violence against women research: The sensitive, the dangerous and the overlooked. *Ethics and Behaviour, 14*(2), 141–174.

Fowler, K. A., & Western, D. (2011). Subtyping male perpetrators of intimate partner violence. *Journal of Interpersonal Violence, 26*(4), 607-639.

Foyster, E. (2005). *Marital violence: An English family history, 1660-1857*. Cambridge University Press.

Ganley, A. L. (2002). Understanding domestic violence: Preparatory reading for participants. *Family Violence Prevention Fund.*

Ganley, A., & Hobart, M. (2010). *Social Worker's Practice Guide to Domestic Violence,* (February), 1–94. Retrieved from: http://www.wscadv.org/docs/Social_Workers_Practice_Guide_to_DV_Feb_2010.pdf%5Cnpapers2://publication/uuid/DFFC9DF2-FDB2-4EB0-B715-73A016EF8944

Gass, J. D., Stein, D, J., Williams, D. R., & Seedat, S. (2011). Gender differences in risk for intimate partner violence among South African adults. *Journal of Interpersonal Violence, 14,* 2764-2789.

Gelles, R. J., & Maynard, P. E. (1987). A structural family systems approach to intervention in cases of family violence. *Family Relations: An Interdisciplinary Journal of Applied Family Studies, 36*(3), 270-275.

Gellman, M. D., & Turner, J. R. (2013). *Psychosocial factors and traumatic events*. Encyclopaedia of Behavioural Medicine. Springer: New York.

Gehz, M. (2001). *Getting the message out: Using media to change social norms on abuse.* Sourcebook on Violence against Women. Thousand Oaks.

Giancola, P. R. (2000). Executive functioning and alcohol related aggression. *Journal of Abnormal Psychology, 113*(4), 541-555.

Gibbons, P., Collins, M., & Reid, C. (2011). How useful are the indices of personality pathology when assessing domestic violence perpetrators. *Psychological Assessments, 23*(1), 164-173.

Gilbert, F., & Daffern, M. (2011). Illuminating the relationship between personality disorder and violence: Contributions of the general aggression mode. *Psychology of Violence, 1*(3), 230-244.

Gilchrist, E., Johnson, R., Takriti, R., Weston, S., Beech, A., & Kebbell, M. (2003). Domestic violence offenders: Characteristics and offending related needs. *Research, Development and Statistics Directorate, 217.*

Giorgi, A. (2005). The phenomenological movement and research in the human sciences. *Nursing Science Quarterly, 18*(1), 75-82.

Goldstein, R. B., Dawson, D. A., & Saha, T. D. (2007). Antisocial behaviours syndromes and DSM-IV alcohol use disorders: Results from the National Epidemiologic Survey on alcohol and related conditions. *Alcohol: Clinical and Experimental Research, 31*(5), 814-828.

Gondolf, E. W., & Fisher, E. R. (1988). *Battered women as survivors: An alternative to treating learned helplessness.* Lexington Books.

Goodman, L. S., Hardman, J. G., Limbird, L. E., & Gilman A. G. (2001). *The pharmacological basis of therapeutics*. New York: McGraw-Hill.

Gottfredson, D.C., Kearley, B.W., & Bushway, S. D. (2008). Substance use, drug treatment, and crime: An examination of intra-individual variation in a drug court population. *Journal of Drug Issues, 0022-0426/08/02,* 601-630.

Gover, A. R. (2009). *21st Century criminology: a reference handbook: Domestic violence.* Sage Publications.

Graham-Bermann, S. A., Howell, K. H, Habarth, J., Krishnan, S., Loree, A., & Bermann, E. A. (2008). Toward assessing traumatic events and stress symptoms in preschool children from low income families. *American Journal of Orthopsychiatry, 78*(2), 220-228.

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods, 3*(1).

Guba, E. G., & Lincoln, Y. S. (1994). *Competing paradigms in qualitative research.* Handbook of qualitative research. Thousand Oaks. Sage Publication.

Gumani, M., & Mudhovozi, P. (2013) Gender-based violence: Opportunities and coping resources for women in abusive unions. *Gender & Behaviour, 11*(2), 5569-5578.

Gunderson, J. G. (2010). Revising the borderline diagnosis for DSM-V: An alternative proposal. *Journal of Personality Disorders, 24,* 694-708.

Gurman, A.S., & Kniskern, D. P. (1981). *Handbook of family therapy, 1.* New York. Brunner and Mazel.

Hales, R. E., Yudofsky, S. C., & Roberts, L. W. (2014). *The American Psychiatric Publishing Textbook of Psychiatry*. (DSM-5 Edition). Sixth Edition.

Hamber, B. (2010). Masculinity and transition: crisis or confusion in South Africa. *Journal of Peacebuilding and Development, 5*(3), 1542-3166.

Hamber, B., Hillyard, P., Maguire A., McWilliams M., Robinson, M., Russel, G., & Ward, M. (2006). Discourses in transition: Re-imagining women's security. *International Relations, 20*(4), 487-502.

Hamberger, L. K., Lohr, J. M., Bonge, D., & Tolin, D. F. (1996). A large sample empirical typology of male spouse abusers and its relationship to dimensions of abuse. *Violence and Victims, 11*, 277-292.

Hanson, R., Cadsky, O., Harris, A., & Lalonde, C., (1997). Correlates of battering among 997 men: Family history, adjustment attitudinal differences. *Violence and Victims, 12,* 191-208.

Harper, F. W. K., & Arias, I. (2004). The role of shame in predicting adult anger and depressive symptoms among victims of child psychological maltreatment. *Journal of Family Violence, 19*, 359-367.

Harris, M., (1976). History and significance of the emic /etic distinction. *Annual Review of Anthropology, 5,* 329-350.

Hedtke, K. A., Ruggiero, K. J., Fitzgerald, M. M., Zinzow, H. M., Saunders, B. E., & Resnick, H. S. (2008). A longitudinal investigation of interpersonal violence in relation to mental health and substance use. *Journal of Consult and Clinical Psychology, 76,* 633-647

Heise, L. L. (1998). Violence against women: An integrated, ecological framework. *Violence Against Women, 4*(3), 262-290.

Heise, L., & Garcia-Moreno, C. (2002). Violence by intimate partners. *World Report on Violence and Health. Geneva, Switzerland: World Health Organisation*.

Helweg-Larsen, K., & Kruse, M. (2003). Violence against women and consequent health problems: A register-based study. *National Institute of Public Health, 31*(1), 51-57.

