

**A QUALITATIVE STUDY OF FIVE WOMEN'S
EXPERIENCES OF ABUSE BY AN INTIMATE MALE
PARTNER.**

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**Submitted in partial fulfilment of the requirements for the
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ABSTRACT

Woman abuse is now well recognised as a local and international concern that has serious repercussions for women's health and well-being. Little however is known about what it feels like to be abused by someone you love. How does a woman make sense of a life of physical and psychological abuse? Why does she stay in the abusive relationship?

To gain more understanding of this complex dynamic, a qualitative study of five women's experiences of violence by an intimate partner was performed.

The first part of this paper, a literature review, examines women's accounts of their experiences in abusive relationships by looking at common themes across these studies. The second part details the research process.

The knowledge uncovered by the women's stories, can provide family physicians with valuable insights for devising strategies to identify and intervene in domestic violence.

1. INTRODUCTION

*She walks hurriedly- head down, eyes averted, shoulders hunched
pulling her coat tighter ever tighter, even though the sun is warm
today and kind.*

Her empty hollow footsteps jar the senses

And reflect the pain mirrored in her eyes,

Her cheek is glistening- blue and purple swelling.

Her lip is trembling- bloody and red

Her frightened eyes glint with tears- rainbow hued.

*No, I am fine! She said vehemently. So stupid! I bumped into the
door (again!) So silly! I fell down the stairs (again and again and
again) this to the neighbour, concerned or curious or both.*

Hidden secrets and shame and living like a shadow on the wall.

Until she chooses to break the chain.

(Poem by an abuse survivor)

1.1. BACKGROUND AND RATIONALE FOR DOING THE STUDY.

Of the most frequently asked questions about abused women are; “Why doesn’t she leave the abusive relationship?” and “Why does a women stay with a man who repeatedly beats her?” As a family physician working in a community primary care clinic, I became sensitised to woman abuse and found that it was a common occurrence amongst the women attending the clinic. I wanted to learn more about their experiences of abuse and how women made sense of the ongoing abuse. I was also curious to learn how experiences of women living in a township in Cape Town, South Africa, will compare with findings of research conducted elsewhere. In searching for the answers to these questions, I conducted interviews with five women who were or had been in abusive relationships.

1.2. DEFINITION OF TERMS

Violence against women is a difficult phenomenon to define because it covers a wide range of actions and subjective components. The following description attempts to describe it:

“Woman abuse is understood as a chronic syndrome that is characterised not by the episodes of violence that punctate the problem, but by the emotional and psychological abuse that the batterer uses to enforce and maintain control over his mate. Violence is thus the ultimate expression of a desire for control and domination. Violence and the threat of violence against the battered woman and her loved ones serves as the means by which her submissiveness and secrecy are enforced. Furthermore, as most battered women report, the physical violence is often the least damaging abuse that she endures. It is the relentless emotional and psychological violence that cripples and isolates the woman”¹

Terminology used to describe violence against women may be interpreted differently in different contexts and cultures. Neutral terms such as "domestic violence", "family violence" and "spouse abuse" often obscure the gendered nature of the abuse. Terms like "wife abuse" and "wife battering" exclude the experiences of many women who are not legally married to partners. The term, "woman abuse", does not differentiate between violence from known or unknown perpetrators. "Violence against women by their partners" expresses the gendered nature of violence and is not limited by legal sanction of the partnership, but it does not clarify whether it refers to same sex partners.²

In this study the terms "woman abuse", "domestic violence" and "gender violence" are used interchangeably. It refers to any act of gender-based violence that results in, or is likely to result in physical, sexual or

psychological harm or suffering to adult and adolescent women by current or former intimate partners. This also includes threats of such acts, coercion, or arbitrary deprivations of liberty, whether occurring in public or private life. ³

2. LITERATURE REVIEW

There is little literature and research on woman abuse prior to 1970. With increasing public awareness and the recognition of woman abuse as a human rights issue as well as a public health concern, a large body of research has been carried out in the past three decades, particularly in the United States and Europe.

I conducted literature searches from 1980-2000 using the databases Medline, Pubmed, POPLINE and the search engine, Google (www.google.com/search) Keywords used were women+abuse+experiences+qualitative research.

2.1 A REVIEW OF QUALITATIVE RESEARCH ON WOMEN'S EXPERIENCES OF ABUSE

I have limited my literature review to qualitative research published within the past twenty years based on women's first person accounts of their abuse experiences. The studies selected took as their primary source of data the perspective of the abused women. Quantitative studies with qualitative components were also included.

The literature review refers to themes identified in the various studies and the comparison of these themes across studies.

2.1.1. HOW WOMEN RATIONALISE THE ABUSE

One of the most frequently asked questions is why women stay in abusive relationships? A study conducted in 1983, looked at how women make sense of their victimisation.⁴ The authors described six techniques of rationalisation used by women who were in abusive relationships.

1. Appeal to the salvation ethic.

Women assume responsibility for helping their "sick" partners overcome their problems. The appeal to the salvation ethic is a common response to an alcoholic or drug-dependent abuser.

2. Denial of the victimiser

Similar to the salvation ethic, but women do not assume responsibility for their abusers' problems. They perceive battering as an event beyond control of both spouses and blame it on external forces such as work pressure, loss of a job or legal problems.

"He's sick. He didn't use to be this way, but he cannot handle alcohol. I think too that this is what he saw at home. His father is a very violent man and an alcoholic too ... So it's really not his fault because this is all he has ever known." ⁴

3. Denial of the injury

For some women the experience of being battered by a spouse is so discordant with their expectations that they simply refuse to acknowledge it. They return to routine life as if nothing had happened.

"I could not believe it had happened and I did not want to believe it. We had only been married for a year and I was pregnant and excited about starting a family ... The next morning he told me he was sorry and it wouldn't happen again, and I gladly kissed and made up." ⁴

4. Denial of victimisation

Women often blame themselves for the violence, thereby neutralising the responsibility of the abusing partner. Women in this study did not believe violence against them was justified, but some felt it could have been avoided if they had been more passive and conciliatory.

5. Denial of options

This comprises of two elements: practical options and emotional options. For a variety of reasons some women do not take full advantage of practical opportunities which are available to escape from an abusive lifestyle and some return to abusers voluntarily even after establishing an independent lifestyle. The denial of emotional options imposes further restrictions with abused women feeling that no one else can provide intimacy and companionship. While physical beatings are painful and dangerous, the prospect of a lonely celibate existence is often too frightening to risk. One woman said:

*"He is all I've got. My dad is gone and my mother disowned me when I married him ... He understands me and I understand him ..."*⁴

6. The appeal to higher loyalties

This appeal involves enduring battering for the sake of some higher commitment, either religious or traditional. Some respondents in this study depicted their partners as victims whose behaviour was the result of childhood injustice. This method of coping redefined bad behaviour as sick behaviour, strengthening the perception that he could get well and improve, and establishing her duty to help him.

2.1.2 CATALYSTS FOR CHANGE OR LEAVING THE ABUSIVE RELATIONSHIP

One study identified six catalysts that shatter the woman's rationalisations and redefine for them that their situation is abusive.⁵

- ***A change in the level of violence***

The severity of violence does escalate over time and the intensity of the abuse is an important factor in women's decisions to leave a violent relationship.

- ***A change in resources***

The emergence of safe homes and shelters has produced a new resource for abused women. While not completely adequate or satisfactory, the mere existence of a place to go alters the situation in which battering is experienced.

- ***A change in the relationship***

The initial phases of the abuse may be followed by remorse and solicitude. But as the abuse progresses, the periods of remorse may shorten or disappear, eliminating the basis of maintaining a positive outlook. One woman recalled:

*“At first we had so much fun together... Since the baby came, it's changed completely ... He does not even talk to me most of the time ... I do not really love him anymore ... ”*⁵

- ***Despair***

When there is a loss of hope that things will get better, rationalisation of abuse may give way to the recognition of victimisation.

- ***A change in the visibility of the violence***

Battering in private is degrading, but public abuse is humiliating. Having others witness abuse may create intolerable feelings of shame which undermine prior rationalisations.

"He never hit me in public before- it was always at home... We went Christmas shopping and he slapped me in the store because of some stupid joke I made. People saw it. I know, I felt so stupid, like, they must think what a jerk I am, what a sick couple. I thought, God, I must be crazy to let him do this ... " ⁵

- ***External definitions of the relationship***

External definitions vary depending on their source and situation. They can reinforce or undermine rationalisations. Abused women who seek help from others either family or officials, may find them unsympathetic.

"It wouldn't be so bad if my own family cared a damn about me ... I got raped and beat as a kid, and now I get beat as an adult. Life is a big joke. My mother- in- law knew what was going on but she would not admit it ... I said Mom, what do you think these bruises are? And she said " Well, some people just bruise easily. I do it all the time, bumping into things... " ⁵

In one study the researcher identified an "Open Window Phase", where women were most likely to seek help and recognise the reality of their abuse.⁶ The Open Window Period occurred most commonly after an acute episode of abuse and prior to reconciliation and resumption of duties.

