THE EXTENT OF PSYCHOLOGICAL DISTRESS AMONG BATTERED WOMEN ATTENDING NICRO WOMEN'S SUPPORT CENTRE

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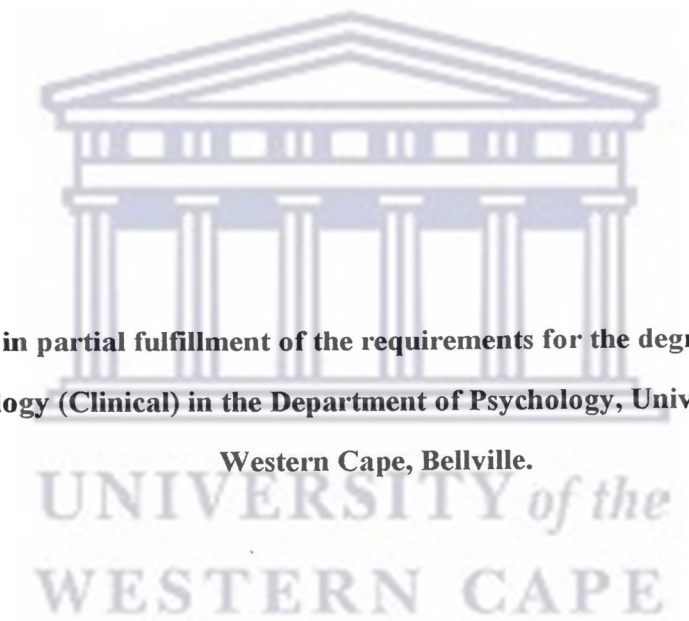

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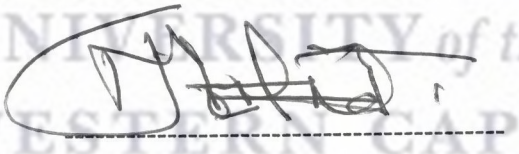
ABSTRACT

The aim of this study was to ascertain the frequency with which battered women attending Nicro Women's Support Centre (NWSC) present with symptoms of psychological distress. The literature centres on debates around the presence or absence of psychological problems amongst battered women. The psychopathological model tends to view women as being in some way responsible for their abuse, linking pathology with their personality or characteristics. The feminist perspective places the blame for such violence with the patriarchal nature of society, so that women's responses are seen as adaptive to their experience of trauma. While recognising the social roots of violence against women, research evidence points to the presence of symptoms such as depression, anxiety, substance abuse, suicidal ideation and Post Traumatic Stress Disorder in women who have a history of abuse. The risks these symptoms pose to women's mental health cannot be ignored. In this study a survey of a random sample of the 1995 intake files at the NWSC focussed on symptoms recorded, using DSM IV criteria as a guide. Evidence of a history of, or referral for psychological treatment, and certain demographic data, were also recorded. More than a third of the women were found to have symptoms of psychological distress, suggestive of a need for resources for their treatment. Recommendations for the assessment and management of these women were made, including the provision of longer term counselling so as to reduce the need to refer women elsewhere.

DECLARATION

The author hereby declares that this whole thesis, unless specifically indicated to the contrary in the text, is her own work.



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CHAPTER 1

INTRODUCTION

1.1 Overview

The problem of violence against women has been endemic world-wide for hundreds of years. Its occurrence and social acceptance have been supported culturally by patriarchal attitudes, legal condonation, and a rejection of interference in family matters from outside agencies. These traditions have resulted in women becoming trapped in violent relationships by the policies and practices within religious, social and legal institutions (Gamache, 1991). The problem in South Africa has reached crisis proportions with research finding one in every four women to have been beaten by their partners (Budlender, 1995).

Herman (1992) has stressed that one of the problems with addressing the crisis of domestic violence and the traumatic and horrible events that constitute it, is the reluctance of the public to hear about and confront those issues they would rather not face. It has only become possible to speak about such things since the women's movement enabled victims to speak out about their violation, and since the emphasis on human rights gave victims the space to find a voice.

The literature in the field has placed an emphasis on the reasons for the development of the problem and a description of the situation as it is seen. Much has been written from the standpoint of the psychopathological and feminist models of understanding,

with two quite disparate sets of ideas of how the behaviour of the victims of abuse should be viewed.

Overall the present study aims to speak to that middle ground where the reality of the psychological distress that battered women experience is acknowledged and can be addressed, but within the context of a feminist understanding of the structural problems out of which domestic violence has grown and become entrenched. Thus the purpose of this research is to determine the extent of the psychological distress experienced among those women presenting for help at a helping agency, the **National Institute for Crime and Rehabilitation of Offenders (NICRO), Women's Support Centre** (NWSC) in Cape Town. This information will then be used to generate ideas that may be useful to NWSC's intake and assessment procedures, which, in turn, may inform management.

In addition, demographic data will be captured so as to provide the NWSC with a picture of their client base for 1995, and this information will also be used to compare those client files that were categorised as Psychologically Distressed, with those that fell outside of this category. The purpose of this is to provide the Centre with some ideas as to what factors may be judged to be protective factors and those that may increase a client's vulnerability to psychological harm. This, in turn, may also inform the Centre's assessment and management procedures.

1.2 Framework of current study

Chapter Two introduces the problem of domestic violence and issues around it's definition, it's incidence and responses to the problem. This is followed by a focus on three approaches to theorising violence against women, how woman abuse, it's impact and consequences, are conceptualised from these differing standpoints. The chapter closes with a look at issues around the assessment and management of battered women.

Chapter Three outlines the motivation for this project, it's aim, and the quantitative methodological approach employed. It deals with the procedure followed, the pilot study and ethical considerations.

Chapter Four reports the results of the study, demographics, information regarding the relationship of the women and their abusers, the abuse experienced, and the psychological distress. It then reports comparisons made between the group of women categorised as Psychologically Distressed with those that fell outside of this category. Chapter Five covers the interpretation and discussion of the above results, allowing for reflection on those findings that are either different to, or consistent with related research.

Chapter Six covers the conclusions and provides a summary of the findings drawn from this study, as well as some ideas regarding the assessment and management of battered women. Limitations of this project and suggestions for future research are also included.

CHAPTER 2

LITERATURE REVIEW

Male violence against women has been a feature of society since time began. However the ways in which it has been constructed have varied with changes in societal norms over the years. Under a patriarchal system the male's position as the household authority, and the woman's as his property, has been upheld as 'right' and 'natural'. This was entrenched first by Roman law, and later by English Common law, to be rescinded eventually in the late 19th century (Stark & Flitcraft, 1988). Although wives continued to be battered by their husbands, their appeals for assistance were ignored or minimalised, labelled 'domestic disputes'. These cases were seldom treated as criminal, and the efforts of the authorities were focussed on the protection and privacy of the family. It was only in response to pressure from feminist movements that legislative changes were made which aimed to protect women from domestic violence. In South Africa the Prevention of Family Violence Act was only passed as recently as 1993.

This chapter will briefly review epidemiological research to highlight the enormity of the problem, followed by a look at responses to this situation and the inadequacies inherent therein. Three different approaches to understanding the problem of woman abuse will then be presented, and issues around assessment and management will receive attention, as the key to unlock the process of healing, both for the individual and society as a whole.

2.1 Epidemiology

Woman abuse is a problem world-wide, transcending social, economic, racial and cultural boundaries. However the extent of the problem can only be estimated, as most battered women fail to report attacks on them. Statistics are thus often flawed, not just because they reflect only reported cases, but also because men's assaults on women are not categorised as a class, so that all inclusive figures seem to be unavailable.

Desjarlis, Eisenberg, Good and Kleinman (1995) cite research from North America, Oceania, South America and China, finding wife beating to be a common experience for women in the low-income countries being studied. Although epidemiological data were scant, statistics from Sri Lanka, Bangladesh, Papua New Guinea, Mexico and Thailand revealed figures that indicate up to 50% of women are battered.

Gelles and Strauss's (1989) first National Family Violence Survey (1975), and their second survey in 1985 (cited in Gelles & Strauss, 1989) together involved interviews with 8000 American families. These revealed that one in six wives reported incidents of physical assault. Hansen and Harway (1993) refer to the suggestion by these authors that these results probably represent an under-estimation of the true incidence of domestic violence, which could be twice as high as reported. This echoes the findings of other research by Steinmetz (1977, cited in Hansen & Harway, 1993) which estimates that reports of spousal assault could be as low as one out of every 250. Cohen (1994) notes submissions from a 1993 report published by the United States Department of Health and Human Services which has on record that private

violence is present in a third of American households.

The implications of the available data become enormous when considered both within the context of the above, and in the light of the wide-reaching effects of such violence. The cost of violence against women is bourne by their children, families and their communities, all of whom suffer the consequences. Cohen (1994) points to research findings that half of those men who batter their wives also abuse their children, that men who were abused as children are ten times as likely as other men to batter their partners, and that 40% of women who abuse their children were themselves victims of child abuse, and so the cycle is perpetuated. Considering that half of the women murdered in the United States are killed by a current or former domestic partner, that between 35 and 40% of abused women make suicide attempts, and half of women alcoholics are abused women, it is almost incomprehensible that more effort has not been made to address the situation.

The problem in South Africa is possibly even more alarming, and despite the gross underestimates of official statistics, it is apparent that increasingly high levels of violence are being experienced by South African women. The African National Congress' draft campaign document on violence against women (1997) cites current Interpol statistics that found South Africa to have the highest incidence of reported rape in the world. The authors warn that the level of violence is so high that it constitutes an emergency situation for the women and children of this country. They cite research on intimate femicide in Johannesburg that found battering to be the number one cause of unnatural deaths for women in that magisterial district.

In the Western Cape during the period from the end of 1993 to October 1997 there

were more than 26 581 applications for interdicts against abusive partners, nearly all of which were granted (Vogt & Keen, 1998). Steenkamp, conducting a study for the Medical Research Council (1998), found that 25% of women attending a day hospital in the Cape Flats town of Mitchell's Plain, reported being abused in their homes. Wilson (1998) found that of 91 women admitted to a psychiatric hospital neuroclinic ward during a 12 month period, 32 reported incidents of physical and / or sexual abuse.

The economic toll of a problem of this magnitude, and the costs to the country as a whole would be expected to constitute a priority. However, efforts to address the problem seem to have been either inadequate or to have failed. This may be partly due to the complexity of the situation, but also due to the need for enormous social change at a bedrock level.