Henning, K., & Renauer B. (2005). Prosecution of women arrested for intimate partner abuse. *Violence and Victims, 20*(3), 171-189.

Henry, J. D., Mazur, M., & Rendell, P. G. (2009). Social-cognitive difficulties in former users of methamphetamine dependent individuals. *Psychopharmacology, 201*(2), 183-193.

Herman, H., & Jane-Llopis, E. (2005). Mental health promotion in public health. *Global Health Promotion, 12*(2), 42-47.

Herrick, C. (2012). The political ecology of alcohol as 'disaster' in South Africa's Western Cape. *Geoforum, 43*(6), 1045-1056.

Hertzog, S. (2007). An empirical test of feminist theory and research. The effect of heterogeneous gender-role attitudes on perceptions of intimate partner violence. *Feminist Criminology, 2*(3), 223-244.

Heru, A.M., S Stuart, G.L., Rainey, S., Eyre, J., Recupero, P. R., & Ryan, P. (2006). Prevalence of severity of intimate partner violence and associations with family functioning and alcohol abuse in psychiatric inpatients with suicidal intent. *The Journal of Clinical Psychiatry, 67*(1) 23-29.

Heyman, R. E., & Slep-Smith, A. M. (2002). Do child abuse and interparental violence lead to adulthood family violence? *Journal of Marriage & Family, 64*(4), 864-870.

Hindin, M. J., & Adair, L. S. (2002). Who's at risk? Factors associated with intimate partner violence in the Philippines. *Social Science and Medicine, 55*(8), 1385-1399.

Hines, D. A. (2008). Borderline personality traits and intimate partner aggression: An international multisite, cross-gender analysis. *Psychology of Women Quarterly, 32*(3), 290-302.

Hines, D. A., & Saudino, K. J. (2002). Intergenerational transmission of intimate partner violence: A behavioural genetic perspective. *Trauma, Violence and Abuse, 3*(3), 210-225.

Holloway, I., & Wheeler, S. (2002). *Qualitative research in nursing, 2nd edition.* Blackwell Publishing.

Holtzworth-Munroe, A. (2000). A typology of men who are violent toward their female partners: Making sense of heterogeneity in husband violence. *Current Directions in Psychological Science, 9*(4), 140-143.

Holtzworth-Munroe, A., Meehan, J. C., Herron, K., Rehman, U., & Stuart, G. L. (1994). Testing the Holzworth-Munroe and Stuart battered typology. *Journal of Consulting and Clinical Psychology, 68*(6), 1000-1019.

Homer, B. D., Solomon, T. M., Moeller, R. W., Mazcia, A., De Raleau, L., & Halkitis, P. N. (2008). Methamphetamine abuse and impairment of social functioning: A review of the underlying neurophysiological causes and behavioural implications. *Psychological Bulletin, 134*(2), 301-310.

Hooks, B. (2000). *Feminist theory: From margin to centre.* New York: South End Press.

Howard, C. J. (2012). Neurobiological correlates of partner abusive men: Equifinality in perpetrators of intimate partner violence. *Psychological Trauma: Theory, Research, Practice and Policy, 4*(3), 330-337.

Howell, K. H., Graham-Bermann, S. A., Czyz, E., & Lily, M. (2010). Assessing resilience in preschool-age children exposed to intimate partner violence. *Violence and Victims, 25*(2), 150-164.

Husserl, E. (1963). *Ideas: A general introduction to pure phenomenology*. New York.

Hycner, R. H. (1999). Some guidelines for the phenomenological analysis of interview data. In A. Bryman & R. G. Burgess (Eds.), *Qualitative research, 3*, 143-164. London: Sage.

Hycner, R. H. (1985). Some guidelines for the phenomenological analysis of interview data. *Human Studies, 8*(3), 279–303. doi: 10.1007/BF00142995

Hyde-Nolan, M. E., & Juliao, T. (2012). *Theoretical basis for family violence.* Jones & Bartlett Learning.

Iverson, L. L. (2000). *The science of marijuana.* New York: Oxford University Press.

Jackson, Y. (2006). *Encyclopedia of multicultural psychology: Domestic violence.* Sage Publications.

Jewkes, R., Levin, J. B., & Penn-Kekana, L. A. (2002). Risk factors for domestic violence: Findings from a South African cross-sectional study. *Social Science and Medicine, 55*, 1603-1617

John, R., Johnson, J. K., Kukreja, S., Found, M., & Lindow, S. W. (2004). Domestic violence: Prevalence and association with gynaecological symptoms. *An International Journal of Obstetrics and Gynaecology, 111*(10), 1128-1132.

Johnson, K. B., & Das, M. B. (2009). Spousal violence in Bangladesh as reported by men. Prevalence and risk factors. *Journal of Interpersonal Violence, 24*(6), 977-995.

Johnson, M. P., & Leone, J. M. (2005). The differential effects of intimate terrorism and situational couple violence: Findings from the National Violence against women survey. *Journal of Family Issues, 26*(3), 322-349.

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher, 33*(7), 14-26.

Johnson, H. (2001). Contrasting views of the role of alcohol in cases of wife assault. *Journal of Interpersonal Violence, 16*(1), 54-72.

Joyner, K., Rees, K., & Honikman, S. (2015). Intimate Partner Violence (IPV) in South Africa: How to break the vicious cycle. *Perinatal Mental Health.*

Kaplow, J. B., & Wisdom, C. S. (2007). Age of onset of child maltreatment predicts long-term mental health outcomes. *Journal of Abnormal Psychology, 116*(1), 176-187.

Keen, E. (1975). *A primer in phenomenological psychology.* New York: Holt, Reinhart and Winston, Inc.

Kendall, T., Pilling, S., Tyrer, P., Duggan, C., Burbeck, R., Meader, N., & Taylor, C. (2009). Borderline and antisocial personality disorders: Summary of NICE guidance. *BMJ, 338.*

Kendler, K. S., Gardner, C. O., & Prescott, C. P. (2002). Toward a comprehensive developmental model of major depression in women. *American Journal of Psychiatry, 159*(7), 1133-1145.

Kernic, M. A., Wolf, M. E., Holt, V. L., McKnight, B., Huebner, C. E., & Rivara, F. P. (2003). Behavioural problems among children whose mothers are abused by an intimate partner. *Child Abuse and Neglect, 27*(11), 1231-1246.

Kernsmith, P. (2005). Treating perpetrators of domestic violence: Gender differences in the applicability of the theory of planned behaviour. *Sex Roles, 52*(11-12), 757-770.