In another study, Landenburger described the complex dynamic by which women become entrapped in abusive relationships and their eventual recovery as a process made up of four stages, which she refers to as **binding, enduring, disengagement and recovery**.⁷ During the **binding stage** violence is initially rationalised or denied, while women focus on the positive outcomes of the relationship. As the violence become more acute and ongoing, it enters the **enduring stage** and there is a shift in women's perceptions. They often cover up the violence, blame themselves for the abuse or modify their own behaviour in an attempt to gain some control over the situation (e.g. leaving work, not seeing friends or doing things that might make their partner angry) Eventually women reach a point where they are able to put a name to what is happening to them. Once able to recognise themselves as abused, they are able to seek help and to begin the process of **disengagement** and eventual **recovery** from the abusive relationship.⁷

2.1.3. EFFECT OF ABUSE ON WOMEN'S SELF-ESTEEM

The majority of study participants in the various qualitative studies noted the devastating affects of abuse on their self-identity. Sample quotations include:

*"... He used to tell me... "You 're an animal, an idiot, you are worthless". That made me feel even more stupid. I couldn't raise my head. I think I still have scars from this and I have always been insecure ... I would think, could it be that I really am stupid"*⁸

*... He twists my breast, he hits me in the face so that my glasses fly off and then I can't see anything. But worst is his contempt as he carries on: "You disgust me, you bitch ... Now you are really going to get it"*⁹

The women in these studies reported feeling numb, passive and confused as well as experiencing loss of identity, dignity and trust.^{7 8,9} They also reported that the emotional abuse was worse than the physical abuse. Verbal and psychological abuse caused devastating feelings of inferiority.¹⁰

"I have been verbally abused as well. You may say you feel good and you may ... But inside you know what has been said to you and it hurts for a long time. You need to build up your self-image and make yourself feel like you're a useful person, that you're valuable, and that you're a good parent" ¹⁰

2.1.4 WOMEN 'S EXPERIENCES WITH THE HEALTH CARE PROFESSION

The abused women consistently commented that health care providers focused on the injury only and ignored social or emotional problems. Women also reported a "code of silence" where they did not reveal the source of their injuries and the health care members usually did not inquire .¹¹

In one study on the experiences of abused women in health care settings, a Systems Model was used to categorise the barriers abused women encounter in health care settings into patient, provider and organisational levels. ¹² The data revealed that at the patient level, many women chose to conceal their abuse from their health care professionals, some fearing retaliation from their partners if they were to reveal the source of their injuries. At a provider level, the women perceived health care professionals to be uninterested and unsympathetic towards the needs of battered women, causing the women to feel ignored and her problem trivialised. At an organisational level, the abused women believed that the

structure of the health care system did not allow health care professionals enough time to deal with issues beyond treating their immediate presenting injuries.¹² The respondents in this study told stories of physicians who treated bruises and broken bones but never asked how it happened.

These perceptions were echoed in another study.¹³ Even when aware of the ongoing abuse, nurses and doctors were often judgmental and condescending, making women feel stigmatised and isolated .

*"They think domestic violence is your own doing and maybe ... You deserve it "*¹³

Some respondents described positive encounters with health care providers who expressed concern and referred them for help. An elderly woman told how she left her abusive husband for good after an interview with a compassionate physician.¹⁴

*"I'd been hit before, but I never figured it was real abuse until my doctor told me I was being abused."*¹⁴

2.1.5 ABUSE IN ELDERLY WOMEN

Little has been written about elderly women who are battered by their partners. One study of domestic violence against elderly women showed that barriers to leaving were greater for these women.¹⁴ Reasons cited were that divorce was uncommon, difficult to obtain and stigmatised. These women recounted the same control issues in language similar to that of the abusers of younger participants. The women also recalled

abusive incidents that happened many years ago and these memories were linked to the ages of their children.

2.1.6. ABUSE DURING PREGNANCY

Women reported that abuse began during pregnancy and escalated as the pregnancy progressed, sometimes resulting in preterm labour or loss of the pregnancy.^{8,9,14} Abusive men enforced and maintained control over their partners by having a child with them. According to one woman:

*"They own you ... part of the purpose of having a baby is to control you."*¹⁵

*"The first time he hit me ... yeah, it was when I was pregnant. But then he would hit me carefully ... it was mostly what you call smacks. Then after the boy was born, it got more serious..."*⁹

2.1.7. MARITAL RAPE

In some of the studies reviewed, abused women described having had forced sex. This often occurred after the beatings. Most did not describe it as rape, and after a severe beating did not resist their partners.^{14,16}

*"If he didn't rape me once, he raped me five times. Like I was not willing, like when I am doing the washing and sewing ... I am not thinking of sex. And he is standing there all exposed ..."*¹⁴

*"He poured water over me and dragged me by the arm from the couch to the bedroom and then proceeded to (pause) ... to make love to me. I did not know what to do. I just closed off my head ..."*¹⁶

2.1.8 CULTURAL PERSPECTIVES

One of the strengths of qualitative research is the access it provides to the cultural context surrounding events. Although woman abuse occurs in almost all cultures, there is diversity in women 's experiences of abuse in the articles reviewed.

A qualitative study that explored the experiences of 15 African American and 15 Anglo American women, found that differences in power relationships and public responses to abuse distinguished the experiences of these participants. Differences in responses also suggested that leaving an abusive relationship was a culture -bound experience.¹⁷

In Mexico, researchers found that by using hypothetical narratives and third person interview tactics in exploring domestic violence, women were able to discuss this sensitive topic.¹⁸ A study in Nicaragua found that wife battering was exacerbated in the context of cultural traditions of wife beating, the concept of machismo and marianismo, and the recent history of warfare.¹⁹ Machismo as an ideology emphasises male economic and social superiority over women. It is a cult of virility in which male aggressiveness and sexual prowess are supremely valued. The concept of marianismo refers to spiritual devotion to the Virgin Mary. Latin American women are expected to emulate the Marian model of spiritual perfection and purity and are valued primarily for their ability to become mothers.

In a large ethnographic study the authors looked at partner violence in non -Western societies.²⁰ They identified four factors that in combination are strongly associated with violence against women. These are: economic inequality between men and women; a pattern of using physical

violence for conflict resolution; male authority and decision-making in the home; and divorce restrictions for women.

More significantly, the researchers identified societies that were essentially free of violence against women. These findings are meaningful in that they indicate that violence is a learned behaviour rather than an innate feature of human nature and therefore by implication it should be possible to unlearn violent behaviours.

Counts, Campbell and Brown have conceptualised domestic violence cross culturally in their "Sanctions and Sanctuary " framework.²¹ This framework theorises that battering of women is more common in societies where women's status is unstable or evolving, and least common in societies where women have either very low or very high status since there is no need to enforce male authority. It is argued further that societies with the least domestic violence are those where both **community sanctions** against violence and **sanctuary** for battered women exist.

2. 2. THE SOUTH AFRICAN CONTEXT

Since the election of a democratic government in 1994, organisations such as the Commission on Gender Equality have expressed a commitment to address the issue of woman abuse. Research on family violence in South Africa has increased in the past ten years. The Medical Research Council has also initiated several research projects on gender violence.²²

The Committee on the Elimination of Discrimination Against Women, a United Nations body charged with the oversight and implementation of the Vienna based Convention for the Elimination of all forms of Discrimination Against Women (CEDAW) incorporates explicit censure of domestic violence. Internationally the South African government ratified CEDAW in 1995 and the first report to CEDAW was made in 1997.²³

The Prevention of Family Violence Act was first introduced in 1993. The Act provides for the granting of interdicts preventing family violence. Although it offered a channel of relief, it had many weaknesses and provided loopholes for the perpetrators of abuse. The revised Domestic Violence Act was introduced in December 1999.²⁴ The revised Act now also includes gay and lesbian couples and couples who have a child but do not live together anymore. The effect of these amendments resulted in shifting the focus away from a concentration on physical violence in a heterosexual marriage relationship to a myriad of tactics of power and control against domestic violence victims including children and the elderly. The revised Act has been widely defined to include physical,

sexual, emotional, verbal and psychological abuse, intimidation, stalking, damage of property and trespassing.

2.2.1. QUALITATIVE STUDIES ON WOMAN ABUSE IN S.A.

A study based on in-depth interviews with 21 women who were past residents of a shelter in Cape Town, documents the difficulties experienced when separating from the batterer, going to the shelter and starting a new life.²⁵ The women identified the shelter as a catalyst in transforming their lives. (The shelter referred to in the study has since closed down due to lack of funds) The experiences encountered in leaving the abusive relationship and the lack of community support was similar to those encountered in other qualitative studies.

In an exploratory study in the Johannesburg region, ethnographic interviews were conducted with women from various community settings.²⁶ Data was grouped and some of the categories identified were: aspects of abuse in South Africa, relationship between abuse and apartheid, the traditional status of women, and perceptions about services. All respondents agreed that a relationship between apartheid and abuse existed although their opinions and explanations varied. As one woman stated:

*" apartheid and woman abuse have in common the intentionality of the perpetrator and the traumatic impact of the abuse on the victim. "*²⁶

Aspects of women abuse that appeared distinct in the South African context seemed less so in a global perspective. The status of particularly Black South African women is however undermined by traditions such as

lobola, dowry and arranged marriages. This tends to objectify women and make them feel like male property.

*"Because he paid lobola, I am expected to be grateful and do my money's worth. He treats me like his property."*²⁶

A qualitative study conducted amongst pregnant teenagers in Khayelitsha, Cape Town showed violence to be a consistent feature of teenage sexual relationships and the primary means by which pervasive male control over female partners was enforced.²⁷ The researchers found that the conditions and timing of sex were defined by men through the circulation of certain constructions of love and sexual entitlement, which was enforced through assault and coercion. The respondents also expressed the perception that abuse though unpleasant, was "normal". From a criminal perspective, it is of concern that acts, which in other circumstances would constitute assault and rape, are regarded as "normal" if perpetrated by a sexual partner.

A Medical Research Council study was conducted amongst Xhosa youth in Umtata, Eastern Cape. The aim of the study was to gain understanding of the circumstances and contexts of violence in young people's sexual relationships.²⁸ The key findings were that violence within youth sexual relationships exists in the form of physical assault and forced sex. Many narratives described actual forced sex.

*"It was against my will. He was using a stick to hit me and then forced me to take off my uniform. When I refused, he grabbed me and took it off by force so that it was torn in the process."*²⁸

2.3. FAMILY MEDICINE AND WOMAN ABUSE

Research has shown that the majority of medical visits related to domestic violence are not to the emergency room but to the primary care physician.²⁹ Patients often present with chronic, vague somatic complaints or stress related illnesses.³⁰

2.3.1 QUALITATIVE STUDIES OF INTERACTIONS BETWEEN FAMILY PHYSICIANS AND ABUSED WOMEN

A qualitative study of doctors' interactions with abused women showed that physicians struggled between approaching domestic violence as a legitimate medical problem or retreating from it as an overwhelming social issue.³¹ Resolution occurred through three stages that changed the doctors' objective from "fixing" the abuse to supporting the patient. As physicians worked through this process, the goal of their intervention shifted to validating the existence of abuse, informing the patient of options and resources, and showing respect for her options. This goal revision required education on the dynamics of domestic abuse, confrontation of personal issues, and the formation of community partnership.