2.2 Responses to woman abuse

Notwithstanding the alarming findings reviewed above, Jackson (1997) points out that regarding domestic violence, generally the response of the South African Police Service (SAPS) has been less than adequate. Despite the ANC-led government's commitment to the protection of human rights and the empowerment of previously disadvantaged and marginal groups, the reporting of the crime tends to be the first and last contact the victim has with the criminal justice system.

Although Jackson found among police officers some understanding of their duties to be performed following the report of a rape, there was a lack of clarity on the police

procedure following a report of domestic violence. Jackson also reported that service organisations dealing with abused women complain of ineffective and biased policing of crimes against women. Thus police attitudes towards violence against women have been an area of concern and therefore came to constitute an important part of the training of policemen in their approach towards gender violence. This is considered to be crucial, as the trauma suffered by an abused woman may be greatly exacerbated and her recovery compromised if her first contact with the criminal justice system serves to increase her stress levels to the point of secondary victimisation. Police treatment that is insensitive and unsympathetic thus only serves to increase the sense of impotence and hopelessness so often experienced by abused women, so that women acknowledge their reluctance to report abuse, a fact that is bourne out by the disparate figures of reported abuse compared with estimates of actual incidents of violence against women in South Africa (Jackson, 1997). Wood and Middleman (1992) also refer to this 'revictimisation' by the so-called helping systems' and point to its deterrent value with regard to the difficulties women may have to face when leaving the abusive relationship. These women do not feel safe either physically or mentally, the latter, because of feelings of worthlessness and self-blame for the treatment they have endured.

Thus, in order that the authorities and policy makers be convinced of the urgency of the problem of violence against women, research findings need to be brought to their attention and advocacy should be increased. Organisations need to liase with one another so that their efforts may be combined towards ensuring more effective and accessible services for those women in need. Mullender (1996) notes that the services available to battered women in crisis have an obligation to ensure that every

woman who puts herself at risk by applying for help, finds that risk to be worth her while.

2.3 Theoretical approaches to understanding battering

Since the late 1960s the area of domestic violence has received extensive attention, with the focus of research reflecting different social narratives, and their intersection with one another as they have changed over the years.

Approaches to understanding the area may be loosely divided into three. The first has associations with the medical model, viewing women as being in some way responsible for their abuse by linking pathology with their personality or characteristics. The second is the feminist approach which places blame with the patriarchal nature of society, so that women's responses are seen as adaptive to their experience of trauma. The third approach views women's experience of psychological distress within the context of this violence, but recognises the risks this poses to their mental health, and therefore the need for intervention.

The literature covering the above will be touched upon, with an emphasis on highlighting the feminist backlash against the first approach. The development of the feminist perspective on violence against women will then be discussed, with the intention of linking this with the third approach.

2.3.1 First approach - problem women

The tendency in research of the first approach (e.g. Brown, 1991, cited in Hansen, 1993; Russell, 1982) is to view certain personality characteristics as psychiatric diagnoses, with the attendant implication that women's psychological predisposing traits are in some way responsible for the battering relationship in which she may later find herself.

Stark and Flitcraft (1988) point out that it was the complex psychosocial profile that battered women tended to present that led to conclusions that battered women were violence prone, and the myth that abuse results from individual dysfunction. This understanding of the problem prompts service providers to rescue the victim, rather than to become advocates for social change. The authors allege that the medical response of labeling 'is a process of metacommunication that legitimates non-intervention, isolation, perfunctory treatment, and punitive responses' (p. 165). This may lead to self-fulfilling prophesies as clinical intervention reinforces the women's partners' picture of them as 'crazy', and continues their history of progressive isolation from the resources and support they need.

Durra (1998) found that the women in her study who presented for counselling at NWSC had often utilised the services of other agencies in the past, where their sense of self-blame and self-doubt was reinforced by helpers' tendency to pathologise both themselves and their problems. These women spoke of the relief they felt at being seen by a counsellor who understood their situation and was thus able to normalise for them their responses to it. This was found to be more helpful than a psychiatric

diagnosis and prescriptions for medication. It is precisely this sort of experience that supports the view of feminist literature that referral for psychiatric help is indicative of blaming the victim, and the woman's depression, suicide attempts or stress come to constitute the problem rather than the batterer's behaviour. Thus the battering remains in the background while the symptoms of abuse become the focus for intervention (Pahl, 1985).

It is because of these concerns that radical feminist therapists view psychiatric treatment as violation, and medical procedures and institutionalisation as violent (Burstow,1992). From this gaze the diagnosis of psychological disturbance in battered women is viewed as complicity with patriarchy and capitalism. Cowger (1994, p. 267) takes this further, asserting that 'diagnosis is associated with a medical model of labelling that assumes unpopular and unacceptable behavior to be a symptom of an underlying pathological condition... and that labelling, accompanied by reinforcement of identified behavior is a sufficient condition for chronic mental illness.'

Viewed within the context of this understanding of the problem, it is not surprising that society has, on the whole, been slow in working towards ending violence against women. Mainstream psychology has failed to provide the kind of support crucial to assisting individual victims of violence.

2.3.2 Second approach - problem society

Grounded in the second approach, Rave (1985) traces the growth of a feminist

analysis of violence against women and points out that, until the revival of the feminist movement in the late 1960s, the professional literature failed to reflect any significant recognition of men's physical, sexual and psychological assault on women. Writings prior to this were scarce and carried the victim-blaming myths predominant in psychology and the wider society at the time.

Register (1993) reviews research that points to a recognition of wife abuse as a social problem of significance, criticising the psychopathological model of battering by stressing the public nature of what has been conceptualised as a private problem. The gendered nature of the issue is seen to be rooted in the abuse of power that is located in and reinforced by patriarchal institutions.

It is within this context that the emphasis has become one of viewing the psychological symptoms of a battered women as a reasonable response to an abnormal situation. This backlash against the failure of clinicians to recognise the problem of women's experience included a rejection by most feminists of the tools of clinical diagnosis as reflective of male-dominated values (Mander & Rush, 1974).

In their report Desjarlis *et al.* (1995) stress the need to understand the social roots of ill-health among women, to deal with the paternalistic attitudes of health care workers, and to empower women in the decision-making process around their treatment. Moreover, they also emphasise the need for policies that will increase women's personal and political power, suggesting progress in the way in which violence against women is understood.

Thus there is a growing acknowledgement of the feminist accusation that patriarchal norms have led to the development of gender-based inequality within the fundamentals of our society. The predominance of men in the institutions of health, mental health, religion, education, social service, the criminal justice system as well as the mass media, calls into question any claims of neutrality with regard to whose needs assume priority.

From a different level, whether abuse can be assumed to lead to psychological distress has been subject to debate. Criticism has been levelled at studies (Herman, 1992; Russell, 1986) showing that women who were subjected to abuse during childhood are left with fundamental problems in basic trust, initiative and autonomy, which may account for their revictimisation via battering, rape and sexual harassment later in life. Levett (1994) asserts that when closely scrutinised, much of what has come to be accepted in psychological theory and practice is based on social constructions. She argues that adopting a simplistic empirical methodology becomes an oppressive behaviour in itself, and it is this that is contrary to the interests of women and children. She points to how societal 'norms' have contributed to the stigmatic effects and taboos associated with childhood experience of sexual abuse, so that it's most damaging effects are not the abuse itself, but the set of discourses which act as self-fulfilling prophesies. Denying Russell's (1991) accusation that she claimed that sexual abuse is not harmful to children, Levett argues against the assumption that 'the damaging effects of child sexual abuse becomes as factual as a broken bone.'(p. 243).

For individuals to take full responsibility for their actions, the greater society and it's

institutions need to view abuse as inexcusable and intolerable (Mullender, 1996). Without fundamental change in these attitudes, battering will continue to be excused and tolerated. Levett (1994) suggests that counter-discourses need development through a process of collaboration which actively engages women and children from inside of their own social groups. Although a major shift is apparent in approaches to understanding violence against women, with social-psychological and feminist theories taking the lead in framing abuse as originating on a social and cultural level, we have yet to find reports on a significant and wide-ranging decrease in the rates of abuse, and research and advocacy needs to continue to this end.

2.3.3 Third approach - dealing with the reality

The third approach has grown out of the need to acknowledge that whatever the reasons for battering, the consequences for the victims are very real. Thus this approach could be seen to have developed in response to the results of battering, and literature pertaining to this will be reviewed before touching on assessment and management issues that are part of this approach to understanding woman abuse.

Reviewing the research on the results of battering, Hansen (1993) points to studies that have focussed on the coping mechanisms used by these women. These may in many instances work against them by further entrenching them in the battering relationship. Thus symptoms such as anxiety, insomnia, terror, nightmares, depression, diminished decision-making and problem-solving abilities, and those associated with PTSD are in evidence. Moreover, it is possible that women who have

been subjected to multiple forms of abuse, both currently and in their past, may experience much higher levels of psychological distress, suggesting a cumulative effect. Herman (1992, p. 57) notes that studies of war and natural disasters have shown a 'dose-response curve' documenting increases in the exposure of the population to traumatic experiences with increases in the percentage of the population reporting symptoms of PTSD. Saunders (1992) refers to research in which up to half of the battered women seeking help were found to have diagnosable PTSD. These women reported intrusive symptoms including flashbacks and nightmares, as well as avoidant symptoms such as avoiding reminders of the abuse. The latter were considered to be cause for concern, as survivors may suppress the trauma to the point where social functioning is decreased without their being aware of this.
O'Leary and Murphy (1992) point out that abused women are often found to be clinically depressed or dysphoric, with low levels of self-regard. They warn that their profiles appear psychotic unless they are viewed within the context of the trauma and stress that accompanies their long-term experience of a life-threatening relationship. Moreover, the psychological effects of battering may be disguised by alcohol abuse which they found to be relatively common among battered women. Other results of such victimisation include symptoms of stress and trauma, such as sleep disturbances, nightmares, headaches, anxiety attacks, stomach problems, uncontrollable crying and irritability. Depression was also cited as a frequently observed clinical symptom.

Desjarlis *et al.* (1995) cite research from North America which points to a powerful association linking psychiatric disorders with domestic violence. Ethnographic data from Oceania, South America and China supported this link. The authors point to evidence finding battered women four to five times more likely to need psychiatric

treatment, and five times more likely to attempt suicide than women who have not been battered. Major depression, substance abuse and PTSD have likewise been connected to histories of domestic violence and abuse.

There is thus the need for an understanding of woman abuse that takes into account the social roots of the problem and advocates for structural changes at this level. Simultaneously it is necessary to deal with both the battering situation and the psychological consequences of the woman's experience of that situation. It should be possible to address these issues concurrently, prioritising one over the other at times, as the situation demands.