Kim, J., & Motsei, M. (2002). Women enjoy punishment: Attitudes and experiences of gender-based violence among PHC nurses in rural South Africa. *Social Science & Medicine, 54,* 1243-1254.

Kimber, M., Adham, S., Gill. S., McTavish, J., & MacMillan, H. L. (2017). The association between child exposure to intimate partner violence (IPV) and perpetration of IPV in adulthood – a systematic review. *Child Abuse and Neglect, 76,* 273-386.

Klostermann, K., Kelley, M. K., Mignone, T., Pusateri, L., & Fals-Stewart, W. (2010). Partner violence and substance abuse: Treatment interventions. *Aggression and Violent Behaviour, 15*(3), 162-166.

Klostermann, K., & Fals-Stewart, W. (2005). Intimate partner violence and alcohol use: Exploring the role of drinking in partner violence and its implications for intervention. *Aggression and Violent Behaviour, 11*(6), 587-597.

Koob, G. F. (2009). Dynamics of neuronal circuits in addiction: Reward, anti-reward, and emotional memory. *Pharmacopsychiatry, 42*(1), S32-S41.

Kraanen, F. L., Emmelkamp, P. M. G., & Scholing, A. (2014). Substance use disorders in forensic psychiatry: Differences among different types of offenders. *International Journal of Offender Therapy and Comparative Criminology, 56*(8), 1201-1219.

Langford, D. R. (2000). Developing a safety protocol in qualitative research involving battered women. *Qualitative Health Research, 10*(1), 133-142.

Latalova, K., & Prasko, J. (2010). Aggression in borderline personality disorder. *Psychiatric Quarterly, 81*(3), 239-251.

Lawson, D. (2003). Incidence, explanations, and treatment of partner violence. *Journal of Counselling and Development, 81*(1), 19-32.

Le, B. T., Dierks, E. J., Ueeck, B. A., Homer, L. D., & Potter, B. F. (2001). Maxillofacial injuries associated with domestic violence. *Journal of Oral and Maxillofacial Surgery, 59*(11), 1277-1283.

Leburu, G., & Phetlho-Thekisho N. (2015). Reviewing gender based violence against women and HIV/AIDS as intersecting issues. *Social Work, 51*(3), 455.

Leggett, T. (2001). Drugs, sex work and HIV in three South African cities. *Society in Transition, 32*(1) 101-109.

Leichsenring, F., Leibing, E., Kruse, J., New, A. S., & Leweke, F. (2011). Borderline personality disorder. *Lancet, 377(*9759), 74-84.

Leonard, K. E. (2001). Domestic violence: What is known and what do we need to know to encourage environmental interactions. *Journal of Substance Use, 6*(4), 235-247.

Leung, L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care, 4*(3), 324-327.

Lieberman, A. F., & Van Horn, P. (2008). *Psychotherapy with infants and young children.* New York, NY: Guilford Press.

Lopez, K. A., & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: their contributions to nursing knowledge. *Qualitative Health Research, 14*(5), 726-735.

Loseke, D. R., Gelles, R. J., & Cavanaugh, M. M. (2005). *Current controversies on family violence*. Sage: Thousand Oaks.

Lowenstein, J. (2016). *Borderline personality disorder and emotion dysregulation.* ISSN: 2051-6673.

Machisa, M., Jewkes, R., Lowe Morna, C., & Rama, K. (2010). The war at home. *Gender based violence indicators project.* Gender Links.

Madras, B. K., Miller, G. M., & Fischman, A. J. (2005). The dopamine transporter and attention-deficit/hyperactivity disorder. *Biological Psychiatry, 57*(11), 1391-1409.

Maneta, E. K., Cohen, S., Schulz, M. S., & Waldinger, R. J. (2013). Two to tango: A dyadic analysis of links between borderline personality traits and intimate partner violence. *Journal of Personality Disorders, 27*(2) 233-243.

Maisto, S. A., Galizio, M., & Connors G. J. (2008). *Drug use and abuse.* Fifth edition. Thomson, Wadsworth.

Marciniak, L. M. (1998). Adolescent attitudes toward victim precipitation of rape. *Violence and Victims, 12*(3), 287-300.

Margolin, G., & Vickerman K. A. (2007). Posttraumatic stress in children and adolescents exposed to family violence: Overview and issues. *Professional Psychology: Research and Practice, 38*(6), 620-628.

Marsh, N. V., & Marinovich, W. M. (2006). Executive dysfunction and domestic violence. *Brain Injuries, 20*(1), 61-66.

Mathison, S. (1988). Why triangulate? *Educational Researcher, 17*(2), 13-17.

Maurico, A. M., Tein, J. Y., & Lopez, F. G. (2007). Borderline and antisocial personality scores as mediators between attachment and intimate partner violence. *Violence and Victims. 22*(2), 139-157.

Mauradian, V. E. (2007). Abuse in intimate relationships: Defining the multiple dimensions and terms. *National Violence Against Women Prevention Research Center.* Wellesley College.

Maxwell, J. A. (2006). *Qualitative research design: An interactive approach.* Thousand Islands: Sage Publications.

McKnight., J. (2008). Through the fear: A study of xenophobia in South Africa's refugee system. *Journal of Identity and Migration Studies 2*(2), 18–42.

McMahon, M., & Pence, E. (1995). *Ending the cycle of violence: Community responses to children of battered women.* Children and Violence. Thousand Oaks, CA: Sage.

Mcphail, B. A., Busch, N. B., Kulkarni, S., & Rice, G. (2007). An integrative model. The evolving feminist perspective on intimate partner violence. *Violence Against Women, 13*(8), 817-841.

Mechanic, M., Weaver, T. L., & Resick, P. (2000). Intimate partner violence and stalking behavior: Exploration of patterns and correlates in a sample of acutely battered women. *Violence Victims, 15*(1), 55-72.

Mehrjerdi, Z. A., Noroozi, A., Barr, A. M., & Ekhtiari, H. (2012). Attention deficits in chronic methamphetamine users as a potential target for enhancing treatment efficacy. *Basic and Clinical Neuroscience, 3*(4), 5-14.

Meredith, C. W., Jaffe, C., Ang-Lee, K., & Saxon, A. J. (2005). Implications of chronic methamphetamine use: A literature review. *Harvard Review of Psychiatry, 13*(3), 141-154.

Merriam, S. B. A. (1995). What can you tell from an N of 1?: Issues of validity and reliability in qualitative research. *PAACE Journal of Lifelong Learning, 4*, 51-60.

Merrick, E. (1999). *An exploration of quality in qualitative research: Are reliability and validity relevant?* Sage Publications.