Another study on physicians' perceptions and approaches to woman abuse, found that family physicians that go through residency and certification felt that they were more aware of the problem of woman abuse but did not necessarily treat it more effectively. Paradoxically, while most physicians thought more continuing medical education in woman abuse was needed, few had attended a course in the previous two years.³²

A qualitative study of battered women's perspective of their family physicians found that women value direct questioning about abuse, referrals to appropriate agencies that can offer assistance, follow-up, attentive, non-judgemental support and understanding and confidentiality.³³

A study that explored interventions used by physicians committed to providing quality health care to battered women, revealed the following: Physicians viewed validation (i.e. providing messages to the patients that they are worth caring about) as the foundation of intervention.³⁴ Other interventions included labelling the abuse as abuse, listening and being non-judgemental, documenting, referring and safety planning, using a team approach, and prioritising violence in the health care environment. Physicians described a range of rewards for intervening with abused patients. This ranged from seeing a patient change her entire life to subtle shifts in the way a woman thinks of her relationships and herself.

2.3.2 PRINCIPLES OF FAMILY MEDICINE AS IT PERTAINS TO WOMAN ABUSE

McWhinney described nine principles of Family Medicine³⁵ Four of these principles can help us as family physicians to understand woman abuse more clearly and to accept it as a health issue.³⁶

The family physician is an effective clinician (the family physician seeks to understand the context of the illness)

The knowledge, skills and attitudes needed to enquire and address violence against women are specific. As family physicians we must be able to ask about abuse during the consultation, to listen to what our patients tell us and to interpret covert messages. We also need to know

how these experiences can impact on someone's health. These are clinical skills that can be learnt and acquired.

The doctor- patient relationship is central to family medicine (The family physician is committed to the person rather than to the disease)

This principle acknowledges the special trusting relationship between physician and patient. This relationship implies commitment for care in the future. It is also a commitment to let survivors know that they are believed and that their disclosures are valued; privacy protected and their decisions respected. This relationship provides space and safety for women to tell their stories when they are ready. Women in abusive relationships have reported that even small signs of compassion from healthcare professionals have made a difference in their lives.³³

The family doctor is community based (family physicians should share the same habitat as their patients)

This implies that we work as closely as possible to our patients to facilitate accessibility and availability. This principle implies that our patients have somewhere else to go during hours when we are not available. In the context of abuse, our patients should know whom to contact and as family physicians, we should be aware of emergency resources that can be accessed.

The family physician is a resource to defined practice population (the family physician is part of a community wide network of supportive and health care agencies)

Woman abuse is a good example of an issue on which we can become resources to our practice. We should increase our skills and knowledge and incorporate resources outside our practices within our communities.

A holistic approach, as was shown in a previous study, has assisted physicians in dealing with woman abuse.³⁴ This involved using a team approach, prioritising domestic violence, developing a culture of caring and sending a powerful message of prevention and intervention to abused patients. Shelters, counselling services and public awareness are only some of the avenues through which we can advocate on behalf of our patients.

3.METHODODOLOGY

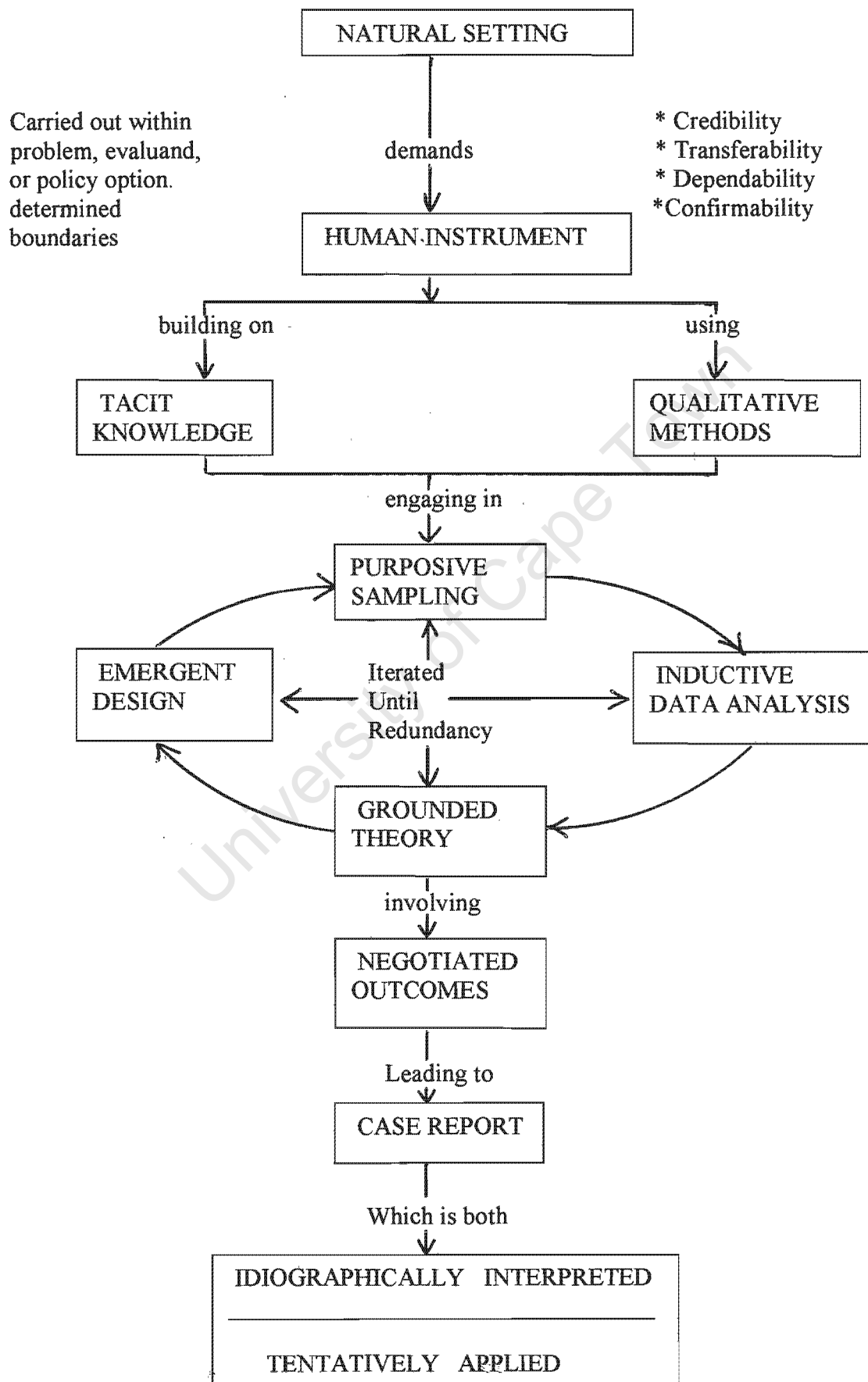
3.1 QUALITATIVE INQUIRY

Qualitative methods have a long history in anthropology, sociology and education. It is described in the following way:

*"Qualitative research is multi-method in focus, involving an interpretative, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of meanings people bring to them"*³⁷

One important concept in qualitative methodology is the process of moving from observations to generalisations or theoretical models using an inductive approach. This implies iterative loops where observations are made and tentative conclusions are drawn that are then brought back to the field situation for checking and are modified according to feedback. The study reaches its conclusion when the iterations no longer reveal new information and when attempts have been made to seek out all relevant interpretations.³⁸

The flow of naturalistic inquiry is perhaps best illustrated by this flow diagram by Lincoln and Guba:

Figure 1. The flow of naturalistic inquiry³⁸

Criticism of qualitative research is common and the following three arguments are often heard: ³⁹

- Qualitative research consists of anecdotes and the researcher's personal impression of the stories heard, and therefore strongly subjected to researcher bias.
- Qualitative research is nearly impossible to reproduce with similar results by other researchers as it is strongly related to the original researcher.
- The results of qualitative research cannot be generalised to other populations. It only produces large amounts of detailed information about a small number of settings.

Mays and Pope argued that any research is selective and that no researcher is capable of encompassing the whole truth. All research is looking for evidence and uses methods relevant to the method being studied. It may be difficult for researchers to perform a survey and to make sure that all respondents uniformly understand language and categories. In the same manner, observational studies performed by one researcher are limited to "one pair of eyes" only. Britten and Fischer summarised this by pointing out that *"There is some truth in the quip that quantitative methods are reliable but not valid, and that qualitative methods are valid but not reliable"* ⁴⁰

3.1.1 Motivation for qualitative methods

Qualitative research can be used to explore people's lives, stories, behaviour, perceptions, and experiences of a phenomenon and interactional relationships. The research question guides the choice of qualitative method and aims to uncover, understand and analyse human behaviour from the perspective of those being studied. Qualitative

research is sensitive to the nature of human, cultural and social contexts, and is guided by the desire to remain faithful to the phenomena being studied. Kvale suggests that "If you want to know how people understand their world and their lives, why not talk to them" ⁴¹

While quantitative research has been useful for understanding the magnitude of and risk factors for woman abuse and its effects on women's physical and mental health, it has not contributed much to the understanding of how women experience abuse. Qualitative research provides a window into the lives of abused women.

3.1.2 Which qualitative approach?

In reading texts and dissertations, I found that qualitative research conveys different meanings to different people. A major source of confusion lies in discussing qualitative research as if it were one approach. All the major social sciences have drawn on and contributed to qualitative methods, but each in a different way depending on the theoretical interests of a particular discipline.

One important source of variety in qualitative inquiry is different theoretical traditions and orientations. Phenomenology aims to understand the essence of experiences about a phenomenon. Grounded Theory strives to develop a theory grounded in the data from the field. Ethnography describes and interprets a cultural and social group. A case study strives at developing an in-depth analysis of a single or multiple cases. Hermeneutics is the study of the interpretation of a text. ⁴²

The different approaches to naturalistic inquiry posed an initial difficulty since many seemed suited to the study. After having read extensively around the different approaches, I have come to the conclusion that each method has its strengths and limitations. There is no universal standard that can be applied to choose between the different frameworks. In fact the diversity itself is a good indicator of the complexity of human phenomena and the challenges involved in conducting qualitative research. The following quotation describes this well: ⁴²

" Every cobbler thinks leather is the only thing. Most social scientists have their favourite research method with which they are familiar and have some skill in using... But we should at least try to be less parochial than cobblers are. Let us ... get on with the business of attacking our problems with the widest array of conceptual and methodological tools that we possess and they demand. This does not preclude discussion and debate regarding the relative usefulness of different methods for the study of specific problems or types of problems, but is different from the assertion of the general and inherent superiority of one method over another on the basis of some intrinsic qualities it presumably possesses".⁴²

For the purpose of this study, I have used a phenomenological perspective as opposed to a phenomenological study. A phenomenological study is guided by the method phenomenology and its specific steps. In such a study the empirical data is collected through the use of this method and presented accordingly. A phenomenological perspective is a philosophical approach or viewpoint. Patton states that while theoretical frameworks and theory generation is important, it is not always a means to an end. ⁴² Since this study did not strive at theory development, but

more at understanding and description, a grounded theory approach was not used.