Addressing the issue of psychological distress remains crucial considering the symptoms of depression, anxiety, anger, low self-esteem, and feelings of powerlessness so frequently reported in studies of abused women (Campbell, Kub, Belknap & Templin, 1997; Orava, McLeod & Sharpe, 1996; Stark & Flitcraft, 1988; Walker, 1996). Herman (1992) goes so far as to assert that given a traumatic experience that is sufficiently intense, no person is immune to psychological distress. Moreover, as extended experiences of abuse have been linked to the development of more serious conditions (Orava *et al.* point to studies that show Borderline Personality Disorder to be one of these), it is important to facilitate a deeper understanding among therapists of the psychological factors linked with the experience of abuse. In this way they may be better equipped to help women leave their abusive partners and recover from the adverse effects before it is too late.

If the abuse is not terminated, Stark and Flitcraft (1988) warn that there are long-term consequences to the abuse experience, listing suicide attempts, alcohol and drug abuse, depression, panic disorder and psychotic breakdown. They also found in their study that the majority of those psychiatric patients with histories of abuse had been diagnosed with a personality disorder, and the authors found that in 60% of these cases the problems were only manifest after subjection to ongoing domestic violence.

Reviewing the findings of two South African studies into the lifetime prevalence of sexual and physical abuse among the same psychiatric population, Strebel and Leon (1996) found widely disparate rates of abuse. The first study by Strebel, Msomi and Stacey (1999) was based on a sample of all women admitted to the three psychiatric hospitals in the Western Cape, and yielded an abuse rate of 10%. The second study by Leon and Thomas (1998) focussed on women in an acute admission ward within one of these hospitals, finding 85% to have been abused in childhood, adulthood, or both. Although the methodological differences that could account for these disparities will be mentioned later, in all likelihood the higher rate is more closely reflective of the situation.

Root's (1992) multifaceted theory of trauma explains that the behaviours of those traumatised must be viewed as the person's survival efforts to make a meaningful reorganisation of their world so that 'disorganised and unusual behavior following horrible experiences are normal responses to traumatic events.' (p. 237). Of significance here is the causal link of abuse resulting in symptoms of psychological distress. It is important to note the presence of this distress, and also to acknowledge the need to provide these women with the resources to work through their pain.

Research has suggested a strong relationship between women's histories of abuse and their psychological health currently. A relationship between the intensity and frequency of physically violent acts and the presentation of psychological symptoms, have been cited by several authors. This highlights the importance of early and appropriate intervention, and the critical part that assessment plays in the process.

2.3.3.1 Assessment and management

Hendricks and Matthews (1982) stress that a thorough assessment is crucial before intervening with a battered woman. If the help provided is not successful there is the danger that the woman will return to the abusive relationship, but more importantly there is the risk that the woman will view herself and others as being powerless to end the violence. The authors recommend that the woman's locus of control, the extent of her learned helplessness, and her system of causal attribution all be assessed so that work in these areas, and the focus of therapy, can be tailored to the woman's individual needs.

Orava *et al.* (1996) refer to research that has shown how human functioning has been seen to be influenced by beliefs about control, linking poor mental health to a lack of perceived control. They found that women with histories of abusive relationships tended to be more depressed, to have lower beliefs in self-efficacy, and lower self-esteem than the women who had not experienced abusive relationships.

This indicates the importance of identifying positive attributes and advantages for women seeking help for the abuse. Cowger (1994) argues for an assessment approach that focusses on client strengths rather than deficits. The author acknowledges that he is coming from a position which assumes many constructions of reality for each client situation, and that these situations are dynamic and ever-changing. He suggests that clients may be assisted towards self-empowerment by helpers believing and following the client's understanding of the facts, their wants and needs.

Empowerment may also be achieved by a joint assessment of personal and environmental strengths, and by making this assessment of strengths multidimensional. He stresses the mutuality of the process, of avoiding blaming or cause-and-effect thinking, and the need to assess and not diagnose.

Taking a more conventional approach, Ammerman and Hersen (1990) point to the neglect of clinical assessment. They stress that the many aetiological factors and causative pathways that contribute to abuse demand that assessment include multiple levels of functioning, including psychopathology, global functioning, social functioning and family functioning, as well as details such as factors precipitating violent interactions.

The approach to assessment is best tailored to the needs of the particular client population, but should perhaps assume health rather than psychopathology, and begin to explore the situation from this point first. The task is a difficult one as clients base their decision to return to a helper on their experience of the first meeting. This results in the temptation to rush an intervention and rescue, diagnose and/or refer

before a proper understanding of the woman's situation has necessarily been reached.

A good assessment is also the key to effective management, and Stark and Flitcraft (1996) point out that the interventions needed for a battered woman presenting for assistance will differ markedly depending on the stage at which she presents. Brown (1997) also emphasises the importance of readiness for change, and that change is characterised by progression through stages. This journey tends to be cyclical rather than linear, with relapse a natural and expected part of progression. Thus relapse needs to be reframed as part of the progression, with emphasis on what has been achieved and learned. The extent to which people progress in changing behaviour with professional interventions tends to be a function of the stage they had reached upon initiating treatment. Thus women evidencing battered woman syndrome would be in the initial stages of change, dealing with PTSD, and still traumatised by the violence that is ongoing. Women who have acted and overcome violence would be in a very different stage.

Likewise a woman may be suffering from depression for a number of reasons, and without their identification, treatment will not be successful. Campbell *et al.*(1997, p. 277) refer to the '*self-in-relation*' theory inspired by Carol Gilligan. This views a woman's sense of self and identity as being developed through her relationships rather than through separation and individuation. It follows that women will attempt to maintain their relationships in order to retain their sense of self. Moreover, the authors and others (Gleason, 1993) cite research that indicates that the potential loss of the relationship implied when a relationship is in serious trouble, was linked to

depression and a loss of self-esteem. The woman's ability to take care of herself and her own needs was also found to be a protective factor against depression.

There also seems to have been an underestimation of the emotional needs of abused women mourning the death of a relationship (Turner & Shapiro, 1986). Helpers need to facilitate acknowledgement and expression of the grief that accompanies the loss, or anticipated loss, of the women's emotional needs for security, closeness and role sharing that may have been met by the relationship despite periods of abusive treatment. Mancoske, Standifer and Cauley (1994) found that upon comparing the outcome of feminist-oriented versus grief resolution-oriented short-term counselling approaches, those women receiving the latter reported greater improvement in self-esteem and self-efficacy.

Overall this chapter has provided abundant evidence of the enormity of the problem of domestic violence and it's association with the experience of psychological distress as well as more long-standing emotional difficulties by its victims. There is also evidence of a resistance by society to acknowledge and work towards eradicating this abuse, and the extent of this is reflected in the differing approaches to understanding the problem. Interventions are indicated on a macro level, however, as Gelles and Maynard (1987) note, there is a tendency for treatment to lag behind research and theoretical development, and the individual as victim or offender remains the major target for treatment strategies.

This is apparent in South Africa as much as anywhere else. However in this country there is a culture of violence within our communities generally. Possibly it is this that

contributes to society's tolerance of, or possibly an anaesthesia of sorts, to the increasingly high levels of domestic violence and violence against women.

An additional problem is the inadequacy of the treatment facilities for these women, especially those with symptoms of psychological distress. One option is admission to a psychiatric ward, although hospitals are inadequately equipped to deal with the problems relating to the abuse (Lebese, Strebel, McCarthy & van Wyk, 1998). The other option is utilisation of one of very few support agencies, whose meager resources result in only crisis management, or at most, short-term intervention. This means that women with more long-standing emotional problems who would benefit from psychotherapy are not catered for. This indicates a need for research into the assessment and management of abused women in this country so that women's healing is prioritised, together with the healing of our communities and our society as a whole.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Motivation for the study

This research emanated from the needs of the Nicro Women's Support Centre (NWSC) (Cape Town), and was planned in consultation with all members of the Centre. The project was initiated in 1996 through a request by the counselling co-ordinator at the NWSC.

NICRO opened the WSC in December 1993. At the time of this study the Centre was staffed by social workers, one psychiatric nurse, volunteer counsellors, a legal team and a community outreach team. Through these workers the Centre aimed to provide advocacy, counselling, legal support and practical advice for abused women, according to a feminist empowerment counselling model (Hill & Keen, 1993). This model emphasises the need to empower the woman by facilitating her discovery of her own strengths and resources, her ability to make decisions and take control of her life, while developing her awareness of, and working through, her own needs and feelings. Within this model the woman's symptoms of psychological distress are viewed as normal responses to an abnormal situation (Pratt, 1995).

The request for research was prompted by a growing concern with the number of women who have presented at the NWSC with psychological symptoms that were felt to be indicative of a possible diagnosis on Axis I or II of the Fourth Edition of the

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (A.P.A., 1994). Symptoms of depression, anxiety, and PTSD were mentioned specifically. This called to question the frequency with which such cases were being identified by the counsellors, and whether their numbers warranted specific attention by the Centre. Likewise, were there a significant number of women needing this type of assistance that remained undetected by the Centre staff?

Women identified by the NWSC as psychologically distressed are referred to agencies or institutions where psychiatric treatment or long-term psychotherapy can be obtained. Considering the difficulty that women have experienced in seeking help for dealing with the abuse that they are suffering, being disbelieved, unheard, or passed from one agency to another, (Cervantes, 1993; Register, 1985; Walker,1984) such referral is viewed as an additional stressor. However, in order to be able to work effectively with these difficulties, it is essential that the helper have both the clinical experience to perform a thorough psychological evaluation, as well as an understanding of both the symptoms and the social origins of violence against women. This raised the issue of whether the Centre should be able to provide such assistance for their clients via a multi-disciplinary team. The staff have extensive experience with abuse but little clinical training or experience. Training in clinical psychology would ensure that psychological problems would be recognised during the assessment process and immediately receive attention. This would also lessen the risk of diagnosing as disordered those symptoms which may be normal responses to the experience of abuse, while taking into account that their presence may still necessitate specialised help.

3.2 Aim

The major purpose of this research was to explore the extent to which the experience of battering included symptoms of psychological distress among the women seen at the Centre.