Messerschmidt, J. W. (1993). *Masculinities and crime: Critique and reconceptualization of theory.* Lanham: Roman & Littlefield.

Mertens, D. M. (2005). *Research methods in education and psychology: integrating diversity with quantitative and qualitative approaches*. Thousand Oaks: Sage Publications.

Miller, W. R. (2012). *The social history of crime and punishment in America: An encyclopaedia.* General Criminology & Criminal Justice, History of Crime. Sage Publications.

Mogale, R. S., Burns, K. K., & Richter, S. (2012). Violence against women in South Africa: Policy position and recommendations. *Faculty of Nursing, 18*(5), 580-594.

Monahan, J., Steadman, H., Silver, E., Appelbaum, P., Robbins, P., & Mulvey, E. (2001). *Rethinking risk assessment: The MacArthur study of mental disorders and violence.* New York: Oxford University Press.

Moore, T. M., Stuart, G. L., Meehan, J. C., Rhatigan, D. C. L., Hellmuth, J., & Keen, S.M. (2008). Drug abuse and aggression between intimate partners: A meta-analytic review. *Clinical Psychology Review, 28*(2), 247-274.

Moore, T. M., & Stuart, G. L. (2005). A review of the literature on marijuana and interpersonal violence. *Aggression and Violent Behaviour, 10*, 171-192.

Moore, T. M., & Stuart, G. L. (2003). Illicit substance use and intimate partner violence among men in batterer's intervention. *Psychology of Addictive Behaviours, 18*(4), 285-389.

Moshe, A. (2013). *Family systems theory: psychotherapy; extramarital intercourse, separation and anxiety.* Psychotherapy & Psychotherapeutic Counselling. American Psychological Association.

Mosquera, D., Gonzalez, A., & Leeds, A. M. (2014). Early experience, structural dissociation, and emotional dysregulation in borderline personality disorder: The role of insecure and disorganised attachment. *Borderline personality disorder and emotion dysregulation, 1*(15).

Mouradian, V. E. (2007). *Abuse in intimate relationships: defining the multiple dimensions and terms.* National Violence against Women Prevention Research Center. Wellesley College.

Mudavanhu, N., & Schenck, R. (2015). Substance abuse among the youths of Grabouw Western Cape: Voices from the community. *Social Work, 50*(3), 370-392.

Murray, C. (2006). Controversy, constraints, and context: understanding family violence through family systems theory. *The Family Journal: Counselling and Therapy for Couples and Families, 14*(3), 234-239.

Mutch, C. (2005). D*oing educational research: a practitioner's guide to getting started.* Wellington: NZCER Press.

NACOSA. (2015). *Guidelines and standards for the provision of support to rape survivors in the acute stage of trauma.* NACOSA.

Naeem, F., Irfan, M. A., Zaidi, Q. A., Kingdon, D., & Ayub, M. (2008). Angry wives, abusive husbands: Relationship between domestic violence and psychosocial variables. *Jacobs Institute of Women's Health 18*(6), 453-462.

Newhill, C. E., Eack, S. M., & Mulvey, E. P. (2009). Violent behaviour in borderline personality. *Journal of Personality Disorders, 23*(6), 541.

Norlander, B., & Eckhardt, C. I. (2005). Anger, hostility, and male perpetrators of intimate partner violence: A meta-analytic review. *Clinical Psychology Review, 25,* 119-152.

O'Campo, P., Kub, J., & Woods, A. (2006). Depression, PTSD and comorbidity related to intimate partner violence in civilian and military women. *Brief Treatment and Crisis Intervention, 6*(2), 99-110.

Offord, D. R., & Kraemer H. C. (2000). Risk factors and prevention. *Evidence-based mental health, 3*(3), 70 – 71.

Oldham, J. (2006) Borderline personality disorder and suicidality. *American Journal of Psychiatry, 163*(1), 20-26.

Osofsky, J. D. (2003). Prevalence of children's exposure to domestic violence and child maltreatment: implications for prevention and intervention. *Clinical Child and Family Psychology Review, 6*(3), 161-170.

Panenka, W. J., Procyshyn, R. M., Lecomte, T., MacEwan, G. W., Flynn, S. W., & Honer W. G. (2013). Methamphetamine use: A comprehensive review of molecular, preclinical and clinical findings. *Drug and Alcohol Dependence, 129*(3), 167-179.

Paradine, K., & Wilkinson, J. (2004). Police response to domestic violence. *British Journal of Criminology, 40*(1), 14-36.

Parry, C. D. H., Pluddermann, A., Bhana, A., Harker, N., Potgieter, H., & Gerber, W. (2006). *Alcohol and drug abuse trends: January-June 2006.* Retrieved from http://www.sahealthinfor.org/admodule/sacendunov2006.pdf.

Patton, M. Q. (2001). *Qualitative evaluation and research methods. (3rd Edition).* Thousand Oaks: Sage Publications.

Patton, M. Q. (1990). *Qualitative evaluation and research methods (2nd Edition).* Newbury Park: Sage Publications.

Payer, D. E., Lieberman, M. D., Monterosso, J. R., Xu, J. Fong, T. W., & London, E. D. (2008). Differences in cortical activity between methamphetamine-dependent and healthy individuals performing a facial affect matching task. *Drug and Alcohol Dependence, 93(*1-2), 93-102.

Peltzer, K., Ramlagan, S., Johnson, B. D., & Phaswana-Mafuya, N. (2010). Illicit drug use and treatment in South Africa: A review. *Substance Use and Misuse, 45*(13), 2221-2243.

Pence, E., & Paymar, M. (1986). *Power and control: Tactics of men who batter.* Minnesota Program Development.

Perden, M., McGee, K., & Sharma, G. (2002). *The injury chart book: A graphical overview of the global burden of injuries.* World Health Organisation.

Perkel, C. (2005). Cannabis- the debate continues: A South African perspective. *African Journal of Psychiatry, 8*(1), 25-30.

Peters, J., Shackelford, T. D., & Buss, D. M. (2002). Understanding domestic violence against women: Using evolutionary psychology to extend the feminist functional analysis. *Violence and Victims, 17*(2), 255-264.

Petrakis, I. L., Gonzalez, G., Rosenheck, R., & Krystal, J. H. (2002). Comorbidity of alcoholism and psychiatric disorders. *National Institute of Alcohol Abuse and Alcoholism, 26*(2).

Pico-Alfonso, M. A., Garcia-Linares, I. M., Celda-Navarro, N., Blasco-Ros, C., Echeburua, E., & Martinez, M. (2006). The impact of physical, psychological and sexual intimate male partner violence on women's mental health: Depressive symptoms, posttraumatic stress disorder, state anxiety and suicide. *Journal of Women's Health, 15*(5), 599-611.