3.2 STUDY LOCATION

Lotus River community health centre is situated in the South Peninsula municipality and health district. It is a predominantly "Coloured" area (98% of the population) There is a range of socio- economic groups, but the majority of families are poor. Unemployment in the area is high at 65%. Alcohol abuse is rife and the area has a reputation for violence, both gang-related and interpersonal. Housing is predominantly sub-economic with densely populated blocks of flats. Afrikaans is the most commonly spoken language (56%) with English as the second most commonly spoken language (42%) (1996 census figures).

The community health centre serves this area. The hospital operates daily from 08.00hrs. to 17.00hrs and is closed during weekends. This is significant since most acute trauma occurs after-hours and during weekends. Health care professionals at the hospital offer mostly curative services. The hospital is not situated along a major public transport route, but is within walking distance of most inhabitants of the area. The hospital also provides training for final year medical students in Family Medicine as well as community service for newly qualified graduates.

3.3 SAMPLING AND STUDY POPULATION

Qualitative studies generally focus in depth on a relatively small number of cases selected purposefully. The goal in qualitative inquiry is to select for information- richness so as to illuminate the question(s) under study. The sample size will depend on the purpose of the research and the specific questions to be addressed. In qualitative sampling, the selection

of respondents usually continues until the point of redundancy (saturation)

Women, 16 years or older, who had been or were in abusive relationship, were approached by the three family practitioners (other than the researcher) to participate in the study. Patients were identified as having been abused by the presentation of physical injuries; direct questioning when symptoms were suggestive of underlying abuse, and by spontaneous disclosure during the consultation.

3.4 RESEARCHER'S BACKGROUND, PRE-UNDERSTANDING AND CULTURAL SENSITIVITY

The researcher is a female doctor who had worked at the community health centre for the past 9 years. She speaks English and Afrikaans fluently and is familiar with the culture of the local community. She first became sensitised to the issue of woman abuse in the community when she did a patient study on two abused women as part of a post graduate course in Family Medicine. Once sensitised, inquiring about abuse during consultations, even when no overt evidence of abuse, rendered overwhelming positive responses. This interest in the topic grew and resulted in the research study. The interviews were conducted and transcribed in 1997. The research was then put on "hold " while the researcher studied in Sweden for a year.

3.5 DATA COLLECTION

3.5.2 THE SEMI-STRUCTURED INTERVIEW

The semi-structured research interview is described as an interview whose purpose is to obtain descriptions of the life world of the interviewee with respect to interpreting the meaning of the described phenomenon. An interview is a conversation that has structure and purpose. It goes beyond the spontaneous exchange of views as in everyday conversation, and becomes a careful questioning and listening approach with the purpose of obtaining thoroughly tested knowledge. The semi-structured interview is not a conversation between equal partners, but the researcher defines and controls the situation. The researcher, who also critically follows up on the subject's answers, introduces the topic of the interview.

Kvale described twelve main aspects of the qualitative interview:⁴¹

- The topic of the qualitative interview is the everyday *lived world* of the interviewee and his or her relation to it.
- The interview seeks to interpret the *meaning* of central themes in the life world of the interviewee
- The interview seeks *qualitative* knowledge expressed in normal language and does not aim at quantification.
- The interview attempts to obtain open nuanced *descriptions* of different aspects of the subject's life worlds
- Descriptions of *specific situations* and action sequences are elicited and not general opinions.
- The interviewer exhibits openness *to new and unexpected phenomena*, rather than having ready-made categories and schemes of interpretation.
- The interview is *focused* on particular themes; it is neither strictly structured, nor entirely "non- directive"

- Interviewee statements can sometimes be *ambiguous*, reflecting contradictions in the world the subject lives in.
- The process of being interviewed may produce new insights and awareness, and the interviewee may in the course of the interview come to *change* his or her descriptions and meanings of a theme.
- Different interviewers can produce different statements on the same theme, depending on their *sensitivity* to and knowledge of the topic.
- A well-carried out interview may be *a positive and enriching experience* for the interviewee, who may obtain new insights into his or her life situation.
- The knowledge obtained is produced through the *interpersonal interaction* in the interview.

Research question: The exploratory statement was: "Will you please describe what your life is /has been like as an abused woman"

By asking questions like "how did it begin" and "then what happened", the informants related their experiences in the form of a story. If relevant information did not surface during the narrative, the probes listed in Appendix 2, were used to explore further.

A pilot interview was conducted with a respondent at her home to monitor the interviewer's style, to check the quality of the sound of the equipment and identify any aspect of the research not covered in the interview guide. This first interview turned out to be a fiasco. The tape recorder did not work properly and lack of experience in guiding the interview led to reams of text not necessarily relevant to the research question.

3.5.2 THE VENUE

Respondents were given the choice of conducting the interview at their homes or at the community health centre. All respondents preferred to be interviewed at the community health centre. Interviews were scheduled for the afternoon when the hospital was quiet and I had finished my patient load. The intention was to conduct the interviews in an environment that was private, had a low noise level and was free of interruptions. It was therefore decided not to use my consulting room. An empty consulting room at a quieter end of the hospital was secured instead.

3.5.3 CAPTURING THE DATA

I did the interviewing. Written consent was obtained and the respondents were assured that nothing that they said would affect their future medical care. Interviews were conducted in the first language of the respondent (English or Afrikaans) and lasted 45 minute to one hour. I removed my white coat in order to diminish the "doctor role". The interviews continued until no new information seemed forthcoming. All interviews were tape-recorded. Non-verbal responses were jotted down during the interviews and field notes were recorded before and after the interviews all the original recordings are available for inspection.

3.5.4 TRANSCRIPTION OF DATA

Interviews were transcribed on a conventional word processor using a dictaphone. A professional typist did the typing. I listened to the interviews using the transcribed hard copies to compare the spoken word to the text and also to assess whether the typist has done justice to the spoken word e.g. pauses, emotion and voice changes. All lines of the transcript were numbered and preceded by the respondents' initials. This

facilitated the identification of origin of quotations. The process of transcribing data was very tedious and one hour of interviewing took approximately five hours to transcribe.

3.6 DATA ANALYSIS

There are as many different ways to analyse qualitative data, as there are means to collect it. Most forms of analysis however, involve indexing the data, reducing it to a more manageable form, displaying it in a form to aid analysis and interpreting it. I have found the following framework of researchers Miles and Huberman most helpful in interpreting qualitative analysis i.e.⁴³

Data reduction means summarising or coding large amounts of text into smaller amounts. It involves selecting, focusing, simplifying and transforming the raw data of field notes and transcriptions into typed summaries organised around themes based on the original objectives of the research. Data reduction continues to occur until the final report is written.

Data display is defined as an organised assembly of information that allows conclusions to be drawn and actions to be taken. Data can be displayed as narrative text or as matrices, graphs, networks and Venn diagrams which make information more compact and data more accessible.

Conclusion drawing/verification refers to the process of deciding what things mean, noting themes, regularities, patterns and explanations. Conclusion drawing occurs in the draft form throughout the data collection process but eventually becomes more explicit and firm when

the final report is written. Conclusions can also be verified during the analysis. As researchers try to explain what the data mean, they should continually examine whether their explanations make sense within the context of the study.

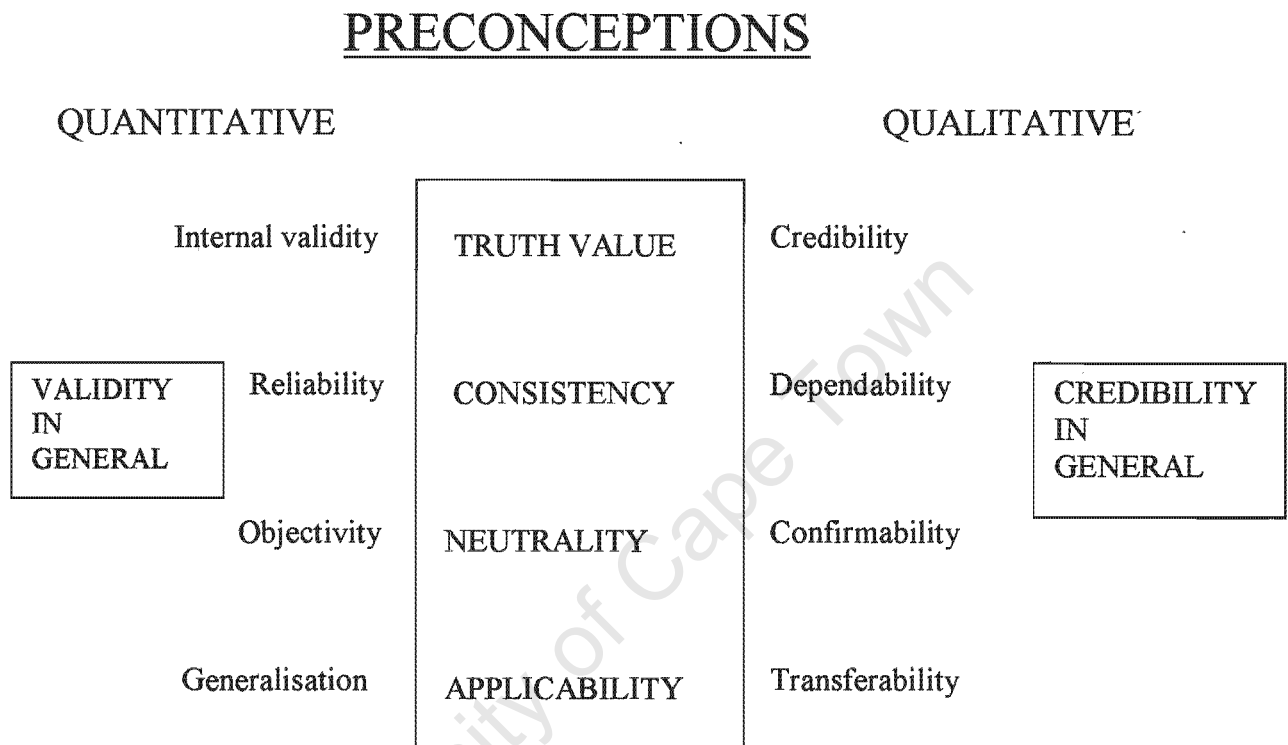
I have used content/thematic analysis in this study. Content analysis is the systematic examination of the text by identifying and grouping themes and coding, classifying and developing categories.⁴² I started by reading through my field notes and interviews several times with the aid of the audiotaped version making comments in the margins. I then began to organise the data into topics labelling the data. The abbreviated topics are written directly on the relevant passages in the margins. The full labels were used to create a separate file, which served to organise data in the initial steps of cutting and pasting. I found that passages can serve several different purposes, patterns or themes and multiple copies were necessary for cutting and pasting. I analysed each case separately. Once this was done, I then grouped responses across cases looking for variations and commonalities. (Cross-case analysis)