To this end the aim was to identify those cases with a clear history of psychological or psychiatric treatment, those with a clear referral for the same, as well as those that were suggestive of criteria by which they may have been identified as in need of such treatment. Those cases that met these criteria were together taken to constitute the *psychologically distressed*. Demographic data was also captured to provide a picture of the client that typically is able to make use of the facilities offered by the NWSC. The cases falling into the category of psychologically distressed were then compared with those that did not, with regards to the demographic data and relationship between the women and their abusers, the length of their relationship, and the types of abuse reported. The purpose of this was to explore the possibility of an association between these variables and psychological distress among abused women, which could be useful in directing future research in this area.

3.3 Methodological framework

Feminist research debates have focussed on the value of qualitative research that is facilitative of a fuller understanding of the data under investigation, within the women's own terms. The concomitant implication is that quantitative research is

patriarchal by nature (Kelly, cited in Radford & Russell, 1992). However, as Russell points out, quantitative data are not expected to provide an explanation for any associations found, but that the value of such data is in their capacity for establishing these associations.

Javaratne and Stewart (1991) find that recent writing on feminist methodology has reached a general consensus on the need for independent assessments of a method's appropriateness. Feminist values cannot prescribe any single method, but it is important to retain an awareness of the problems associated with both qualitative and quantitative research, addressing them when necessary.

Schnetler (1989) notes the advantages of quantitative research using the survey method, which is of relevance to this research. The systematic nature of the procedure ensures specificity, logicality and formality in the research process. This allows for an unbiased selection of a sample of the population under investigation so that the data are representative of this group. This method will also facilitate access to the maximum amount of data while ensuring efficiency in terms of time and financial resources.

A descriptive, cross-sectional research process was chosen, comprising a survey of a random sample of the files of all woman presenting at, or contacting, the NWSC for counselling during the year 1995. A quantitative method was felt to be well suited to a survey of intake files, so as to extract the necessary data and make the appropriate comparisons.

All the data collection was done by this researcher, thus eliminating the problems associated with a number of researchers' differing interpretations of the data. The use of data already on file eliminates problems associated with respondent fatigue, other respondent effects, or effects of the environment. Although a deeper analysis of the data has to be sacrificed, the study is exploratory in nature, and may provide an indication of directions for future research in the area.

The scale of measurement will be nominal as the only variables being scored are indicators of psychological distress, that is, either the data indicates psychological distress, or not.

The descriptive nature of this study with it's focus on looking for trends or indications of patterns lent itself to working with percentages. It was thus decided that to submit the results to statistical tests of significance would be inappropriate.

3.4 Sample

All files listed in the numerical register at the Nicro Women's Support Centre from 1st January 1995 to 31st December 1995 were accessed. There were a total of 843 intake sheets for 1995. From these the 603 counselling intake files were separated from the legal intake files, as only the former are relevant to this research. These files then constituted the population of interest. A random sample of the total number of counselling intake files was then extracted. The computer generated sample was achieved by using a linear congruential method, yielding a sample total of 92. Of this total, six were not used as they were inappropriate, not involving domestic violence

at all. Thus the sample consisted of 86 cases, all of whom had received some counselling, from one intake interview only to several sessions either face-to-face or telephonic.

The files used were those of women who had heard about, or been referred to the NWSC by medical staff in hospitals or clinics, by social workers, employers, colleagues, friends, family, religious leaders, or advertising in the media. The women were from different areas, predominantly in the Western Cape, including the Cape Flats, southern suburbs, northern suburbs, City Bowl, Atlantic Seaboard, and outlying country areas.

3.5 Procedure

Prior to embarking on this project a pilot study utilising 10 files was undertaken to get an indication as to whether there was likely to be sufficient information regarding indications of psychological distress to warrant the full study. As the results indicated that 70% of the sample had some suggestion of psychological distress, continuing with the larger sample was felt to be viable.

All intake files are assigned a file number in the register and are coded according to whether they are counselling cases. The computer generated random sample was then achieved from the total of these files, and those that fell within the sample were extracted from the archives manually. The information from each of these intake forms was perused and the relevant data listed on a form constructed for this purpose (see Appendix A). This form was based on the intake sheets used by the interviewers

at NWSC, and the information provided for tended to be overinclusive, designed to capture a maximum amount of information in a minimum amount of space, so as to make this as easily accessible as possible. The decision as to how much of this was to be utilised was based on what was felt to be appropriate within the limits of this study. An adequate response rate was also felt to be important, and some categories were not included due to a paucity of information.

The section that aimed at detecting symptoms of psychological distress included reports of psychiatric treatment, diagnosis, medication prescribed, or any hospitalisations. A section was also included to provide for a general description of the woman's psychological functioning.

Demographic information included language, age, educational level and employment status. This information was collected to build a picture of the client base utilising the service and to investigate any possible associations with the extent of psychological distress experienced by women.

Information regarding the abuse experienced included: the relationship between the woman and her abuser; the length of their relationship; the types of abuse reported; and the duration of the abuse. This information was used to compare the women that fell within the category of psychologically distressed with those that fell outside of this category. This allowed for an indication of any association between the characteristics of these women or their abuse history, and the extent of the psychological distress that they were experiencing.

The information on each data sheet was then perused to identify those that could be classified as Psychologically Distressed. Evidence of psychological distress was identified by (1) information regarding the psychological sequelae of the abuse experience, including the nature of the help sought or needed, the duration of symptoms, as well as the impact the emotional responses had on the overall ability of the woman to function within her social, occupational, and other important roles. (2) Mention of a previous or current hospitalisation in a psychiatric facility, of treatment by a psychologist or psychiatrist, and/or a diagnosis by a medical or a paramedical professional. (3) Mention of a suicide attempt.

Using the criteria from the Diagnostic and Statistical Manual of Mental Disorders IV (A.P.A., 1994), a psychiatric diagnosis was attempted from the data sheets. As this was generally not possible due to a lack of information in the files, those data sheets that had sufficient information to strongly suggest a diagnosis were also placed within this category. This generally included data that offered sufficient diagnostic criteria, but without any indication of the time period over which the symptoms had been present, thus making a firm diagnosis impossible.

The percentage of those found to be psychologically distressed was then compared with those without sufficient evidence to categorise as psychologically distressed. This was then used to help ascertain whether the extent of psychological distress experienced by women presenting at the NWSC was sufficient to suggest that the Centre should consider making provision for their assessment and/or treatment needs.

The major problem with this procedure was the structure of the intake forms utilised by the NWSC, as well as the paucity of the information either elicited or recorded by the intake interviewer. The forms do provide for information of depressive symptoms, possibly contributing to the high percentage of depression suggested among the women seen. However there is little provision for investigation of symptoms of anxiety, personality disorders, or other forms of psychological distress.

The interviews were generally conducted by lay counsellors and social workers. The training of these interviewers may have failed to equip them with the skills necessary to recognise psychological symptoms, to suspect the possibility of a disorder, and then to fully explore the extent of psychological distress, with a view to referral for specialised treatment.

It is acknowledged that the NWSC operates from an empowerment model which is strongly opposed to pathologising the symptoms presented by abused women. Moreover it must also be taken into account that the level of distress the woman is experiencing, as well as the relief of talking to someone about her problems, results in the interviewer making every effort to contain the client, with little time left to explore the situation thoroughly in the first interview. The woman may then fail to return, preventing the completion of the intake form. An additional problem in this regard is that there is no separation in the intake register of those counselling interviews conducted face to face, and those done telephonically. It may be assumed that the amount and nature of the information obtained telephonically is limited, especially since the woman is generally persuaded to make an appointment to come

to the Centre for counselling. However this may never happen for various reasons, and so the intake form remains incomplete.

3.6 Ethical considerations

Strict confidentiality was maintained throughout every step of the research process. Permission by the Centre to access confidential files was granted, and the required release forms signed by the researcher. Throughout this study the names of the women whose files constituted the data base were not recorded, the files being identified by number alone. The project as a whole was presented to the NWSC team for their consideration. Approval was granted prior to the research going ahead, and they will be supplied with a copy of the completed project which they may use to inform their intake procedures.

CHAPTER 4

RESULTS

Data was collected from all the cases utilised in this study and will be presented in two parts. Data for the total sample will be reported first, followed by data from which comparisons were made between the cases that fell within the category of Psychologically Distressed and those that did not.

The total sample drawn for this study consisted of 92 cases, however 6 of these were not used as they were inappropriate in that they did not involve domestic violence. This reduced the sample to 86, and all calculations have been based upon this total.

4.1 The total sample

4.1.1 Demographics of the total sample

The demographics extracted for the total sample included Age, Language, Employment Status and Educational Level. The relatively high percentage of women for whom there is no information is illustrative of the problem encountered around the lack of necessary data recorded on the intake interview sheets. Thus, although the total sample consisted of 86 cases, percentages are calculated on that portion of the total sample for whom there was information available (n).

The age of the majority of women interviewed was not recorded on the data sheets. Of those cases reported, ages ranged from under 20 years old to over 50 years old, with a median age of 33 years. Half the women fell within the 30 to 39 years age group, while almost a quarter were women in their twenties.

Language was recorded more often, probably due to the difficulty of failing to notice this feature in an interview. However, despite this, there were still almost a fifth of the cases in which language was not recorded on the data sheets. Of the rest of the sample, just over half were English-speaking, and more than a fifth were Afrikaans-speaking. The rest were either bi-lingual or Xhosa-speaking.

Of the total cases, almost three-quarters lacked information as to the educational level of the women interviewed. Of those cases where information was recorded, a quarter had failed to achieve Grade 10, almost a half had attained between a Grade 10 and Grade 12, and a further quarter had a tertiary level education.

The employment status of one third was not recorded. Of the remainder, the majority were currently employed, while the balance were unemployed. In two of the cases the women were scholars (see Table 1).

Table 1 Demographics of the total sample.

Variable		n	%
Age	Under 20 years	5	10%
	20 - 29 years	11	23%
	30 - 39 years	24	50%
	40 - 49 years	7	15%
	50 + years	1	2%
Language	English	36	51%
	Afrikaans	16	23%
	Xhosa	10	14%
	Zulu	1	1%
	English/Afrikaans	7	10%
Educational Level	Under Grade 10	7	27%
	Grade 10 - 12	12	46%
	Grade 12 +	7	27%
Employment Status	Employed	34	59%
	Unemployed	22	38%
	Scholar	2	3%

4.1.2 Relationship with abuser

Information recorded pertaining to the relationship between the woman and her abuser included the nature of their relationship to one another and the length of this relationship.

Of all the categories included in this study, the one regarding the nature of the relationship between the woman and her abuser was the one for which there was most often information given (90% response rate). It is possible that this was due to the women referring to their abuser in terms of his relationship to them.
Of these cases, the majority were married to their abuser, with almost a fifth being unmarried, but living together. The rest were either divorced or separated from their abuser, or were abused by their father.