Pihl, R. O., & Hoaken, P. N. S. (2002). Biological bases to addiction and aggression in close relationships. *The violence and addiction equation. Theoretical and clinical issues in substance abuse and relationship violence.* New York: Brunner-Routledge.

Plichta, S. B. (2004). Intimate partner violence and physical health consequences: policy and practice implications. *Journal of Interpersonal Violence, 19*(11), 1296-1323.

Pluddemann, A., Dada, S., Parry, C., Bhana, A., Perreira, T., Carelsen, A., Kitleli, N., Gerber, W., Rosslee, C., & Fourie, D. (2009). Monitoring alcohol and drugs trends in South Africa (July 1996 – December 2008). *SACENDU Research Brief, 12*(1). Cape Town.

Rakovec-Felser, Z. (2014). Domestic violence and abuse in intimate relationships from a public health perspective. *Health Psychology Research, 2*(3), 1821.

Rappaport, R. A. (1974). Sanctity and adaption. *The Coevolution Quarterly, Summer, 54-68.*

Rataemane, S., & Rataemane, L. (2006). Letter to the editors. Alcohol in South Africa. *International Journal of Drug Policy, 17*, 373-375.

Rawson, R. A., & Condon, T. P. (2007). Why do we need an addiction supplement focused on methamphetamine? *Addiction, 102*(1), 1-4.

Rehm, J., & Parry, C. (2009). Alcohol consumption and infectious diseases in South Africa. *Violence and Injuries in South Africa: Prioritising and Agenda for Prevention, 374*(9707).

Reid, G., & Walker, L. (2005). *Men behaving differently: South African men since 1994.* Culture and Health & Sexuality, 7(3), 225-238.

Riggs, D. S., O'Leary, K. D., & Breslin, E. C. (1990). Multiple correlates of physical aggression in dating couples. *Journal of Interpersonal Violence, 5*(1), 61-73.

Rivara, F. P., Anderson, M. L., Fishman. P., Reid, R. J., Bonomi, A. E., Carrell, D., & Thompson. R. S. (2009). Age, period, and cohort effects on intimate partner violence. *Violence and Victims, 24*(5), 627–638.

Rockmore, T. (1981). *Marxism and alternatives. Towards the conceptual interaction among soviet philosophy, neo-thomism, pragmatism, and phenomenology.* Reidel Publishing Company.

Romanelli, F., & Smith, K. M. (2006). Clinical effects and management of methamphetamine abuse. *Pharmacotherapy, 26*(8), 1148-1156.

Romney, M., Kennedy, B. B., & Flynn, E. A. (2006). *The children of domestic violence. A report to the governor's commission on domestic violence.* Retrieved from, http://www. mass.gov/gcdv.

Ross, J. M., & Babcock, J. C. (2009). Proactive and reactive violence among intimate partner violent men diagnosed with antisocial and borderline personality disorder. *Journal of Family Violence, 24*(8), 607-617.

Rossman, R. B., & Rallis, S. F. (1998). *Learning in the field: An introduction to qualitative research.* Thousand Oaks. Sage Publications.

Rubino, T., Relaini, N., Braida, D., Guidi, S., Capurro, V., Vigano, D., Guidali, C., Printer, M., Sala, M., Bartesaghi, R., & Parolaro, D. (2009). Changes in hippocampal morphology and neuroplasticity induced by adolescent THC treatment are associated with cognitive impairment in adulthood. *Hippocampus, 19*(8), 763-772.

Sadala, M. L. A., & Adorno, R. F. (2001). Phenomenology as a method to investigate the experiences lived: A perspective from Husserl and Merleau-Ponty's thoughts. *Journal of Advanced Nursing, 37*(3), 282-293.

Salkind, N. J. (2005). *Encyclopedia of human development*. Sage Knowledge.

Sakalh, N. (2001). Beliefs about wife beating among Turkish college students: The effects of patriarchy, sexism and sex differences. *Sex Roles, 44*(9-10), 599-610.

Sansone, R. A., & Sansone, L. A. (2012). Borderline personality and externalised aggression. *Innovations in Clinical Neuroscience, 9*(3), 23-26.

Saunders, B., Jim, A., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality and Quantity, 52*(4), 1893-1907.

Satre, D. D., & Wolf, J. P. (2015). Alcohol abuse and substance misuse in later life. *APA Handbook of Clinical Geropsychology, 2,* 121-145.

Schumacher, J. A., Slep, A. M. S., & Heyman, R. E. (2001). Risk factors for male-to-female partner physical abuse. *Aggression and Violent Behaviour, 6*(2-3), 281-352.

Seedat, M., van Niekerk, A., Jewkes, R., Suffla, S., & Ratele, K. (2009). Violence and injuries in South Africa: Prioritising an agenda for prevention. *Lancet, 374*(9694), 1011-1022.

Semple, S. J., Zians, J., Grant, I., & Patterson, T. L. (2005). Impulsivity and methamphetamine use. *Journal of Substance Abuse Treatment, 29*(2), 85-93.

Shepard, M. (1992). Child-visiting and domestic violence. *Child Welfare, 71*(4), 357-365.

Shiu-Thornton, S., Senturia, K., & Sullivan, M. (2005). Like a bird in a cage: Vietnamese women survivors talk about domestic violence. *Journal of Interpersonal Violence, 20*(8), 959-976.

Siegel, R. B. (1994). *The modernisation of marital status law: adjudicating wives rights to earnings.* Yale Law School.

Silva, E. P., Lemos, A. L., Andrade, C. H. S., & Ludermir, A. B. (2018). Intimate partner violence during pregnancy and behavioural problems in children and adolescents: A meta-analysis. *Journal de Pediatria, 94*(5), 471-482.

Simonson, K., & Subich, L. M. (1999). Rape perceptions as a function of gender role traditionality and victim-perpetrator association. *Sex Roles, 40*(7-8), 617-634.

Sitaker, M. (2007). *The ecology of intimate partner violence: Theorized impacts on women's use of violence.* The Haworth Press.

Skuja, K., & Halford, W. (2004). Repeating the errors of our parents? Parental violence in men's family of origin and conflict management in dating couples. *Journal of Interpersonal Violence, 19*(6), 623-638.

Smith, P. H., Homish, G. G., Leonard, K. E., & Collins, R. L. (2013). Marijuana withdrawal and aggression among a representative sample of U.S. marijuana users. *Drug and Alcohol Dependence, 132*(0), 63-68.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods*, 51-80. Thousand Oaks, CA, US: Sage Publications, Inc.