3.7 TRUSTWORTHINESS

Within the context of health service research, qualitative research is sometimes seen as a soft option, lacking scientific rigour. Guidelines and checklists have appeared in the literature in recent years promoting the legitimacy and trustworthiness of qualitative research.⁴⁴ In quantitative research, internal and external validity, reliability and objectivity measure trustworthiness. Within the naturalistic paradigm of qualitative research the criteria of credibility, transferability, dependability and conformability have been suggested. This has been encapsulated further within the concepts of "truth value", "applicability", "consistency", and

"neutrality."³⁸ A structured overview of the relations between the different criteria is presented below.

Figure 2. Indicators to describe scientific rigour in research ⁴⁵



Truth value: internal validity versus credibility

Credibility corresponds to some extent to internal validity in traditional research. It relates the truthfulness (credibility) of the data both when collected and when analysed. The credibility of a study commonly refers to the studied subjects' ability to recognise themselves in descriptions and interpretations. A prerequisite to credibility is therefore a degree of "closeness" between researcher and subject. This closeness may at the same time pose a threat in that the researcher may have difficulties separating her experiences from that of the subject. This may lead to "premature closure" or "going native".³⁸ Ongoing reflection by the researcher is therefore important. A colleague interviewed me regarding

my perceptions about women abuse. Although I had not met any of the respondents before the study, I saw them subsequently as patients and felt a sense of "closeness" to them.

Another technique to establish credibility is triangulation. This has come to refer to the use of multiple perspectives to check one's own perspectives against. Denzin identifies four basic types of triangulation³⁷ Data triangulation refers to the use of a variety of data sources in a study. Investigator triangulation refers to the use of several different researchers or evaluators. Theory triangulation is the use of multiple perspectives to interpret a single set of data and methodological triangulation refers to the use of multiple methods to study a single problem. In this study none of the above methods of triangulation were used.

Member checks imply that members of the studied group are given the opportunity to see and comment on collected data and interpretations. I have not made use of this technique formally, but found it to be part of the process of data collection. The dynamics of the inductive approach is to 'play back' summaries of condensed statements and interpretations to the respondents during and after the interview.

Consistency: reliability versus dependability

Traditionally the demand for consistency is termed reliability or repeatability in the positivist paradigm. However real life is always changing and the demand that a study should be repeatable in different circumstances is not conceivable in qualitative research. Dependability means that the study adapts to changes in the studied environment and to new inputs obtained during the period. It is however important that others are able to follow the development of the study. Notes and memos of

thoughts and ideas during the research process provided an audit trail and was a key criterion for dependability.

Neutrality: objectivity versus conformability

Conformability in qualitative research corresponds to objectivity in quantitative designs. Both defend neutrality i.e. research should represent the reality of those being studied and not distort it in any way, either due to subjectivity on the part of the researcher or poor analysis. Other researchers should be able to judge findings by looking at transcripts, codings, classifications and memos.

Applicability: external validity versus transferability (fittingness)

Transferability relates to generalisability but in qualitative research findings cannot be generalised. It is important to describe the demographics such as ethnicity, family situation and socio-economic status of the respondents i.e. provide a thick description of the research context and process. Readers can then decide whether the findings are relevant in other situations.

The process of analysis in qualitative inquiry is very distinct from that in quantitative research. In qualitative research the analysis as well as the data collection form part of the emergent design. The process starts, as data is being generated i.e. ongoing analysis ³⁸

3.8 BIAS/PRECONCEPTIONS

Critics of qualitative research charge that the approach is too subjective. The researcher's theoretical outlook, interests and personal experiences influence the research process. The researcher is the instrument of both data collection and interpretation. Glaser and Strauss in their earlier work

claimed that researchers should be free of any preconceived ideas.⁴⁶ However, they later on highlighted the importance of being aware of one's preconceptions in order to avoid "conceptual blinders".

Empathy develops from personal contact with the people interviewed. Empathy involves being able to take and understand the stance, position, feelings, experiences and worldview of others. Qualitative inquiry promotes empathy and gives the researcher an empirical basis for describing the perspectives of others while also reporting her own feelings, perceptions, experiences and insights as part of the data. The phrase *empathic neutrality*⁴² may at first appear contradictory. Empathy however is a stance towards the people one encounters, while neutrality is a stance towards the findings. Empathy communicates interest in and caring about people, while neutrality means being non-judgemental about what people say and do during data collection. Neutrality can facilitate rapport and help building relationships that support empathy by disciplining the researcher to be non-judgemental and open. Neutrality is not an easily attainable stance. Research strategies and techniques are however available for assisting the researcher to become aware of and deal with personal biases and theoretical predispositions.⁴² This is discussed in more detail in the section on "Trustworthiness"

3.9 ETHICAL CONSIDERATIONS

Research on violence against women raises important ethical, safety and methodological issues. It has been shown that research on woman abuse can be conducted with full respect of ethical and safety considerations.⁴⁷ It has also been shown that when interviewed in a non-judgemental manner in an appropriate setting, most women will discuss their experiences of violence. Assuring informed consent, protecting the

confidentiality of sources and protecting the rights of participants are primary considerations. Sensitivity is required in reporting the data since the results may impact on respondents' lives.

Another consideration is to avoid exacerbating violence against women while researching it. Ensuring the safety of respondents and researchers are paramount. Where informants need medical care and further counselling appropriate referral services should be in place. In this study some respondents needed treatment for depression and posttraumatic stress syndrome. They were referred back to the doctor who had originally seen them.

I aimed to end interviews in a way that allowed interviewees to feel contained, affirming their strengths and reinforcing coping strategies. Participants were also reminded that the information they provided was important and would aid the understanding of this complex phenomenon. All respondents spontaneously commented that they found the interaction beneficial and felt much better after the interview. I found listening to the stories of abuse and violence draining and at times overwhelming. I am grateful for the support of empathic colleagues who could provide the necessary support and debriefing when needed.

Approval to do this study was obtained from the Research Ethics Committee at the University of Cape Town. (See appendix 3)

4. FINDINGS

Profile and background of patients interviewed

Information on the patients was gathered from my field notes as well as the respondents' hospital folders. In terms of racial and ethnic profile, all five respondents belonged to the so-called "Coloured" race group, which matched the local population.

The women's stories described how and when specific events occurred ("what happened") as well as informing about the context and meaning that events had for them. ("What it was like")

4.1 INDIVIDUAL INTERVIEWS AND THEMES

4.1.1 INTERVIEW 1

(KO) is a 22-year-old woman who presented to a colleague for a pregnancy test. She was very anxious not to fall pregnant and had been on the injectable contraceptive without her husband's knowledge. She had two children. The eldest was from a previous relationship. She had no immediate family or support system, as her parents were deceased. Her husband had been in gaol previously for housebreaking and now works as caretaker at a mosque. He abuses cannabis. Throughout the interview she remained tearful.

What facilitated disclosure?

KO has been in an abusive relationship for two years and disclosed the abuse to the referring doctor two weeks prior to the interview. Some qualities in the doctor appeared to have facilitated disclosure.

KO 6 *Sy is 'n lekker persoon om openlik mee te kan wees daarom het ek na haar toe gegaan om haar te sê ... van die probleme wat ek het .*

KO 29 *Ek het elke keer vir my 'n appointment gemaak by haar net om te sien watter soort persoon sy is ... of ek haar kan vertrou of so ... maar sy is baie betroubaar.*

Confidentiality and a relationship of trust with the health care provider appeared to be prerequisites. KO saw Dr. S on a few occasions before she opted to disclose the abuse. Even then she did not share her full story.

KO 116 *... want ek het nog nie oor alles gepraat nie wat ek moet praat. Dis somtyds swaar om te kan praat, om jou hart skoon te maak.* When asked about the Imam (spiritual leader) she remarked that one cannot talk to anybody because you never know whether they will discuss it with other parties.

KO 119 *... want ek praat nie sommer met enige ene nie ...*

Effects of the abuse

KO gave a graphic description of the psychological effects of abuse.

Fear and anxiety:

KO 62 *Dan is ek amper 'n nervous wreck ...*

KO 68 (Dr) *En hoe laat dit jou voel? (KO) Bang baie bang ... Ek is baie bang as hy begin te slat ... want hy dreig my ... "ek gaan jou met die mes steek" ...*

KO 143 *Ek is soos een wat 'n nervous breakdown kry.*

KO 214 *My bors trek toe en alles bewe soos 'n kat wat nat kry.*

Loneliness and isolation:

KO 109 -114 (Dr) *How would you describe your feelings? (KO) (sobbing) ... baie alleen ... baie alleen. Ek mis my ma ... as ek nog 'n ma gehad het, dan het ek lankal gegaan na haar toe. Ek kan na niemand toe gaan nie ...* This feeling of isolation was exacerbated by the fact that her husband's family knew about the physical abuse but did nothing to prevent it.

Suicidal ideation and intent:

On several occasions during the interview, KO referred to previous attempts at self-harm and future intentions to end her life.

KO 125- 130 ... *maar as hy so met my baklei dan voel ek somtyds om 'n klomp pille te drink ... ek het dit al eenkeer probeer ... toe kom hy in die toilet en toe sny hy die tou af wat daar hang.*

KO 217 ... *voel ek kan 'n klomp pille vat ... maar dan dink ek weer aan my kind ... maar aan die eenkant dink ek ook dit is goed.*

Loss of self-worth:

KO 199-202 *Ek is 'n niks, so amper soos 'n ... ag jy is ook maar net 'n ... amper soos een wat hy gebruik ...*

KO also expressed frustration and anger at her own helplessness.