Information on the length of the relationship between the woman and her abuser was not recorded in over half of the total sample. Of the remainder, the majority had been in the abusive relationship for between 10 to 14 years, and close to one quarter had been in the relationship for between 5 and 9 years. Most of the rest had been in the abusive situation for over 20 years, and some for between 2 and 4 years, while only two women had presented for help within the first year of the abusive relationship (see Table 2 below).

Table 2 Relationship between the woman and her abuser.

Variable		n	%
Relationship	Married	51	59%
(n = 77)	Unmarried	14	16%
	Divorced	7	8%
	Ex- girlfriend	3	3%
	Father/Daughter	2	2%
	No information	9	10%
Duration of Rel.	Under 1 year	2	2%
(n = 38)	2 - 4 years	5	6%
	5 - 9 years	9	10%
	10 - 14 years	13	15%
	15 - 19 years	3	3%
	20 + years	6	7%
	No information	48	56%

4.1.3 Abuse experienced

This information included the duration of the abuse and the types of abuse experienced. There was no information pertaining to the duration of abuse in almost two thirds of the cases. Of those cases where this information was available a quarter of the women had endured abuse for between 1 and 4 years, and exactly the same number again for between 10 to 14 years. Most of the rest of the women had been abused for between 5 to 9 years, and only a few women for less than a year or more than 15 years.

The intake interview sheets provided for the recording of the types of abuse suffered, whether verbal, emotional, physical and sexual abuse. Financial or 'other' abuse are also included. Thus one woman may report up to four or five different types of abuse.

Of the total sample over 90% of the cases had information recorded regarding the types of abuse perpetrated. The overwhelming majority reported physical abuse, and emotional and verbal abuse were reported almost as frequently. Financial abuse was reported in almost a quarter of the cases, while sexual abuse was reported far less frequently (see Table 3).

Table 3 Abuse experienced.

Variable		**n**	**%**
Duration of abuse	Under 1 year	3	9%
(n = 33)	1 - 4 years	9	27%
	5 - 9 years	7	21%
	10 - 14 years	9	27%
	15 - 19 years	2	6%
	20 - 29 years	3	9%
	No information	53	61%
Type of abuse	Verbal	48	61%
(n = 79)	Emotional	53	67%
	Physical	63	80%
	Financial	19	24%
	Sexual	12	15%
	Other	4	5%
	No information	7	8%

4.2 Extent of psychological distress

The overall findings regarding that portion of the total sample that fell within the category of Psychologically Distressed and those that fell outside of this category will now be reported. The results of comparisons of the Psychologically Distressed with those cases that were not categorised as such will then be presented with regard to demographics, relationship between the women and their abusers and the abuse experienced.

Table 4 suggests that a sizeable proportion (more than one third) of the cases that presented for counselling fall within the category of Psychologically Distressed. Of the total files, 31 had sufficient data to be categorised as Psychologically Distressed, while the remaining 55 cases had insufficient information to be placed within this category, thus falling under the category of Not Psychologically Distressed.

Table 4 Extent of Psychological Distress.

Category	n	%
Psychologically Distressed	31	36%
Not Psychologically Distressed	55	64%

4.2.1 Designation of cases as psychologically distressed

Table 5 details how cases were designated a place within the category of Psychologically Distressed. Psychiatric diagnosis, either by a medical or paramedical professional, or a strong suggestion of a diagnosis based on the criteria listed in DSM IV, accounted for the majority of cases placed within this category. A quarter of all cases were placed within this category by virtue of evidence of a history of, or of current psychiatric or psychological treatment, with or without a diagnosis. Some of the cases met the criteria for inclusion more than once, for example, received a diagnosis as well as a report of treatment. The overwhelming majority of cases that received a diagnosis were found to be depressed.

Table 5 Designation of cases to the Psychologically Distressed category.

Psychological distress	**n**	**%**
Diagnosis	**29**	**94%**
Post Traumatic Stress Disorder	1	3%
Depression	18	58%
Acute Stress Reaction	1	3%
Anxiety Disorder N O S*	1	3%
Mixed Anxiety-Depressive Disorder	4	13%
Psychotic features	1	3%
Substance Abuse	1	3%
Personality Disorder	2	7%
Psychiatric Treatment	**8**	**26%**
Admission to Psychiatric Ward	7	23%
Out Patient Psych. Treatment	1	3%
Suicide Attempt	**2**	**7%**

*Not otherwise specified

4.3 Comparison of the two groups

Those falling within the Psychologically Distressed group were compared with those not falling within this category. Generally there was more information recorded for the cases that fell within the category of Psychologically Distressed than for those that did not.

4.3.1 Demographics

The demographics extracted from the total sample included age, language, educational level and employment status. These were broken down to allow for comparison of the sample categorised as Psychologically Distressed (PsychD - n =31) with those remaining cases that had insufficient information to be placed within this category (Not PsychD - n =55). There was generally a high percentage of cases with no information recorded in each category, so that only those cases with information were utilised when making comparisons between categories. Age, Language, Employment Status and Educational Level were all compared to discover whether any associations could be suggested. It must be emphasised that this is not to be interpreted as any suggestion of causality, it is merely used in a descriptive sense.

When comparing the age spread within the categories, those women placed within the Psychologically Distressed category showed no marked differences from those women who had not been placed within this category.

Regarding language, of the Xhosa-speaking women, less than one-fifth fell into the category of Psychologically Distressed, and there were over 10% more English-speaking women within this category.

More than half of the women in the category of Psychologically Distressed were unemployed, as compared with only about one-quarter of the women who did not fall within this category. This category also had far fewer employed women when compared with an almost 70% employment rate among the women who were not categorised as psychologically distressed.

More of the women who were not categorised as psychologically distressed had achieved a tertiary level education, yet fewer had achieved between a Grade 10 and 12 level schooling, when compared with those falling within the Psychologically Distressed category. Those women within the latter category tended to more frequently have an educational level higher than a Grade 10 (see Table 6 below).

Table 6 Comparison of the two groups with regard to demographics.

Variable		Not psych. distressed		Psych. distressed	
		n(55)	%	n(31)	%
Age	Under 20 years	3	6%	2	7%
	20 - 29 years	6	11%	5	16%
	30 - 39 years	11	20%	13	42%
	40 - 49 years	5	9%	2	7%
	50 + years	0	0%	1	3%
	No information	30	55%	8	26%
Language	English	21	38%	15	48%
	Afrikaans	10	18%	6	19%
	Xhosa	9	16%	1	3%
	Zulu	0	0%	1	3%
	Eng/Afrik	5	9%	2	7%
	No information	10	18%	6	19%
Educational Level	Under Grd 10	5	9%	2	7%
	Grade10 - 12	6	11%	6	19%
	Grade 12 +	5	9%	2	7%
	No information	39	71%	21	68%
Employment Status	Employed	23	42%	11	36%
	Unemployed	9	16%	13	42%
	Scholar	1	2%	1	3%
	No information	22	40%	6	19%

4.3.2 Relationship with abuser

Of the women categorised as Psychologically Distressed, nearly three-quarters were married, whereas those that fell outside of this category were only married to their abusers in about 60% of the cases where information was available. Conversely, many more women in the second category were divorced from their abusers. Unmarried women did not differ markedly from each other in this grouping, and there was one woman from each category abused by their fathers.

With regard to the length of the relationship between the woman and her abuser, more women in the Psychologically Distressed category were in the abusive relationship for between 5 years and 19 years (see Table 7 below).

Table 7 Comparison of the two groups with regard to the relationship.

Variable		Not Psych. distressed		Psych. distressed	
		n(55)	%	n(31)	%
Relationship	Married	27	51%	23	74%
	Unmarried	9	16%	5	16%
	Divorced	6	11%	1	3%
	Ex-girlfriend	2	4%	1	3%
	Father/daughter	1	2%	1	3%
	No information	9	16%	0	0%
Length of rel.	Under 1 year	1	2%	1	3%
	2 - 4 years	3	6%	2	7%
	5 - 9 years	5	9%	4	13%
	10 - 14 years	6	11%	7	23%
	15 - 19 years	0	0%	3	10%
	20 + years	4	7%	2	7%
	No information	36	7%	12	39%

4.3.3 Abuse experienced

With regard to the duration of abuse, of the women who fell within the category of Psychologically Distressed, none had experienced abuse for less than one year, while approximately a sixth of the women outside of this category had experienced abuse for a period not exceeding one year. Those categorised as Psychologically Distressed more frequently fell into the 1 to 4 year and into the10 to 14 year periods, and less frequently into the 5 to 9 year period than those who did not fall into this category. The rest of the sample experienced abuse for roughly the same time periods.

The type of abuse experienced was more frequently reported than other information categories, with most women reporting more than one type of abuse. Of the women who fell within the category of Psychologically Distressed, more than three-quarters had reported Emotional Abuse, as compared with about 60% of the women who did not fall within this category. Likewise, almost double the percentage of women reporting Financial Abuse fell within the first category when compared with the second category. Moreover, only women falling within the first category reported Sexual Abuse. The other types of abuse were reported with similar frequencies by both categories (see Table 8).

Table 8 Comparison of the two groups with regard to the abuse experienced.

Variable		Not psych. distressed		Psych. Distressed	
		n(55)	%	n(31)	%
Abuse					
Duration	Under 1 year	3	6%	0	0%
	1 - 4 years	4	7%	5	16%
	5 - 9 yaers	5	9%	2	7%
	10 - 14 years	4	7%	5	16%
	15 - 19 years	1	2%	1	3%
	20 - 29 years	2	4%	1	3%
	No information	36	65%	17	55%
Type	Verbal	31	56%	17	55%
	Emotional	30	55%	23	74%
	Physical	39	71%	24	77%
	Financial	9	16%	10	32%
	Sexual	0	0%	12	39%
	Other	2	4%	2	7%
	No information	5	9%	2	7%

In conclusion, the total sample consisted of 92 cases, of which only six cases were judged to be inappropriate in that they did not involve woman abuse. Initially demographic information was extracted from the 86 appropriate cases so as to build a general picture of the client population utilising the services of the NWSC, and to explore whether any of these demographic characteristics could be linked to the presence or absence of psychological distress.

Overall the majority of women in the total sample tended to be aged between 20 and 40 years old, with a median age of 33 years old, English-speaking, employed, with an educational level the equivalent of between ten and twelve years of schooling. They were generally married to their abuser, and their relationship with him had continued for between 5 and 14 years, while the abuse had often been ongoing for between 1 and 14 years. Most of the women had suffered physical, emotional and verbal abuse, while only about one in four women reported financial abuse, and only 15% sexual abuse.