Smith, J. P., & Williams, J. G. (1992). From abusive household to dating violence. *Journal of Family Violence, 7*(2), 153-165.

Smith, M. D. (1990). Patriarchal ideology and wife beating: A test of a feminist hypothesis. *Violence and Victims, 5*(4), 257-273.

Sohal, A., Feder, G., & Johnson, M. (2012). Domestic violence and abuse. *Innovait, 5*(12), 250-758.

Sokoloff, N. J., & Dupont, I. (2005). *Domestic violence at the intersections of race, class, and gender. Challenges and Contributions to Understanding Violence Against Marginalised Women in Diverse Communities.* Sage Publications.

Sommers, I., & Baskin, D. (2006). Methamphetamine use and violence. *Journal of Drug Issues, 36*(1), 77-96.

South African Community Epidemiology Network on Drug Use (SACENDU) (2015). Monitoring alcohol and drug abuse trends in South Africa. Research report. Retrieved from: http://www.sahealthinfo.org/admodule/sacendu.htm

Speziale, H. J. S., & Carpenter, D. R. (2007). *Qualitative research in nursing: Advancing the humanistic imperative.* Philadelphia: Lippincott Williams & Wilkins.

Stanley, B., & Siever, L. J. (2010). The interpersonal dimension of borderline personality disorder: Toward a neuropeptide model. *The American Journal of Psychiatry, 167*(1), 24-39.

Stein, M. B., & Kennedy, C. (2001). Major depressive and posttraumatic stress disorder comorbidity in female victims of intimate partner violence. *Journal of Affective Disorders, 66*(2-3), 133-138.

Stenbacka, C. (2001). Qualitative research requires quality concepts of its own. *Management Decision, 39*(7), 551-555.

Sternberg, K. J., Lamb, M. E., Guterman, E., & Abbott, C. B. (2006). Effects of early and later family violence on children's behaviour problems and depression: A longitudinal, multi-informant perspective. *Child Abuse and Neglect, 30*(3), 283-306.

Stith, S. M., Smith, D. B., Penn, C. E., Ward, D. B., & Tritt, D. (2004). Intimate partner physical abuse perpetration and victimization risk factors: A meta-analytic review. *Aggression and Violent Behaviour, 10,* 65-98.

Stith, S. M., Rosen, K. H., Middleton, K. A., Busch, A. L., Lundeberg, K., & Carlon, R. P. (2000). The intergenerational transmission of spouse abuse: A meta-analytic review. *Aggression and Violent Behaviour, 10,* 65-98.

Straus, S. M. (2008). Dominance and symmetry in partner violence by male and female university students in 32 nations. *Children and Youth Services Review, 30,* 252–275.

Straus, M. A., & Gelles, R. J. (1986). Societal change and change in family violence from 1975 to 1985 as revealed by two national surveys. *Journal of Marriage and the Family, 48,* 465-479.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage Publications, Inc.

Streatfeild, D. (2001). *Cocaine: An unauthorised biography*. New York: St. Martin's Press.

Stuart, G. L., Temple, J. R., Follansbee, K. W., Bucossi, M. M., Hellmuth, J. C., & Moore, T. M. (2008). The role of drug use in a conceptual model of intimate partner violence in men and women arrested for domestic violence. *Psychology of Addictive Behaviours, 22*(1), 12-24.

Stuart, G. L., Ramsey, S. E., Moore, T. M., & Kahler, C. W. (2003). Substance abuse and relationship violence among men court-refereed to batterer intervention programs. *Substance Abuse, 24*(2), 107- 122.

Sulzer, D., Sonders M. S., Poulsen, N. W., & Galli, A. (2005). Mechanisms of neurotransmitter release by amphetamines: A review. *Progress in Neurobiology, 75*(6), 406-433.

Sutherland, C. A., Bybee, D. I., & Sullivan, C. M. (2002). Beyond bruises and broken bones: The joint effects of stress and injuries on battered women's health. *American Journal of Community Psychology, 30*(5), 609-636.

Swanberg, J. E., Logan, T. K., & Macke, C. (2005). Intimate Partner Violence, Employment, and the workplace. Consequences and Future Directions. *Trauma, Violence and Abuse, 6*(4), 286-312.

Swogger, M. T., Walsh, Z., & Kosson, D. S. (2007). Domestic violence and psychopathic traits: Distinguishing the antisocial batterer from other antisocial offenders. *Aggressive Behaviour, 33*(3), 253-260.

Symes, L., Maddoux, J., McFarlane, J., Nava, A., & Gilroy, H. (2014). Physical and sexual intimate partner violence, women's health and children's behavioural functioning: Entry analysis of a seven-year prospective study. *Journal of Clinical Nursing, 23*(19-20), 2909-2918.

Terre Blanche, M., Durrheim, K., & Painter, D. (2006). *Research in practice: Applied methods for the social sciences.* Juta and Company Ltd.

Tjaden, P., & Thoennes, N. (2000). Extent, nature and consequences of intimate partner violence: Findings from the national violence against women survey. *NIJ Research Report.*

Tuli, F. (2011). The basis of distinction between qualitative and quantitative research in social science: Reflection on ontological, epistemological and methodological perspectives. *Ethiopian Journal of Education and Sciences, 6*(1), 97-108.

Turner, H. A., & Kopiec, K. (2006). Exposure to inter-parental conflict and psychological disorder among young adults. *Journal of Family Issues, 27*(2), 131-158.

Ulin, P. R., Robinson, E. T., & Tolley, E. E. (2004). *Qualitative methods in public health: A field guide for applied research.* Jossey-Bass

Ullrich, S., & Coid. J. (2009). Antisocial personality disorder: co-morbid Axis I mental disorders and health service use among a national household population. *Personality and Mental Health, 3*(3), 151-164.

United Nations General Assembly (2006). *In-depth study on all forms of violence against women: report of the secretary general New York.* UN division for the advancement of women.

United Nations Office on Drugs and Crime. (2012). *World drug report.* New York.

University of Washington. (2013). *Learn about Marijuana. Science-based information for the public. Alcohol and Drug Abuse Institute*. Retrieved on September 1, 2014 from http://learnaboutmarijuana.org/factsheets/whatiscannabis.htm.

Vallerand, R. J., Cuerrier, P. D., Pelletier, L. G., & Mongeau, C. (1992). Ajzen and Fishbein's theory of reasoned action as applied to moral behaviour: A confirmatory analysis. *Journal of Personality and Social Psychology, 62*(1), 98-109.