KO 156-158 *Ek voel baie woedend vir myself ... omdat ek niks kan maak nie.*

Coercive sex/sexual abuse

Descriptions of forced sex were offered during the interview. One might speculate that this common finding would have been reported even more often if one had asked about it directly.

Experiences of seeking help and barriers to getting help

KO reported the abuse to a female police officer that advised her to get an interdict. She did not carry this through because of lack of money.

Abuse in public

KO described an incident at their child's birthday when her husband threw a plate of food at her and started hitting her in the presence of his family.

KO 196-198 *Toe baklei hy saam met my voor almal ... sy ma-hulle ... hy baklei met my ... Tot in die pad in ... hy skop sommer in my gesig as ons in die pad loop.*

Attempts at conflict resolution

KO described her attempts at conflict resolution. These were met by sulking and emotional manipulation.

KO182-187 *As ek met hom daaroor praat dan sê hy vir my, los nou daai. Ons praat oor iets anders.*

Child abuse

KO also related incidents of her husband abusing their two-year-old. On further questioning it appeared that her husband was abused by his father as a child and tried to justify his (the husband's) actions by doing the same to his child.

The future

The hopelessness of the future was echoed on two occasions.

KO 140 *Daar is nie 'n toekoms vir ons meer nie.*

KO 211 *Ek het nie 'n toekoms as ek saam met hom gaan wees nie*

4.2 INTERVIEW 2

SA is 27 years old. She has a daughter from a previous relationship who lives with her parents. She lives with her 50-year-old boyfriend. The boyfriend is divorced with two adult children. She has a standard eight education. The boyfriend is a semiskilled labourer. SA has had several admissions to psychiatric hospitals for depression and two previous suicide attempts.

In the beginning

Initially the relationship went well. The boyfriend provided materially. Things changed when she confronted him about still being married.

Effects of abuse

Suicidal/parasuicidal ideation/intent:

SA 62 *Ek kon dit nie meer vat nie en toe gaan ek hulp soek by V . hospital waar ek wil suicide commit het. Dis nou al die sesde keer wat ek suicide wil commit.*

Physical abuse:

SA 129- 132 *Hy het my geslaan en my by die huis kom uitsmyt. Hy het my uit sy kar uit gegooi.*

Perceptions of the police

She mentioned that she had taken out an interdict once. Unfortunately I did not explore this further to find out what happened.

Power relationship and social isolation

Uncontrolled power and possessiveness helped to maintain SA in a position of subordination. The last violent episode occurred after she went out with friends.

The aftermath

After the physical assault, her boyfriend would come back asking for forgiveness. He will also buy her presents.

SA 29-30 *Dan kom hy weer die next dag na my toe en sê vir my hy is sorry. Hy sal dit nie weer doen nie. Dan allow ek om hom om weer terug te kom en in die ou end support hy my weer.*

Experiences with health care profession

SA mentioned episodes with some health care providers where she never got an opportunity to disclose the abuse.

SA 151-155 *Hulle is net haastig ... het eintlik nie tyd vir jou nie.*

SA 161 *... Die doctors het nooit uitgevra nie.*

Family

The interview provides us with a view of SA's family of origin. The home of origin is ridden with conflict. The present relationship allowed some escape from this.

Yearnings

She desires a better life for her child.

SA 90-95 *Ek wil nie hê sy moet dinge deurgaan wat ek deurgegaan het nie. Wat ek verlang is om met my ou en met my kind ... om 'n normale lewe te lei.*

4.3 INTERVIEW 3

GK is an attractive 51 year old woman. She is a widow and has two teenage daughters. She met the perpetrator a year after her husband's death. He moved in with her and her daughters. The abuse (physical and emotional) continued for eleven years. During that time she had taken him back 32 times. I interviewed her 18 months after she had (finally) terminated the relationship.

In the beginning

GK's initial role was that of rescuer, taking in the perpetrator after they met on the station while travelling to work.

GK3-16 ... *about twelve years ago I met this guy and he seemed to be a really nice guy. We use to meet at the station every day. That was a year after my husband's death. I would give him my sandwiches ... because he was such a sweet person ... you know such a sweet guy.*

Control and power

The first episode of beatings started soon after he had moved in with her. They returned from a social gathering and he accused her of having affairs. He also became controlling and manipulative.

GK 60- 66 ... *Why is the broom standing here? ... and why is this and that ... I use to say ... maybe I did not have a chance to put the broom away. Then he would just take his hand and smack me around.*

GK 85-91 *He came home very drunk and demanded hot food when the food is cold . Then he says "why isn't it hot?" And when it is hot, he ask me "why isn't it cold?" That is how he used to start ... having arguments with me ... and even when I am in bed, he used to pull me out of bed and drag me into the kitchen to get him some coffee and to feed him. Then suddenly he's got to have an argument because he's got to start fighting. He demands answers to things which I do not even know (the answer) of.*

What facilitated disclosure?

It again appeared that something in the doctor's approach and personality triggered disclosure.

GK 281-202 *I do not know ... there is something about Dr. S ... I do not know what it is ... I do not know whether she can see right through me.*

Cycle of violence/The aftermath

From GK's account, she took her partner back 32 times. One such episode is described.

GK 78 *I got an interdict, had him moved out and I moved back into my house ... after two weeks he came knocking on the door. I feel sorry for him and he says "I will never do this again" ... then I used to take him back. Just a month after that he starts ... drinking and starts hitting us and swearing. Her daughter nearly died from taking an overdose of tablets following a row with the abuser.*

GK 147-150 *Her heart was going ... she was on the heart machine. At that time he was away from me. He eventually came back and I took him back again.*

The turning point/precipitating event for getting help

The final straw came a few months after the above episode when he hit her daughter, resulting in a swollen eye and lip and a laceration of her tongue. GK fainted and was dragged to the bedroom by the perpetrator. He threw a bucket of water over her and then left.

GK 157-162 *... then I looked up and I saw my daughter and I thought "No, not this, no, no, no. This has got to stop! This is the end ... I wanted this to be over and done with now ... I wanted him to be locked up. Even after this episode the perpetrator returned pleading with her to take him back.*

The episode with the social worker at NICRO also served as a catalyst.

GK 259-265. *"Just do it" she said . I said ... but I am crying all night ... I cannot sleep. I miss him. She said: " just two more months" and I use to think , oh yes, remember the times he used to hit you.*

GK 166 - 167 *In the meantime, he still phoned me and wanted to come back and I said 'No!' I am sorry for what you've done ... this is now the end ...* It is interesting that she apologised to him, neutralising the abuse and accepting responsibility for the episode.

Child abuse

GK's daughters were abused too by the perpetrator; both physically and verbally. She later found out that he had been abusing his previous wife as well as his baby.

GK 189-190 ... *he took the baby and put the baby's head in the toilet bowl and pulled the chain.*

Barriers to leaving

GK 217 *I asked myself what women would take back a man 32 times even when he nearly killed your daughter and lied to you repeatedly.*

GK 217 *In my heart I knew he was telling lies but I use to take him back every time.*

This is expressed very poignantly in GK 307-310 ... *you know the physical part of having a boyfriend, like kissing and hug me and holding me close. And the children won't really hold you that close like your boyfriend does.*

GK 311 *My boyfriend used to hold me close and kiss me and touch me, but it was heartache. It was terrible. You could not believe he was holding you now and the next minute you are going to be beaten up.*

The future

GK 269-278 *I'm the happiest woman on earth today ... my children ... they can now have friends. They can bring their friends home now and we*

are so happy! I can just put my arms in the air and say "thank you God I'm out of it, I'm out of it"

GK 303 I am going to stick to my children. I am not going to have anything to do with this guy anymore! ... other things will come naturally.

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4.4 INTERVIEW 4

SP is 55 years old divorcee. She has five children but lives with her two youngest sons. She suffered severe physical abuse at the hands of her husband and finally divorced him in 1996. She has a standard eight education. Her ex-husband is currently unemployed. She believes that extramarital affairs is the main precipitating factor why men abuse their wives.

Experience of abuse

SP was pregnant when she got married. The abuse started during pregnancy.

SP 9 ... *since my marriage , after two weeks ... he started hitting me. He had a girlfriend already.*

SP 14 ... *he use to smack me in my face. He use to take my head and knock it against the wall ... my hands would go stiff and then I would pass out.*

SP 64 *When I was nine months pregnant, he hit me with a stick. I told him I am gonna lose the baby, he's gonna hurt the baby ... so she was two weeks before the time.*

Effect of abuse on the children

SP 28 *She doesn't talk about her father. She does not want to recognise him as her father because she knows what I went through all these years*

SP 97-101 ... *the baby, it affected him because there is something wrong with him. He is at the Technikon but he told his father "I have no respect for you whatsoever" He has got birthmarks because I was under stress with his birth. All my children I got under stress.*

Coerced sex/marital rape

SP 82 *Then he hit me ... and sodomise me and that I could not take.*

Self perception

SP 86 ... *who must I talk to then? ... because I was very stupid.*

SP 92 *I told the magistrate I'm a battered woman.*

Barriers to leaving

SP 127 *Because he was the breadwinner and the children ... I was thinking of the children. And there was a time when I really loved him.*

SP 37-40 *It was for the sake of the children that I stayed. I never left them. I was always there for them. I waited till my baby did matric ...*

SP 128 *I was thinking of the children. When the children were small, that was my husband and their father.*

The turning point/catalyst for change

SP 130 *But love turns to hate ... and I just hate him! I used to run after him. But now I can't take it ... he is a rotten, rotten man. Men that abuse their wives will never, never stop!*

The future

SP 141 *I feel much better. I feel much better, definitely. I feel much better with my health ...*

4.5 INTERVIEW 5

MA is 36 year old. She looks much older than her age. She is a well-spoken and spunky woman. She has 3 children: a son of eight years and twins of 2 1/2 years. Husband is a labourer. He is illiterate and abuses alcohol. At the time of the interview M was separated from her husband and in hiding.

Types of abuse

MA gives a vivid description of the types and experiences of abuse she had to endure. These descriptions dominated the interview.

Physical abuse: This began within three months of marriage. The head injuries sustained during physical abuse resulted in post traumatic epilepsy.