Of the total sample 31 (36%) were found to have sufficient of the necessary criteria to be categorised as Psychologically Distressed, while 55 (64%) cases fell within the category of Not Psychologically Distressed. The women who were categorised as Psychologically Distressed were in their 30s, English-speaking, unemployed, with between 10 and 12 years of schooling. They were mostly married or in a long-term partnership that had endured for between 5 and 14 years, and many had suffered abuse for between 1and 4 years, or 10 and 14 years. They had suffered more, and a wider range of abuse than that computed for the total sample.

CHAPTER 5

DISCUSSION OF THE RESULTS

This chapter aims to allow for some consideration of the results presented in the previous one. Firstly issues around categorisation of the two groups will be mentioned. The demographics will then be discussed, with an emphasis on comparison of the two groups with regard to these results. Information pertaining to the relationship between the women and their abusers, the duration of the abuse, as well as the types of abuse experienced will then follow. Lastly, attention will be given to the psychological sequelae of the abuse as evident among the women categorised as Psychologically Distressed. Overall the intention is to allow for reflection on those aspects of this research that either follow on or diverge from the findings of other researchers in the area.

The vast majority of cases that fell into the Not Psychologically Distressed category did so because of insufficient information and not necessarily because of evidence of psychological health. For example, there would at times be sufficient symptoms listed to strongly suspect a diagnosis, but without any reference to the length of time that these symptoms had been present, a diagnosis would not be possible. The intention is not to perpetuate discourses of trauma (Levett, 1991; Wilson, 1998), or to ignore the resilience of women who have had to deal with abuse and a range of other psychosocial stressors by suggesting that battered women should necessarily have signs of psychological distress. The intention is to note that the files that fell outside

of this category often did so due to information that was not there, rather than due to the information recorded.

5.1 Comparison of the two groups

5.1.1 Demographics

The majority of the women fell within the age category of 30 - 39 years, which is consistent with the ages of the abused women in the studies conducted by Strebel *et al.* (1999) and Leon and Thomas (1998). This bears out the observation of Angless (1990, citing Orayson and Smith, 1981) as noting that help-seeking behaviour is more often apparent in women in their thirties. The percentage of women classified as Psychologically Distressed in this age group is double those falling outside of this category. However, in this sample there were also a number of women in their twenties, with a slightly higher percentage of these falling within the category of Psychologically Distressed. It is possible that their greater distress drove them to find help earlier than those falling outside of this category.

Regarding race, the sample included very few black women (only 14.30% of the women in the sample were Xhosa-speaking), and only 3% fell into the category of Psychologically Distressed. However, this study was unable to include race within the demographic information about the sample as there was no provision for this category on the NWSC intake form. If it is possible to assume that the majority of Xhosa-speaking women are black, then it would be surprising that in the light of the literature, and the large Xhosa-speaking population in the Western Cape, that there

were not significantly more abused black women, or that they were not presenting for help at the NWSC. If 'coloured' * women were to be included under 'black', and 'coloured' women may feel that they should also be categorised as women of colour, this would substantially increase the figures in that racial category, but this is impossible to estimate as there was no information recorded that would enable their identification as such.

Stein (Cape Times, 2000) reports on a similar profile among treatment centre statistics for alcohol abuse, with many more 'coloured' and white patients than black. The figure for the black population within the Cape metropolitan area is recorded as totalling 26%, yet only 4% of those receiving treatment in the area are black. Vale (1997) reporting 1996 figures for the NWSC also recorded only 11% Xhosa-speaking clients attending the Centre during that year. Strebel *et al.* (1999) recorded admissions of a sample of all patients admitted to the three psychiatric hospitals in the Western Cape during 1994 and found women to be 16% black, 59% coloured, and 25% white. Thomas and Leon (1998) found coloured women to constitute the majority of those hospitalised in an acute admission ward in 1995 (60% coloured and 19% each of white and black women). However it is likely that admission to an inpatient facility and presentation for help at a centre for abused women constitute two very different experiences

The under-representation of the black population receiving counselling at the NWSC may be due to constraints such as transport and financial difficulties, language barriers, suspicion, distrust and immigrant status. Strebel *et al.* (1999) point out that although the first democratic elections took place in 1994, the socio-political legacy

of oppression and discrimination would still have an impact on socio-economic conditions in the country. The black and coloured population tend to reside in areas far away from the NWSC, transport is expensive and sometimes unreliable, there is often a lack of confidence and trust in authorities and the helping professions, and opportunities are limited. Moreover, a large portion of the black population in the Western Cape are relatively new to the area because of the history of influx control and 'pass' laws.

Although it is important to note that comparing South African black women with African American women may be inappropriate, Crenshaw (1994), writing about black women in the United States, points out that non-English-speaking women may not be aware of, or be unable to take advantage of available support services. She also suggests that immigrant women may often depend on their husbands for information regarding their legal status, and so may be intimidated by threats regarding deportation, arrest, or similar. These women may also live with extended family, leaving them with little privacy, and possibly little opportunity for leaving the house to seek help. There is also much written (Crenshaw, 1994; Jackson, 1997; Vetton, 1995) about women's (and particularly black women's) hesitance with regard to the involvement of the authorities, especially the police, sometimes due to a sense of futility as either the police fail to respond, or fail to assist the victim, preferring to attempt to settle the conflict or merely warning the abuser. Often the woman is disbelieved or blamed, and the report of the crime is frequently the only contact the abused woman has with the criminal justice system (Jackson,1997).

It was also noted that only two black women (one Xhosa- and one Zulu-speaking, using language as a guide) were categorised as Psychologically Distressed, the rest of these women fell outside of this category. Either, as mentioned, black women are not using the NWSC or, as has been suggested in the literature, there is research indicating that within black communities the role of resilience and social support may provide a protective function (Gibbs & Fuery, 1994; Williams,Takeuchi & Adair, 1992 in Strebel *et al.*, 1999).

Regarding education, the majority of women in this sample had achieved a high school education equivalent to between 10 and 12 years. This was higher than the median of 8 years of education found for the sample of coloured and African men and women in the research findings of Strebel, *et al.* (1999). However whites of both genders were found to have more years of education (11 years). About half of the remaining women in this sample had either achieved less than 8 years, or a tertiary level education. This would appear to suggest that these women are less constrained due to a lack of schooling, however the unemployment rates in the area are extremely high, so that even women with a tertiary level education cannot be assumed to be able to find employment. When comparing the two categories there were more women categorised as Psychologically Distressed with between a Grade 10 and Grade 12 level of schooling, which would not suggest that lack of education could be implicated as a significant factor in their vulnerability to the psychological sequelae of abuse.

Surprisingly the majority of women for whom information was recorded were employed, which is in contrast to the findings of Leon and Thomas (1998) and Strebel *et al.*(1999), both of which noted the vast majority of their samples to be unemployed. However the sample from these studies were made up of a psychiatric population whose psychological distress could be assumed to be both more acute and chronic, and thus more likely to adversely affect their functioning within occupational roles.

In the present study the rate of unemployment among the women categorised as Psychologically Distressed was more than double that for those who did not fall into this category. This would suggest that employment, for its empowerment both financially and in terms of self-esteem, serves a protective function.

Crenshaw (1994) noted that many women who utilise shelters in minority communities in Los Angeles were unemployed or underemployed, and very often poor. They invariably have to shoulder the responsibilities of child-care, and seldom have the job skills necessary to find viable employment. These are problems that trap women in abusive relationships by constraining their alternatives. She notes that these problems are magnified for women of colour, and their particular disadvantages also mean that family and friends are less often able to offer them material support or temporary shelter. Crenshaw thus concludes that structural intersectionality, 'the various ways in which race and gender interact to shape the multiple dimensions of Black women's employment experiences' (1994, p.94) shapes the experiences of black women through economic factors, such as access to employment, wealth and housing, and thus define the battering experience for them. Novitz (1996) echoes this

with regard to the South African context where she points out that an impoverished background together with race, is likely to constrain women's options and so trap them within the cycle of violence.

5.1.2 Relationship with abuser

With regard to the relationship of the women to their abusers, in this sample the majority of the women were married to their abuser, and a number of women were living together with their abuser. Thus in three-quarters of the cases the women and their abusers were in long-term relationships. This is in keeping with the findings of other researchers who show husbands, common-law partners and boyfriends to be the group responsible for the largest proportion of cases of physical and sexual assault (Leon & Thomas, 1998; Randall & Haskell, 1995; Strebel & Leon, 1996).

When comparing the relationship status of the women who were classified as Psychologically Distressed with those who were not, more of the former were married, with a similar percentage in a live-in relationship. More women in the latter group were divorced. This was in contrast to the findings of Strebel and Leon (1996) who found that more abused women were single, and brings into question whether marriage provides a protective function for women, or whether being married to an abuser places women in a high risk position. In this study many more women categorised as Psychologically Distressed were in the abusive relationship for between 5 and 19 years, than those not falling within this category.

Moreover Leon and Thomas (1998) found that in nearly all cases the perpetrators of adult physical abuse were either the husband or the boyfriend of the victim, and in more than a third of the cases they were responsible for sexual abuse. In half these cases the physical abuse was ongoing, while in more than a third of the cases the sexual abuse was ongoing, suggesting that being in a relationship does not provide women with security from abuse.

5.1.3 Abuse experienced

With regard to the types of abuse endured by the women in the total sample, most of the women reported physical abuse, with emotional abuse the second most frequently reported. When comparing women from the two categories in terms of type of abuse reported, women categorised as Psychologically Distressed reported more abuse in almost every category. This supports Hansen and Harway's (1993) suggestion reported earlier that higher levels of psychological distress may be the result of an accumulation of experiences of multiple forms of abuse. Notably a higher percentage in the Psychologically Distressed group reported emotional abuse, and all women that reported sexual abuse fell within this category. They also reported financial abuse more often. Yelsma (1996) suggests that psychological violence might be a precursor to physical violence, especially among men and women who are lacking in verbal skills and in awareness of their own and others' affective information.

The very presence of physical abuse could be expected to account for a degree of emotional abuse, and Stark and Flitcraft (1988, p. 174) point out that the experience of battering is characterised by a dual trauma: 'fear and anger induced by violent

subjugation combined with a sense of increasing entrapment. A process of institutional victimisation is combined with partner violence to transform a persistent, assertive woman into a "helpless victim" for whom "nothing can be done".'
Revictimisation may be experienced when unsuccessful attempts to take action to end the violence instead may increase depression and a sense of hopelessness or outrage. Thus a high frequency of physical and emotional abuse, together with a high rate of depression and anxiety-related disorders, such as has been found within this sample of women, could be expected to occur together.