Vandello, J. A., & Cohen, D. (2003). Male honour and female fidelity: Implicit cultural scripts that perpetuate domestic violence. *Journal of Personality and Social Psychology, 84*(5), 997 -1010.

Van Manen, J. (1990). Researching lived experience: Human science for an action sensitive pedagogy. *Phenomenology and Pedagogy, 8,* 361-368.

Vetten, L. (2014). The ghost of family's past: Domestic violence legislation and policy in post-apartheid South Africa. *Empowering Women for Gender Equity, 28*(2), 28-57.

Vetten, L. (2000). Gender, race and power dynamics in the face of social change: Deconstructing violence against women in metropolitan South Africa. *Reclaiming women's spaces: New perspectives on violence against women and sheltering in South Africa.* Nisaa Institute for Women's Development.

Vos, T., Astbury, J., Piers, L. S., Magnus, A., Heenan, M., Stanley, L., Walker, L., Wakefield, A., & Fleming, J. (2009). *Domestic violence.* The Sage Dictionary of Policing. Sage Publications.

Wallace, H. (2002). *Family violence: Legal, medical, and social perspectives.* Social Science. Pearson/Allyn & Bacon.

Wang, L. (2016). Factors influencing attitude towards intimate partner violence. *Aggression and Violent Behaviour, 29,* 72-78.

Walsh, S. L., Donny, E. C., Nuzzo, P. A., Umbricht, A., & Bigelow, G. E. (2010). Cocaine abuse versus cocaine dependence. Cocaine self-administration and pharmacodynamic response in the human laboratory. *Drug and Alcohol Dependence, 106*(1), 28-37.

Walters, G. D. (2014). *Drugs, crime and their relationships. Theory, research practice and policy.* Department of Criminal Justice. Kutztown University.

Waters, E., & Cummings, E. M. (2000). A secure base from which to explore close relationships. *Child development, 71*(1), 164-172.

Watt, M. H., Meade, C. S., Kimani, S., MacFarlane, J. C., Choi, K. W., Skinner, D., Pieterse, D., Kalichman, S. C., & Sikkema, K. J. (2013). The impact of methamphetamine ("tik") on a peri-urban community in Cape Town, South Africa. *International Journal of Drug Policy, 25*(2), 219-225.

Weber, M. (1968). *Economy and Society: An outline of interpretative sociology.* New York: Bedminster Press.

White, H. R., & Chen, P. H. (2002). Problem drinking and intimate partner violence. *Journal of Studies on Alcohol, 63*(2), 205-214.

Whitefield, C., Anda, R. F., Dube, S. R., & Felitti, V. J. (2003). Violent childhood experiences and the risk of intimate partner violence in adults. Assessment in a large health maintenance organisation. *Journal of Interpersonal Violence, 18*(2), 166-185.

Widiger, T. A. (2012). *The Oxford Handbook of Personality Disorders*. Oxford Library of Psychology. Oxford University Press.

Williams, J. R., Ghandour, R. M., & Kub, J. E. (2008). Female perpetration of violence in heterosexual intimate relationships: Adolescence through adulthood. *Trauma Violence Abuse, 9*(4), 227-249.

Winter, G. (2000). A comparative discussion of the notion of 'validity' in qualitative and quantitative research. *The Qualitative Report 4*(3), 1-14.

Wolfe, D. A., Crooks, C. V., Lee, V., McIntyre-Smith, A., & Jaffe, P. G. (2003). The effects of children's exposure to domestic violence: A meta-analysis and critique. *Clinical Child and Family Psychology Review, 6*(3), 171-187.

World Health Organisation. (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence.* World Health Organisation.

Xie, H, Farmer T. W., & Cairns B. D. (2003). Different forms of aggression among inner-city African American children: Gender configurations and school social networks. *Journal of School Psychology, 41*(5), 255-375.

Yoshihama, M. (2000). Reinterpreting strength and safety in a socio-cultural context: Dynamics of domestic violence and experiences of women of Japanese descent. *Children & Youth Services Review, 22*(3-4), 207-229.

Yount, K. M. (2005). Resources, family organization, and domestic violence against married women in Minya, Egypt. *Departments of Global Health and Sociology, 67*(3), 579-596. doi.org/10.1111/j.1741-3737.2005.00155.x

Yllo, K. A. (1993). *Through a feminist lens: Gender, power and violence.* In: Gelles, R. J., Loseeke, D. R., eds. Current Controversies on Family Violence. Sage Publications.

Yllo, K. A., & Bograd, M. (1988). *Feminist perspective on wife abuse: An introduction*. Sage Publications.

Zanarini, M. C., Frankenburg, F. R., Reich, D. B., Hennen, J., & Silk, K. R. (2005). Adult experiences of abuse reported by borderline patients and Axis II comparison subjects over six years of prospective follow-up. *Journal of Nervous and Mental Disease, 193*(6), 412-416.

Zweben, J., Cohan, J., Galloway, C. D., Salinardi, M., Parent, D., & Iguchi, M. (2004). Psychiatric symptoms in methamphetamine users. *American Journal on Addictions, 13*(2), 181-190.

APPENDICES

Appendix A: Research form – Participant Copy

My name is Cherie Dreyer and I am registered as a Master's student in Psychology at the University of South Africa (Unisa). As part of the Master's course I am required to complete a research project. The aim of conducting this research is to describe Tshwane-based South African women's lived experiences of domestic violence and to identify the psychosocial risk factors (e.g. alcohol and drug abuse, violence in the family of origin, personality factors) that are associated, and contribute to domestic violence. My hope is that this research may benefit and be helpful to professionals and lay people (people who are not an expert in a particular field of study) who deal with related issues.

For quality assurance purposes only, the interview will be made available to my dissertation supervisor, Prof. Juan Nel. There will be no personally identifiable details (e.g. name, surname and address) that will be provided only general information so as to protect your anonymity.

Your name will not be recorded anywhere on the transcribed interview, and no one will be able to link the information to you. All personal information will remain strictly confidential.

The interview will last around one hour. I would like you to be as open and honest as possible in answering the questions I pose to you. Some questions may be of a personal and/or sensitive nature. I will also ask some questions that you may not have thought about before and which involve thinking about the past or future. Even if you are not absolutely certain about the answers to these questions, try to think about them and answer as best you can. When it comes to answering these questions there are no right or wrong answers.

Your participation in this research project is absolutely voluntary. If you do not wish to answer a specific question you may refrain from doing so. Even if you agreed to participate initially you may stop at a later stage and discontinue your participation. If you refuse to participate or withdraw at any stage, you will not be prejudiced in any way.

If I ask a question that makes you feel sad or upset, we can stop the interview. There are also people to whom I can refer, you to and who are willing and able to talk it through with you if that is your wish. If you need to speak with anyone at a later stage a professional at the Unisa psychotherapy clinic can be reached at the following telephone number: (012) 429 8390 or LifeLine Pretoria: (012) 804 3619.

I may require (an) additional interview/s at a later stage and may also like to discuss my findings and proposals around the research with you. An electronic copy of a summary of my research findings will be made available once the research has been completed.

If you have any other questions relating to my study please feel free to contact my dissertation supervisor Prof. Juan Nel, at the University of South Africa via email: nelja@unisa.ac.za

Appendix B: Interview Schedule

Establish Rapport

My name is Cherie Dreyer and I am registered as a Master's Degree student in Psychology at the University of South Africa (Unisa). As part of the Master's course I am required to complete a research project. The aim of conducting this research is to describe Tshwane-based South African women's experiences with domestic violence and to identify which risk factors in their intimate relationships may have contributed to the occurrence thereof.

I would like to ask you questions about your background, your education, and some experiences you have had with domestic violence in order to learn more about you. I will share this information strictly confidentially and anonymously in my dissertation. In essence this means that I will not share your identity in any manner whatsoever and I will remove all identifying details and replace them with pseudonyms.

The interview should last around 60 – 90 minutes.

Information around conducting the interview

Because semi-structured interviews are conducted with a fairly open framework which allows for two-way communication not all my questions will be designed ahead of time. I will have a list of key point/questions that I would like to cover but most of my questions will be formulated during the interview. This will allow both myself and the person being interviewed the flexibility to go into details when needed. The following set of questions will only serve as a guideline which I may stray from depending on how the interviewee responds. I will change the order of the questions and leave out questions that may appear redundant during the interview. The main idea is to get the interviewee to talk freely and openly while I make sure that I get the in-depth information on what I am researching.

Guideline Questions:

1. How long have you lived in Tshwane?
2. How old are you?
3. Can you please describe your educational background?
4. Can you please describe your immediate family?
   (a) Are you married, divorced or in a committed relationship?
5. How many children do you have, if any?

I would like to proceed with questions of a more personal nature which are specifically focused on domestic violence. You may refrain from answering any questions that makes you feel uncomfortable.

6. Please tell me the story of the first encounter you have had with domestic violence?
   (b) Can you please elaborate on your experiences with domestic violence?
7. What is your relationship with the abuser(s)?
8. Can you please tell me about some of the good and bad experiences you have had with your abusive partner(s)?
9. How would you describe the seriousness of the problems in that relationship?
   (a) Elaborate please?
10. How long have you had or are you still having problems in that relationship?
    (a) Elaborate please?
11. Can you please tell me about a typical argument between yourself and the abusive partner?
12. Can you please describe one of the worst arguments you have had with the abusive partner?

13. Can you please describe which forms the abuse took e.g. physical, emotional, sexual and or financial?
14. How would you describe the frequentness of abuse over the course of your relationship?
15. How has domestic violence affected your life, if at all?

Research has shown that domestic violence perpetrators tend to score higher on measures of anger, hostility and antisociality.

16. What are your thoughts regarding this in relation to your own experiences?
17. How would you describe your partner's behaviour outside your home environment?
18. Have you ever felt manipulated, controlled by this partner or sometimes even lied to?
    (a) Can you please elaborate?

Antisocial behaviour entails people behaving in a moody, impulsive or unpredictable manner. The person may be loving and caring in one moment and in the next seem so vicious you can hardly recognize them.

19. What are your thoughts on this in relation to your own experiences?
    (a) Can you please elaborate?
20. How would you describe your partner's behaviour after a domestic violence incident?
21. How would you describe your partner's behaviour relating to suicidal behaviour, gestures or threats?
22. Do you know if your partner has ever been diagnosed with a personality disorder by a psychologist or psychiatrist?
    (a)If yes, can you please elaborate?

According to research not all alcohol and drug users and abusers are necessarily violent although alcohol has been found to be present in perpetrators as well as victims in many violent situations.

23. What are your thoughts on this in relation to your own experience?
24. Do you or your partner have a history of drug or alcohol abuse?
25. Has there ever been an incident/s of domestic violence that occurred due to drug and/or alcohol abuse?
26. How would you describe your partner's alcohol or drug use, if any?
27. How would you describe your partner's behaviour after using alcohol and/or drugs?

Extensive research has shown that exposure to violence and harsh parenting during childhood can lead to a higher risk of becoming adult perpetrators or victims of domestic violence.

28. What are your thoughts on this in relation to your own experience?
29. Can you please describe your childhood home?
30. What do you know about the childhood home of your abusive partner?
31. Did you or your abusive partner – whilst growing up – ever witness any serious arguments between your respective parents?
32. How much violence did you or your abusive partner witness as children, if at all?
33. Tel me about yourself prior to the abusive relationship?
34. How do you see yourself now?
35. What are your plans for the immediate future, or long term?
36. Is there anything else you would like to tell me?
37. How do you feel after sharing?

Appendix C: Consent form – Researcher Copy

I hereby agree to participate in the research regarding South African women's lived experiences of domestic violence and to identify the psychosocial risk factors that are associated and contribute to domestic violence. I understand that I am participating freely and voluntarily. I also understand that I can stop this interview at any point should I not want to continue and that this decision will not prejudice me in any way.

The purpose of the study has been explained to me, and I understand what is expected of me. I understand that this is a research project, which may or may not necessarily benefit me personally. I have received the telephone number of a person to contact should I need to speak about any issues that may arise as a result of this interview. I understand that this consent form will not be linked to the research documentation, and that my personal information will remain confidential. I understand that, if possible, feedback will be given to me on the findings of the completed research.

Signed at _____, on this _____ day of _____ 20___.

_____	_____
Name of Participant	Name of Researcher
_____	_____
Signature of Participant	Signature of Researcher

Additional consent to audio recording:

In addition to the above, I hereby agree to the audio and/or video recording of this interview for the purposes of data capture. I understand that no personally identifying information or

recording concerning me will be released in any form. I understand that these recordings will be kept securely in a locked environment and will be destroyed or erased once data capture and analysis are complete.

Signed at _____, on this _____ day of _____ 20___.

_____	_____
Name of Participant	Name of Researcher
_____	_____
Signature of Participant	Signature of Researcher