MA 185 ... *en hy slaan nie ander plekke nie. Hy slaan net teen my kop want hy weet waar die swak punt lê. (He only hits against my head because he knows it is a vulnerable spot)*

Verbal abuse:

MA 70 *Hy praat nie mooi nie. Daar is geen respect nie.*

MA 82 *Dis die woorde wat hy uithaal. Hy praat nie mooi nie*

Financial abuse:

MA 69 *Ek weet nie wat hy met sy geld maak nie.*

MA 225 *Want elke dag word ek vermaak van geld. Ek word vermaak van bly plek want ek is die een wat nie werk nie. Daar word vir my gesê ek moet vir my 'n "f" werk gaan soek. Hy is nie daar om my te supply met vrete nie.*

The children

MA's eldest son has been ill since birth.

MA 25 ... *The baby was born and landed in hospital but the abuse just carried on. He is not concerned about the child. Those were terrible times. Worse than any other times.*

Abuse of children

MA 141 *Ek kom toe terug en vind hy het die twins geslaan met sy kaal hand dat die kinders snik-snik gaan slaap het. Die kinders is so bang! (When I returned, I found that he had given the twins a hiding with his bare hands. The children are so afraid!)*

MA 147 ... *want hy is geweldig en hy sê vir die kind ... "maar jy sal sien hoe moer ek jou met die kaal hand.*

Experiences of seeking help

MA 74 *Jy bel die polisie. Die polisie sê vir jou "mevrou, dit is 'n domestic problem (I phoned the police and they said it is a domestic problem)*

MA 151 *Want kom jy by die polisie stasie, gee jy jou storie en dit is wat hulle vir jou sê "Mevrou, dit is domestic problems. Ons kan nie daarmee opgeskeep sit nie, want ons het te veel werk. Gaan hof toe" (When you go to the police, this is what they say to you "Missus, it is a domestic problem. We cannot be saddled with it. We have too much work. Go to the court")*

MA 186 *Ek kon dit nie meer vat nie ... toe gaan ek polisie stasie toe. Toe sê hulle vir my, "Mevrou, daar is niks wat ons kan doen nie. U moet by die hof of 'n maatskaplike werkster uitkom" (The police said "there is nothing we can do. You must go to court or see a social worker)*

Abuse in pregnancy

During her first pregnancy M was beaten so severely that she landed in hospital.

Barriers to leaving

MA 128-132 ... *want ek het 'n diep vrees in my. Hy sê vir my susters hy gaan my in my slaap doodmaak. En dis wat my die bangste maak*

(I do fear him. He told my sister that he will kill me while I am asleep. That's what scares me the most)

Self -worth/self-esteem

MA has endured severe physical as well as verbal and financial abuse.

MA 228 *Dit laat my minderwaardig voel. (It makes me feel inferior)*

The future

MA 250 *Solank ek saam met hom is is daar geen hoop vir die toekoms nie. Tensy ons nie hulp kry nie, is daar geen hoop vir die toekoms nie want dit sal elke keer so donker en duister bly voor my. (While I am with him, there is no hope for the future. Unless we get help, there is no hope for the future. The future is dark ...)*

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5. DISCUSSION

5.1 COMMON THEMES

5.1.1 Power and control

The pattern of male dominance and female subordination, so often described by feminist scholars, was evident in my study too. Feminist theorists use the concept of "patriarchy" to explain the societal structure that fosters woman abuse.⁴⁸ Patriarchy constitutes the constellation of social relations and institutions that give men greater status, power and privilege over women. It has two basic components: social structure that preserve the dominant position of men and a set of beliefs through which this arrangement is accepted as normal and good by the majority of the population. This pattern however suggests greater complexity over time. Some of the interviews showed that this hierarchical order is reversed in the aftermath phase. The perpetrator fell to a subordinate position begging for forgiveness, promising that it will not happen again and the respondent's relative influence increased.

GK 78-79 *"He would come back after two weeks saying: "I will never do it again" I would feel sorry for him and take him back"*

SA 29-31 *"... dan sal hy weer die next dag na my toe kom en se hy is sorry en hy sal dit nie weer doen nie ... ek moet net nie uitgaan met wie ever ek wil uitgaan nie"* (reinforcing power and control).

5.1.2 Preconditions for disclosure

A study regarding disclosure of stigmatising conditions such as abuse by a partner, found that a trusting, sustained relationship and privacy within the disclosure were essential conditions.⁴⁹ The researcher in this study also described a process which she described as "invitational disclosure" wherein the discloser provides sufficient clues that "something is wrong"

to invite the listener to inquire further. If the listener then picks up the cue and asks in a way that does not make the discloser feel comfortable, she has the opportunity to retract without disclosing.

Looking at the different responses in the five interviews, it is apparent that the doctor's personality and a patient centred approach played a role. A relationship of trust was also a central condition for disclosure.

KO 6 “ *Sy is ‘n lekker persoon om openlik mee te kan wees*”

KO 29 *Ek het elke keer vir my ‘n appointment gemaak by haar net om te kan sien watter soort persoon sy is ... of ek haar kan vertrou of so ...*

All the referring doctors in my study were female and it is not possible to say whether disclosure would have taken place if the doctor had been of the male sex. My own experience has been that women are willing to talk about their experiences if one is genuinely interested and willing to listen without making judgements. One respondent however reported negative experiences with the health care profession.

SA 151-155 *Hulle (die dokters) is net haastig ... het eintlik nie tyd vir jou nie.*

SA 161 ... *Die dokters het nooit uitgevra nie.*

The perceptions were also echoed in the studies in the literature review.^{11,13} Although my study did not examine doctors perceptions towards abused women, the literature suggest that physicians who felt uncomfortable about enquiring about abuse and incompetent in providing support, had low disclosure rates.³¹

5.1.3. Low self-esteem and powerlessness “ Ek is ‘n niks ... ”

All five women in this study reported low self-esteem and feelings of powerlessness.

MA 228 *“Dit laat my minderwaardig voel.”*

KO 199-202 *“ Ek is ‘n niks, so amper soos een wat hy gebruik ... ”*

KO 156-158 *“ Ek is woedend vir myself omdat ek niks kan maak nie ”*

SP 86 ... *“because I was very stupid.”*

Low self-esteem and feelings of powerlessness and hopelessness in two of the respondents contributed to depression and difficulty in leaving the abusive relationship.

Low self-esteem is particularly associated with emotionally controlling abuse. Research findings in the literature review indicate that low self-esteem among abused women results from battering rather than preceding or contributing to it.⁴ Questions however remain about the processes that contribute to the association between witnessing parental violence and later victimisation. It may not be low self-esteem that leads to partnering with an abuser, but some form of matching based on familiarity. Much more research is needed on this possible relationship.

5.1.4 Depression and suicide ideation

It is not surprising given well-documented levels of major depression among abused women that they often think about, attempt or commit suicide. This was apparent in the two respondents that were still in abusive relationships.

SA 62 *“Dis nou al die sesde keer wat ek suicide wil commit”*

KO 125 *“ ... maar as hy so met my baklei dan voel ek somtyds om ‘n klomp pille te drink ... ”*

In both these respondents there was increasing isolation and not being able to discuss abuse with others. They also express hopelessness about the future and there was no way out of the relationship.

KO *“ Daar is nie ‘n toekoms vir ons meer nie ”*

Research on suicide attempts among abused women is limited, but generally supports a theory of escalating violence, threats, lack of support, and eventually complete hopelessness.⁵⁰ Although I did not specifically screen for post traumatic stress syndrome, it is now well recognised in abused women.⁵¹ As part of a comprehensive assessment and intervention against abuse, it is essential to enquire about dreams, flashbacks and terror attacks .

5.1.5 The process of leaving

The process of terminating the relationship involved taking back the perpetrator several times before ending the relationship for good. (32 times in the case of one respondent!) The three women who left their abusive relationships, described hardships, loneliness, poverty, and difficulties with single parenting. They also reported longing for the lost relationship and missed not being loved and caressed.

SP 127 *“And there was a time when I really loved him”*

GK 310 *“ ... and the children won't really hold you that close, you know, like your boyfriend does”*

They were however unanimous in voicing relief at being out of the relationship and were determined not to return. The escalating nature of the violence had been the main catalyst in all three instances.

No systematic research has been conducted on the influence children exert on their battered mothers, but it seems probable that the willingness of children to leave a violent father would be an important factor in a woman's decision to leave. In one of interviews this was indeed the case.

SP 156 *“ My daughter knows what I went through. My daughter said: “No, this thing cannot happen anymore” and she helped me.”*

5.1.6 Barriers to leaving

In my study the women cited several reasons for staying in the abusive relationship. These include: economic and emotional dependence on the abuser, concern for children, lack of support from family, fear of reprisals, and the hope that "he will change"

KO 110 "... as ek nog 'n ma gehad het, dan het ek lankal gegaan na haar toe"

SP 37-40 "*It was for the children's sake that I stayed ... I waited till my baby did matric*"

Qualitative studies performed with women who left abusive relationships, suggest that it should be viewed as a process rather than a discrete incident.^{10,17} Moreover, it should be noted that ending a relationship does not necessarily reduce the risk, as some partners become more violent once the woman attempts to leave.⁵

5.1.7 Yearnings

The longings expressed by the respondents were for a better life for them and their children. One respondent wished for a life free of abuse with her partner and child.

5.1.8 Emotions experienced

A wide range of emotions were described by the respondents ranging from shame and guilt, fear and apprehension, anger, depression, happiness and confusion. One respondent expressed her joy over her newly acquired freedom in this way:

GK 276-278 "*I am so happy! I can just throw my arms into the air wherever I walk and say: Thank you God! I am out of it! I am out of it!*"

Her confusion about her boyfriend's actions that fluctuated between tenderness and violence are evident in this quote:

GK 311-313 “ *My boyfriend use to hold me close and kiss me and touch me, but it was heartache. It was terrible. I could not believe that he was holding me now and the next minute he was going to beat me up.* ”

Women who escape abusive relationships must deal with strong, sometimes conflicting feelings in attempts to build new lives free of violence.⁴ Family physicians can play a pivotal role in this process, in that the kind of responses women receive when seeking help, can determine the effect these feelings have on subsequent decisions.

5.1.9 Types of abuse

The types of abuse experienced by the respondents included sexual, verbal, economic, psychological and physical abuse. The physical abuse in all five instances was severe, often comprising of blows to the head. Three of the respondents gave vivid descriptions of coercive sex and rape.

5.1.10 Abuse in pregnancy

Two women reported that the abuse first started during pregnancy.

SP 64 “*When I was nine months pregnant, he hit me with a stick. I told him that I was going to lose the baby, that he’s gonna hurt the baby ... so she was two weeks before the time*”

One of the respondents was beaten so severely during her first pregnancy that she landed in hospital.

MA 18-20 “*Gedurende my swangerskap word tot die polisie ingeroep. Ek skree om help want dis te erg die way hy baklei. Ek beland in die hospital en bly daar vir die res van my swangerskap*”

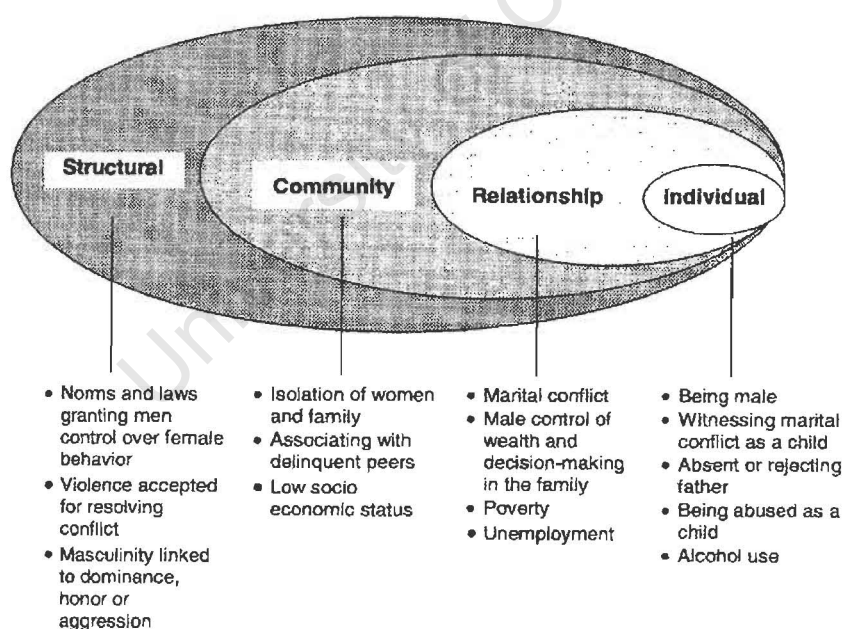
A third respondent feared falling pregnant and used contraception without her husband knowing.

5.1.11 Help-seeking experiences with other agencies

In all the accounts, the police, social workers, religious leaders and family members played an important part in the women's decision to leave or stay in the abusive relationship. Two women reported positive experiences in dealing with the police while two women said that the abuser had friends in the police force and that they felt powerless in seeking help.

Social workers in two of the accounts helped to facilitate change. Where there was little or no support from extended family, the women also remained in the relationship. One woman remarked that she felt too ashamed to discuss the abuse with a religious leader.

5.2 THE ECOLOGICAL FRAMEWORK



The findings of my study may be easier to interpret in the light of the ecological model proposed by Heise to conceptualise gender-based

violence as a multifaceted phenomenon rooted in the interplay between personal, situational and socio- cultural factors.⁵² These factors comprise four different levels conceived as concentric circles. The inner circle is comprised of individual factors that have consistently been associated with partner violence such as educational level, income, violence towards children and witnessing violence as a child or adolescent. The second circle refers to the immediate context in which the abuse takes place i.e. the intimate relationship. Male dominance and patriarchy have been strong predictors of abuse in this domain. The third circle contains the world of the extended family, work, neighbourhood and social networks. Previous research has indicated a strong association between abuse and women's isolation and lack of social support both at an individual and community level.²¹ The fourth and outer circle includes the dominant cultural views and attitudes that prevail in society at large. This includes laws, social and economic policies and cultural norms.

By combining individual risk factors with cross cultural comparisons, the ecological framework contributes to understanding gender-based violence by explaining why some societies and individuals are more violent than others and why women are so consistently the victims. It has also been useful for understanding the meaning women themselves ascribe to the violent relationships and the way in which the immediate and cultural context of abuse shape women's strategic responses to violence.

5.3 LIMITATIONS OF THE STUDY

The study of woman abuse is a sensitive and difficult area to research and is limited by practical and ethical barriers. By far the most common problem with research in this area is the selective nature of the samples.

Many of the women interviewed in the literature review were from shelters, whereas the women in my study were either living with the abuser or had left the abusive relationship. I found that there were no obvious systematic differences between the responses from the different settings.

The purpose of this study was to discover and explore. I felt that more information could have been obtained had it not been for my relative inexperience in qualitative interviewing. I also went to great lengths describing techniques to aid trustworthiness of the study, but have failed to apply them consistently in my study because most of the theoretical knowledge was obtained after the interviews were conducted.

5.4 THE UPS AND DOWNS OF THE RESEARCH PROCESS

It was difficult to pick up the research again after a break of nearly two years while I lived and studied overseas. When we returned, we sold our house and changed career paths. Gentle but persistent nudging from colleagues and my husband set the research process in motion again.

There were times that it felt as if the project just was not moving. A relevant article was difficult to access or simply unobtainable. I had a catastrophic experience when my master diskette and back up copies became corrupted and I could not open it to access work done. I had saved it on a hard copy and eventually had to retype everything onto a new diskette. There were times of extreme exhaustion when I felt I had to set aside the manuscript. This was compounded by a sense of urgency to complete the research within a specific time frame. There were also periods of inspiration and energy. Analysing the transcripts and reading

women's accounts of the abuse were at times harrowing and I am grateful for the support of colleagues.

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6. CONCLUSIONS/RECOMMENDATIONS

This study has been conducted in order to better understand the experiences of women in abusive relationships; why they stay, how they cope with the abuse and the role other agencies, including the family physician. While this study highlighted previously identified concepts, it has helped to explain women's decisions to remain in or to leave an abusive relationship.

It has also identified many unexplored areas of this very complex dynamic such as; abuse during childhood, harsh patriarchal fathers and partners and men's use of religious ideology to justify abuse. Another relatively unexplored area is what happens when abused women leave the abuser and how custody and access issues affect them.

In this study the abuse of children was a consistent feature. It is therefore imperative to screen for child abuse when intimate partner violence is identified and vice versa.

Encouraging women to stay in abusive relationships is a controversial subject. Some women may never be able to be protected while they remain in the relationship, while for others, there may be the possibility of changing patterns of violence. Counselling services therefore need to explore and adapt models of couple therapy for those who wish to continue their relationships. Services are becoming available for the perpetrators of violence. These groups encourage men to take responsibility for their actions, to recognise the reasons why they act the way they do and to acknowledge the consequences of abuse on their partners and children. The success of these measures has not yet been determined.

How do we as Family Physicians work with abused women beyond treating the immediate biomedical concerns? One of the most important actions is to ask about the abuse. When we initiate the discussion, we communicate to patients that this problem is not too shameful, deviant or insignificant to talk about, that the patient's discomfort and reaction to victimisation are rational and that the situation is not hopeless.

Physicians who are knowledgeable about the implications of interpersonal violence can more easily elicit relevant information from the patients that will improve the ability to diagnose and treat the victimised patient. It is therefore recommended that interpersonal violence be incorporated into the core curriculum for undergraduate, graduate and continuing education for all health professionals.

Violence against women is not just a health issue; it is also a legal, social and personal issue. Family physicians are an important resource to women who are in abusive relationships. Together with the other agencies, they have the ability to make an impact and to be there as caring resources for abused women in their journey from violence.

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APPENDIX 1 (Consent form)

I would like to undertake research to learn more about women's experiences of abuse by an intimate male partner. The aim of the research is to look at issues concerning domestic violence from your point of view in order to develop more effective ways to protect women from abuse and to prevent further abuse.

I would like to include you in this study if you are willing to participate. The interview will last approximately one hour. I would like to tape record our conversation if you have no objection. I would like to assure you that anything you say will be confidential, and when I write a paper from the research or present the findings, it should not be possible to identify you. Your future health care at this centre will not be affected if you for any reason object to participate in this study.

If you have questions about the research at any stage or would like to contact me about the study, you may do so.

Dr. F. Christians

Lotus River Community Centre

Tel: 733131

WOMEN'S EXPERIENCES OF DOMESTIC VIOLENCE

I,....., the undersigned, consent to be interviewed for this research project and agree to the interview being audio-taped .

Signed.....

Date.....

APPENDIX 2 (Interview guide)

Thank you for agreeing to participate in this study and for coming today. Your participation is completely voluntary and I will respect any decisions you may make.

Now if you will allow me , I am going to ask some questions about your relationship with your (ex) partner. We know that this is often a difficult subject to talk about, but sometimes talking can help to bring about changes in our lives. Please let me know if you need a break.

KEY QUESTION:

Can you tell me what your relationship with your (ex) partner has been like ?

PROBES:

Onset of abuse. Events that exacerbated abuse e.g. pregnancy.

Has your partner ever prevented you from leaving the house, visiting friends, getting a job, using contraceptives or continuing your education?

Has your partner ever forced you to have sex when you did not want to?

Did he ever force you to engage in sexual practices that make/made you feel uncomfortable?

Has your partner ever threatened or abused your children?

What finally made up your mind to leave? (this was only asked of the women you have left the abusive relationship)

Who did you turn to for help? Did you have any support from friends, family, and confidants?

How do you feel about: the police, doctors, social workers, and religious leaders?

What was your biggest fear when suffering abuse, and what is your biggest fear now?

How do you see the future for you (and your children)?



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31 December 1996

ERC REF NO: 251/96

Dr F Christians
c/o Dr B Schweitzer
Dept of Primary Health Care

Dear Dr Christians

A QUALITATIVE STUDY OF WOMEN'S EXPERIENCE OF DOMESTIC VIOLENCE DONE ON
SELECTED WOMEN ATTENDING A COMMUNITY HEALTH CENTRE

I have pleasure in informing you that formal approval for the above study was granted by the Research Ethics Committee on the 31 December 1996.

Included is a list of Research Ethics Committee Members who have formally approved your protocol.

Yours sincerely

Prof. JP de V van Niekerk
Dean: Faculty of Medicine

rec96