This would support Strebel and Leon's (1996) suggestion that the higher rate of mood and anxiety-related disorders among women could be connected to the very high rates of physical and sexual abuse found among women as compared with men admitted to psychiatric hospitals, although they also acknowledge the part female gender stereotypes and women's disempowered socio-economic position may play in the diagnosis of these disorders.

Leon and Thomas (1998) in their study on the abuse histories of female psychiatric patients, found that of the 85% of the subjects reporting one or more forms of abuse, 41% reported sexual abuse and 53% physical abuse during their adult lives. The researchers speculate that this could be related to the high rate of violence in this city, and in South Africa generally. Cape Town is reported to have one of the highest rates of rape and murder worldwide (Quarterly Crime Report, 1998).
Randall and Haskell (1995) found that 50% of the women who reported physical abuse in their intimate relationship were also sexually abused by the same male

intimates. They concluded that sexual abuse is 'a significant and often simultaneous dimension of the experience of physically assaulted women.' (p. 25)

In the light of these figures it is surprising that the reports of sexual abuse among the sample of women attending the NWSC are so low, with this type of abuse being cited in only 15% of the cases. Possibly sexual abuse was under-reported due to a reluctance on the part of the woman or her interviewer to deal with the subject. This is of concern in view of the high risk of impaired psychological functioning following sexual abuse, and especially rape (Leon & Thomas, 1998). This is borne out in this study by the concentration of all sexual abuse cases within the Psychologically Distressed category, with no cases falling into the second category.

The length of the relationship and the duration of abuse within the total sample was not reported most of the time, and those cases with this information recorded gave a picture of a wide range of time periods, especially with regard to relationship length. Following the notion of an accumulative effect of abuse it could be expected that those women experiencing psychological distress would have endured abuse for a longer period than those in the Not Psychologically Distressed group. The results show the duration of abuse tended to be clustered around between 1 and 14 years, with most women categorised as distressed enduring abuse for between 1 and 4 years, or between 10 and 14 years. Perhaps those women that fail to leave the abuser within the first 4 years find themselves trapped in the relationship for many more years. There were also more distressed women with a relationship length of between 5 and 19 years.

Moreover, a number of the women in this study had left their abuser at the time of the interview, which leaves a question as to whether this was indeed the end of this relationship, and of the abuse, or whether either or both would continue or resume. Rosen and Bird (1996) point out that taking the point at which the woman leaves her abuser as the end of the abuse or the end of the relationship is not necessarily going to be an accurate reflection of events. They found that a minimum of one third of the women in shelters return to their abuser immediately, and up to 60% return within two months. Those involved with programmes for battered women cite the women's tendency to return to the abuser many times before being able to leave finally, as one of their greatest frustrations. Similarly, although the woman may leave her abuser, the abuse may continue. This highlights the difficulty of making definitive statements about when a relationship is terminated or when the abuse ends.

5.2 Psychological distress

Using the criteria suggestive of psychological distress listed earlier, a quarter of the cases were categorised as Psychologically Distressed based on their contact with a mental health professional or admission to a psychiatric facility. This contact has been noted by Novitz (1996), who reports that battered women are four to five times more likely than women without a history of abuse to require psychiatric treatment, and Leon and Thomas (1998) who found an especially high prevalence of sexual and physical abuse among their sample of psychiatric patients.

Over 90% of the women were placed in the Psychologically Distressed category by virtue of a psychiatric diagnosis. This is in keeping with research that finds abuse

leading to problems in psychological health, both short- and long-term. Stark and Flitcraft (1988) stress the far-reaching consequences of woman battering, listing diagnosis of psychiatric disorders, disorders of the personality, low self-esteem, homicidal rage, drug abuse, and alcoholism as psychological sequelae. Moreover the severity of the psychological consequences has been connected to the increasing intensity and frequency of the trauma of abuse. Herman (1992) notes that the nature of the traumatic event is what determines the extent of psychological harm, and that the personality of the individual offers little protection when confronted with events that are overwhelming in their traumatic impact. Strebel and Leon (1996) also noted the especially violent and traumatic nature of the abuse episodes suffered by the women in the samples they studied. They linked this with the more severe psychological sequelae in evidence. Thus the impact of sexual and physical violence on women has been found to both precipitate and exacerbate psychiatric morbidity (Bergman & Brismar, 1991; Desjarlis *et al.*, 1995).

Only 2 cases (7%) were categorised as Psychologically Distressed because of a reported suicide attempt, which is surprising when compared with the literature. Stark and Flitcraft (1988) found one in four suicide attempts to be domestic violence-related, and report that 19% of battered women have attempted suicide at least once. Cohen (1994) notes submissions from a report published by the United States Department of Health and Human Services that found between 35% and 40% of abused women try to end their lives. In this country Novitz (1996) notes that these women are five times more likely to attempt suicide than women without histories of domestic violence. Leon and Thomas (1998) found that the experience of childhood abuse and/or adult sexual abuse significantly increased the risk of self-harm

behaviour among their sample of psychiatric patients. The figures in these studies suggest that suicide attempts were possibly under-reported at the NWSC, perhaps due to a fear of stigmatisation or due to a lack of opportunity or a reluctance on the part of the interviewer to explore this area.

The literature suggests that demographic variables such as unemployment, lower educational levels, together with the experience of feeling trapped in an abusive relationship, sometimes from a young age and for a substantial period of time, could all be suggestive of greater stress levels generally, and therefore increased vulnerability to psychological distress (Desjarlis *et al.*, 1995). These stressors may also have a negative impact on women's perceptions of their own control, and in this way affect their ability to function optimally (Orava *et al.*, 1996). Campbell *et al.*(1997) also cite research finding demographic variables such as those mentioned above to be factors contributing to depression among battered women.

Regarding the range of diagnoses accounting for women being placed within the category of Psychologically Distressed, mood disorders, specifically depression, accounted for almost 60%. This predominance of depression amongst battered women is well documented in the literature (Campbell *et al.*, 1997; Orava *et al.*, McLeod & Sharpe, 1996; Rawlings & Green 1991; Stark & Flitcraft, 1988). Gleason (1993) found that women subjected to ongoing battering by their intimate partner evidenced depression as the primary mental health response. Novitz (1996) states that battered women are likely to suffer from depression, and are five times more likely to attempt suicide than those women who have not been abused. Strebel and Leon (1996) found mood disorders to constitute the main Axis I diagnosis among

their sample of women psychiatric patients, and research by Leon and Thomas (1998) found mood disorders to be one of the most frequent diagnoses among women in an acute admission ward.

Strebel *et al.* (1999) do cite research findings from various parts of the world that have repeatedly found more women generally to be depressed when compared with their male counterparts. However these authors agree with others (Desjarlis *et al.*, 1995) that factors such as women's disempowerment socio-economically, their subjection to sexual and physical abuse, and the possibility of diagnostic bias due to gender stereotypes, probably have a significant influence on the rate of depression recorded among this population.

Moreover, research has found that the severity of depression increased with a rise in the frequency and severity of the abuse experience (Kemp *et al.*, 1991; Orava *et al.*, 1996). These findings would suggest that there is a strong relationship between women's histories of abuse from a partner and current psychological health. Walker (1991), contrary to her expectation that battered women who had left the abusive relationship would be less depressed than those that had not left, found the former to be more depressed. In addition, the end of the relationship does not always end the abuse. Although in this study information was only available for approximately 60% of the cases, a qualitative look at the data indicated that almost half of these women had left their abuser, while a few had returned to their abuser following a separation. Turner and Shapiro (1986) suggest that the emotional needs of these women are often ignored or underemphasised, and that it is the pain of the losses experienced at the end of a relationship that need to be worked through before

the women can be expected to move on. Without some sort of grief resolution, depression and anxiety may be seen to increase rather than decrease. Thus this may play a part in the high rate of depression in this sample, considering nearly half the women for whom information was available were currently separated from their abuser. Despite the literature citing up to a 70% rate of reconciliation between abused women and their partners, this was not bourne out by this study where only seven (approximately 10%) reported that they had returned to their partners. However their visit to the Centre may in all likelihood have been precipitated by a crisis point in their relationship, such as a separation, and this separation may or may not be permanent.

Another area of diagnosis was anxiety-related disorders, which together accounted for just under a quarter of the diagnoses assigned to the women in this sample. Strebel *et al.* (1999) also found high rates of anxiety disorders which they postulated could, together with the high rates of depression, be indicative of female gender stereotypes, and also of women's less powerful position socio-economically. Randall and Haskell (1995) place emphasis on the long-term impact of the sort of violation ongoing physical assault may have on women. In their study women reported high levels of fear and anxiety, both as a result of the violence of the assault, and the possibility and unpredictability of the next attack. They found that in 36% of the cases, women who experienced physical assault also reported being afraid that their abuser would one day kill them. Saunders (1992) found that women tend to think of suicide when they feel especially trapped in a relationship

Interestingly, although the development of a personality disorder, particularly Borderline Personality Disorder, has been documented as one of the risks of long-standing abuse (Orava *et al.*, 1996; Stark & Flitcraft, 1988; Walker, 1984), there were only two cases among this sample. Likewise, Leon and Thomas (1998) found an Axis II diagnosis was seldom given, while in contrast the majority of abused women in the sample studied by Strebel *et al.* (1999) were diagnosed with a personality disorder, including Borderline Personality Disorder. However, these results could be attributed to the contexts within which the research took place. The Leon and Thomas study took place in an acute admission ward which would have accommodated a majority of psychotic patients, while the Strebel *et al.* project covered all wards, including neuroclinic wards where Axis II diagnoses tend to be more frequent. It is also likely that there were few diagnoses of this disorder at NWSC due to the absence of a clinical assessment and an adherence to a feminist empowerment model that would encompass a reluctance to diagnose.

This study has highlighted once again the far-reaching damage the experience of battering may inflict on it's victims' psychological health. It points to the need to encourage women to seek help as early as possible after abuse begins, and to provide them with the resources to take the action necessary to both end the abuse and to regain a sense of psychological equilibrium. This places emphasis on the role of the police, the criminal justice and social welfare systems, and their accessibility and efficiency. It also underlines the importance of a thorough assessment when counselling battered women so that they may be provided with the kind of assistance that will be of value to them at their particular stage in the process of change in which they are engaged.

CHAPTER 6

CONCLUSIONS

This chapter presents an integration of the research findings discussed in the previous chapter, with an emphasis on recommendations for the assessment and management of battered women. The chapter closes with a reflection on the limitations of this project, and suggestions for future researchers in the area.

6.1 Integration of findings and recommendations for assessment and management

At the beginning of Chapter 3 the question was raised as to whether the NWSC counsellors were identifying cases suggestive of a possible psychiatric diagnosis. The data collected would indicate that although some cases of depression were reported, on the whole this sort of psychological distress was not noted in the file. However it should once again be bourne in mind that this sort of assessment has been contrary to the feminist empowerment model that guides the NWSC's work with women.

The research findings have indicated that more than a third of the cases seen by counsellors could be identified as experiencing some level of psychological distress.

Studies show that exposure to severe trauma will result in some damage, and authors such as Herman (1992, p. 3) assert that 'People who have endured horrible events suffer predictable psychological harm'. Research also shows that the more promptly this is detected and addressed, the sooner health is regained. However failing this, psychological health in both the long- and short-term may be severely compromised. Despite these assertions, it would appear that the role of resilience and protective factors cannot be dismissed, suggesting that an assessment of both strengths and vulnerabilities is crucial to inform decisions about case management.

The importance of making a sensitive, but thorough assessment of the client's present situation as well as her abuse history cannot be underestimated. Both individual experience and the political or social context need to be understood in their entirety in order for the battered woman to feel her experiences are being validated and her needs met (Herman, 1992). Those symptoms that are reported in the intake interview need to be placed within the context of the events of the past in order for their full meaning to be understood.

Salient information may easily be overlooked in an intake interview, and Eilenberg *et al.* (1996) found in their study of mandated enquiry into trauma histories, that histories of abuse and trauma may be missed even when clinicians were required to ask, whether this be due to neglect or to reluctance due to discomfort with the subject. The studies conducted by Leon and Thomas (1998) and Strebel *et al.* (1996) generated vastly disparate figures for histories of abuse among their sample of psychiatric patients. It is likely that the 85% found in the first study was due to the in-depth individual interviews of each case by the researchers, while the

approximately 10% reported in the latter study was because abuse histories were taken from the case files. Wilson (1998) suggests that it is not simply a matter of eliciting a detailed history, but of conducting an interview in a way that will allow the trauma of the past to find a voice.

The above highlights the importance of the first interviews for assessing the needs of the client, the stage of change she may be in, and the strengths and vulnerabilities that need to be taken into account before deciding on how to go forward. Cowger (1994) has provided guidelines for assessing strengths, both personal and situational. Although these goals are consistent with the goals of the NWSC, the client's vulnerabilities also need to be appraised. Her level of psychological distress will determine which interventions will be appropriate, and some emotional healing may be indicated before she is able to make decisions about her future. Much has been written about the immobilising effects of depression, and the debilitation of other disorders (Herman, 1992; Saunders, 1992), and this needs to be accommodated for, and preferably by the Centre. Referring women elsewhere is likely to further alienate and isolate them, and admission to one of the psychiatric hospitals also needs to be avoided if possible. Apart from the stigmatisation and subjection to the problems associated with conventional medical intervention, these hospitals lack the facilities to deal adequately with the problems relating to battered women.

The counselling intake form utilised by the Centre during the time of this study was successful in directing attention towards depressive symptoms. Although it is unrealistic to propose a comprehensive form that will identify all symptoms of psychological distress, it is conceivable that a form, designed to pick up on some of

the major symptoms of a variety of the most commonly occurring disorders, could be utilised. Symptoms recorded that may be indicative of psychological distress could then prompt a consultation with a clinically trained staff member, who could advise and supervise the counsellor dealing with the client.

Although the empowerment model may be suitable for many battered women, and possibly for most if introduced at the appropriate stage, it cannot be expected to eradicate long-standing symptoms or patterns of behaviour, and it has it's limitations when it comes to healing deep wounds. Although it may help to contain some women in the short-term, superficial signs of health may give way to depression or other signs of deterioration at a later stage. Moreover, without substantial growth and change, unresolved issues may leave a woman vulnerable to repeating behaviour patterns that are destructive.

Research has documented an association between childhood abuse and later abuse as an adult (Herman, 1992; Leon & Thomas, 1998; Russell, 1986), and these childhood issues that link into difficulties being experienced within current relationships need deep exploration and holding by an experienced counsellor or therapist. Such therapy would also be indicated where deep-seated issues may have damaged the woman's sense of self, where helplessness, powerlessness, abandonment, grief, and intimacy issues need working through in order for the woman's healing to be holistic.

The possibilities offered by short- as well as long-term therapies appropriate to the needs of battered women warrant exploration. Alternatively, the services of appropriate therapists that are prepared to do pro bono work, or work at a reduced rate, may be enlisted to assist the Centre with their work.

Finally, the reasons for the non-utilisation of the services of the NWSC by the black, or more specifically, the Xhosa-speaking population needs to be investigated. It seems that accessibility may be one of the factors contributing to this problem, and this is an area that the NWSC aims to rectify. Phase 3 of the development of the aims of the project is to assist with the building of self-help structures within communities so as to maximise the proximity of their services to all women who need them. Another obstacle may be the provision of an Anglicized form of therapy for a population who may be struggling with issues of white-black dominance and oppression (Levett, 1994). Whatever the causes of the under-utilisation of the Centre by black women, research has indicated that the problems of abused black women are widespread and often exacerbated by social, economic and political disadvantages, implying the need for urgent attention in this direction.

6.2 Limitations of the present study and suggestions for future research

Although the overall aim of this research was achieved as far as was possible, that is, the extent of psychological distress among the 1995 client population of NWSC was determined, this was not without obstacles. This section will allow for reflection on those areas within this project that presented difficulties, which may prove useful to future research in the area.

One of the main problems was that the data used was not originally collected for the purposes of this study, or for research purposes at all, so that the project was limited by the information available. Should the interviews have been conducted with the purposes of this project in mind, the data would probably have been more appropriate to the research question.

Also problematic was this study's investigation of the psychological distress of women attending the NWSC, making this a selective sample that cannot be assumed to be representative of the general population of battered women. There was also no control group with which comparisons of this sample could be made. Moreover, the difficulty in quantifying psychological distress has been acknowledged elsewhere (Strebel *et al.*, 1999).

Results obtained from this research focus on the psychological damage that accompanies physical and psychological abuse in a relationship. However it would be useful to look at the interaction of these factors with more practical ones (e.g. financial considerations), emotional issues (e.g. loss or anticipated loss of the emotional needs satisfied within the relationship) and societal concerns (e.g. societal attitudes towards violence against women) that often account for the difficulty women experience in leaving the abusive relationship. These factors are also likely to serve a protective function by contributing to the woman's resilience or vulnerability.

Another related difficulty encountered in this study was the paucity of information in some of the files. There is no way of knowing the reasons for this, it may have been due to a lack of opportunity on the part of the interviewer (Vale, 1997), a lack of

experience, a failure to make a thorough enquiry or failure to record the information. It may have been due to the client's inability, reluctance or even her active refusal to take part in the discourse of victimology (Levett, 1994), by revealing certain information. Whatever the reason, it is apparent that this is an area that is problematic, as it is hard to make decisions regarding the management of a case without a thorough assessment.

However, even were this information readily available in the files, it has to be acknowledged that there is also some difficulty with regard to the validity of women's recollections of data such as details of the abuse, the physical or emotional symptoms experienced, and treatment received, due to the retrospective nature of both this study, and of women's reports of their abuse histories generally. There was also some trouble with the tools of measurement, that is, diagnosis based on the information contained in file notes is likely to be open to a multitude of problems as far as accuracy is concerned. Following from this, there is likely some difficulty with the categorisation of cases based on this method of diagnosis, as well as based on reports of diagnoses given, hospitalisation or treatment received, or even attempts at suicide. This is especially so as the meaning women give their experiences of abuse, their encounters with helpers, and the labels assigned to them by the medical establishment are not always clear.

It also needs to be bourne in mind that due to the cross- sectional nature of this study, the focus is on women's experiences at a particular point in time, which fails to allow for the influence of other life events, either currently or in the past, as well as accuracy of recall. Moreover, as Briere (1992) points out, when time-specific abuse

sequelae are the focus there is the problem of abuse-related symptomatology varying across the life span.

A statistical analysis of the data was considered but thought to be unnecessary. Being of an exploratory nature, this study may provide an indication of directions for future research and data from this may lend itself to deeper analysis.

Lastly, further research is needed with samples that are larger and more diverse than the present one in order to improve generalisability to women who are not recipients of services for abused women. This could be a convincing call for a more diverse range of services for battered women, especially for those who are experiencing enduring psychological problems as a result of their abuse experiences.

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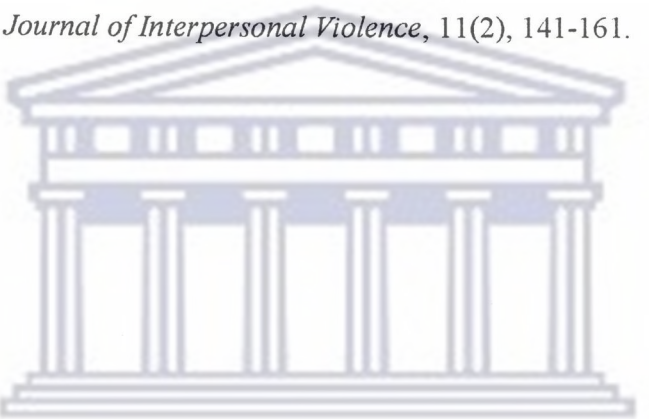

APPENDIX A

DATA CAPTURING FORM **FILE NO:.....**

Checklist for files: (If no info given - leave blank.)

AGE:

AREA OF RESIDENCE:

UN/EMPLOYED:

EDUCATION:

REFD TO:

OTHER ACTION TAKEN/AGENCIES SEEN:

LANGUAGE:

REL. TO MAN:

DURATION OF REL:

LEFT MAN:

TYPE OF ABUSE:

DURATION:

SEVERITY:

INDICATIONS OF PSYCHOLOGICAL DISTRESS:

PSYCHIATRIC TREATMENT:

PSYCHIATRIC DIAGNOSIS:

PSYCHIATRIC HOSPITALISATIONS:

SUICIDE ATTEMPTS:

DESCRIPTION OF PSYCHOLOGICAL FUNCTIONING: