MENTAL HEALTH EFFECTS OF DOMESTIC VIOLENCE EXPERIENCED BY WOMEN IN A LOW SOCIO-ECONOMIC AREA IN GAUTENG, SOUTH AFRICA

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ABSTRACT

The World Health Organization (WHO, 2001:1) views domestic violence as the world's most prevalent form of human rights violation with devastating effects on both the physical and mental well-being of these victims, mostly women. The purpose of this study was to explore and describe the mental health effects of domestic violence as experienced by women utilising a mobile primary healthcare (PHC) clinic in a low socio-economic area in Gauteng, South Africa. A qualitative, contextual, explorative and descriptive research design was followed. The study was conducted in a mobile PHC in a low socio-economic area in Gauteng. Participants were selected purposefully from the women attending this clinic. Data were collected by conducting ten semi-structured interviews when data saturation occurred. The transcribed interviews and field notes were analysed using Tesch's method of qualitative data analysis.

Women exposed to domestic violence related the mental health effects in terms of physical, psychological, spiritual, and social experiences. They described the physical pain and related symptoms as well as the emotional hurt, anxiety and sadness. The violation they experienced was reflected in social isolation and distrust towards men. Although the hopelessness of their situation was evident, participants displayed certain coping mechanisms.

Keywords: Domestic violence in South Africa, mental health aspects of domestic violence, resilience of victims of domestic violence, women's experiences of domestic violence

INTRODUCTION AND BACKGROUND INFORMATION

Domestic violence is defined as the collective methods used to exercise power and control by one individual over another in an adult intimate relationship (Olds, London, Wieland, Ladewig & Davidson, 2004:172). The collective methods described in South Africa's Domestic Violence Act (DVA) (118 of 1998) include physical, sexual, verbal, and psychological abuse; in this article domestic violence refers to physical violence inflicted to a woman by her intimate partner.

Domestic violence is a public health problem causing health and mental health problems, with impacts beyond the obvious harm with potentially devastating consequences for women. Fatal outcomes such as suicide, homicide and increased maternal mortality have been linked to domestic violence (WHO, 2005:1; Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2006: 1260). Regardless of whether the violence is physical, sexual or psychological, it increases the incidence of mental illness, which can cause additional healthcare problems and over-utilisation of healthcare resources (Campbell, 2002:1331; Moultrie & Kleintjies, 2006:347).

Despite established legal structures to empower and protect women in South Africa (DVA118 of 1998), domestic violence remains a common occurrence. Research by Pillay and Kriel (2006:589) found that from a total of 422 women attending a district level clinic in South Africa, 50% had relationship problems, 48% reported violent partners while 37% viewed their partners as being oppressive.

PROBLEM STATEMENT

Domestic violence might often remain unreported and many victims might not seek help. The healthcare system can identify and refer women exposed to domestic violence (UNICEF, 2000:18). Yet healthcare professionals might only enquire about domestic violence in cases of unexplained physical injuries, and might miss the accompanying stress-related ailments and mental health symptoms (Garcia-Moreno, 2002:1509). Failure to identify a woman exposed to domestic violence implies a lost opportunity to intervene in the cycle of violence and address the associated health and mental health effects (Taket, 2003:1). Although healthcare professionals might find it difficult to enquire about domestic violence and women might be reluctant to discuss it, sensitive questioning can encourage disclosure (Boyle & Jones, 2006:258).

The researcher and other professional nurses working in a mobile PHC clinic, in a low socio-economic area in the Gauteng province of South Africa, realised that many women utilising this clinic's services, experienced domestic violence. Exposure to domestic violence was not addressed as part of the healthcare management programme. Women exposed to domestic violence left the clinic without receiving help or support

for potential mental health problems. The research question was: What mental health effects of domestic violence do women, utilising a mobile PHC clinic in a low socio-economic area in Gauteng, experience?

PURPOSE OF THE STUDY

The objective of this research was to explore and describe the mental health effects of domestic violence, as experienced by women utilising a mobile PHC clinic in low socio-economic area in Gauteng. Based on the findings, recommendations could be made for promoting the mental health status of women exposed to domestic violence.

THEORETICAL FRAMEWORK

The Theory for Health Promotion in Nursing (University of Johannesburg, 2009:1-8) was used as the theoretical perspective for the study. According to this theory, a woman is seen holistically in interaction with her environment in an integrated manner. The environment includes the internal (physical, psychological and spiritual) and external (physical, social and spiritual) environment. The "nurse/midwife as a sensitive, therapeutic professional" should demonstrate knowledge, skills and values to facilitate health promotion. Nursing, as an interactive process, indicates a mutual involvement between the nurse and the patient (University of Johannesburg, 2009:1-8).

In this article, the PHC nurse is viewed as a therapeutic professional promoting health by mobilising resources. Mental health refers to interactions in a woman's internal and external environment which could contribute to physical, psychological (emotional, cognitive and volitional) as well as spiritual well-being (University of Johannesburg, 2009:1-8).

RESEARCH METHOD AND DESIGN

The design adopted for the study was qualitative, contextual, explorative, and descriptive (Polit & Beck, 2008:752). The aim was to explore and describe the mental health effects of domestic violence, as experienced by women as narrated by them from their own perspectives.

Research setting

This study was conducted among women in a low socio-economic area in Gauteng who used a mobile PHC clinic's services. Although the clinic mainly provides child

immunisation, family planning, lifestyle diseases, cancer screening, and palliative care, it is also utilised by women for general health concerns.

Population and sampling

The accessible population comprised all the women utilising the clinic, as described under the research setting. Purposive sampling (Strydom, 2005:202), was used to select the participants. The sample size was determined by data saturation, obtained after 10 interviews. Participants were selected based on the following inclusion criteria: women aged 18-59, using the mobile PHC clinic's services, willing to give informed consent and disclose information regarding their experiences of domestic violence. Participants should have experienced domestic violence within one year preceding the interview to ensure description of experiences within a similar time-frame and context.

Data collection

Data were gathered through semi-structured interviews and field notes. A pre-test interview, excluded from the data analysis, was conducted to refine the data collection methods and questioning technique. The interviews were scheduled on usual clinic days to protect participants' anonymity. Interviews were conducted in a private room in the clinic. During each semi-structured interview the researcher asked the participant to describe the effects domestic violence had on her life as a person and to elaborate on the feelings and thoughts related to the domestic violence.

Field notes (including methodological, personal and theoretical aspects) were recorded during the interviews to enhance reflexivity and trustworthiness (Polit & Beck, 2008:405).

Data analysis

Data analysis was done following the steps described by Tesch (in Creswell, 2009:125). Content analysis was utilised as a process of transforming the raw data into themes and categories, which were substantiated with participants' quotes.

TRUSTWORTHINESS

Trustworthiness was established according to the strategies as promoted by Lincoln and Guba (in Creswell 2009:196). Credibility was established through prolonged and varied engagement in the field. To ensure confirmability and dependability an experienced independent coder analysed the data. The final themes and categories were identified after a consensus discussion between the researcher and the coder. Personal field

notes helped the interviewer to maintain neutrality through identifying her own pre-conceptions and biases regarding the research problem. Triangulation was obtained through the use of semi-structured interviews and field notes for data collection. A chain of evidence was kept through detailed recording of the research methodology and the data analysis process.

ETHICAL CONSIDERATIONS

Approval to conduct the study was granted by the Research Ethics Committee of the Faculty of Health Sciences of the University of Pretoria (ref: S58/2010), the City of Tshwane Municipality (ref: TMREC: 2010/31) and the UNEDSA programme manager of the mobile clinic services. Informed consent was obtained from each participant. Anonymity and confidentiality were ensured by using sequential code numbers without any references to participants' names or clinic numbers. The interviews were conducted in a private room in the mobile clinic. Participants who experienced emotional discomfort during the interviews were referred for counselling or to social services.

RESEARCH FINDINGS

Participants' demographic profile

The ages of participants ranged between 18 and 59 years. The participants came from different language and socio-cultural groups: four spoke Setswana, one spoke Ndebele, one spoke isiZulu, three spoke Sesotho.Three were married and the other seven were cohabiting. The educational level of the participants varied from never attending school to one participant who had passed grade 12. Six participants were unemployed, one was receiving a disability grant and three were employed, either formally or part-time.

Themes and categories

Table 1 outlines the themes and categories discussed in this article.

Table 1:

Themes	Categories
Physical effects of domestic violence	Insomnia and fatigue
Psychological effects of domestic violence	Cognitive and emotional
Spiritual effects of domestic violence	Hopelessness, thoughts of death and suicide

Social effects of domestic violence	Distrust and negative attitudes towards men and social isolation
Survival coping mechanisms	

Physical effects: insomnia and fatigue

The Theory for Health Promotion in Nursing (University of Johannesburg, 2009:6), stipulates that the body includes all the anatomical structures and physiological processes and involves the health status of a woman. Insomnia and fatigue were reported as physical effects of domestic violence.

Participants experienced difficulties to sleep. One woman was so upset by the emotional abuse and fear of her partner that she was unable to sleep:

> *"Him calling me names hurts more, I struggle to sleep even at night… I did not sleep last night as well; serious, even today I was sleeping during the day. I'm scared of him serious; I'm scared, last night his up and down, he was planning something… I am not feeling well at night, at night I have fear. I am scared straight, how will I sleep. I'm just scared that this person can do something bad to me and run away."*

Related to insomnia, some participants experienced fatigue and could not fulfil their daily activities, as explained by this disclosure:

> *"I just want to sleep always, my child does everything and cook".*

Psychological effects: cognitive and emotional

The term "psychological" is described in the Theory for Health Promotion in Nursing (University of Johannesburg, 2009:6) as including all the intellectual, emotional and volitional processes of a person. The psychological effects will be discussed according to the cognitive and emotional effects that emergedduring the interviews.

Cognition is described by Uys and Middleton (2010:829) as psychological processes including "thoughts, memory, attention, perception and interpretation." Subcategories that emerged, revealing participants' thoughts, included the realisation of being exposed to domestic violence and the consequences of such situations; constant worrisome or stressful thoughts about being exposed to domestic violence, thoughts of regret, and the wish to be relieved from domestic violence.

Participants verbalised their realisation of being exposed to domestic violence, of living with a violent partner; and the dangers of being involved in such a situation. One woman stated:

> *"I realise then that I would get hurt and be killed by this man and I call the police and they arrest him and they released him".*

The participants were aware of their partners' violent behaviour and the consequences of domestic violence; they would phone the police, some considered returning to their parents' houses but often their social circumstances prevented them from making final decisions.

Domestic violence is a traumatic experience, and guilt is a normal post-traumatic stress response as the person feels a sense of regret or shame about these incidents (Meintjes & Killian, 2010:671). Regret, related to being infected with HIV as a result of unsafe sexual practices and the abuser's infidelity, is reflected by this statement:

> *"In the end he infected me with this diseases, I was not like this, this is not my natural body even this things in my face, as I am living with this virus, I went to test, I live on ARVs".*

Some women asked themselves why they remained in the abusive situation and tolerated the abuse, as revealed by one participant who stated:

> *"I am thinking about the life that I have been living with this guy and I ask myself what was I persevering, for, why did I stay and not come back home, and I think sometimes he used to say this and this, why didn't I act like this, even the words he used to say to me. I think about them one by one".*

The women experienced constant troubling or stressful thoughts about being exposed to domestic violence. Some participants described these thoughts as "stress":

> *"I had stress and I was not able to speak to people, I would just sit and sleep."*

This participants' "stress" had certain effects such as loss of appetite:

> *".....maybe I become troubled and think a lot, I love food neh! But I can stay for the whole week without eating anything even if there are nice things, I just can't eat because of his word".*

Emotions are a complex state of feelings with psychic, somatic, and behavioural components, related to the individual's affect and mood (University of Johannesburg, 2009:6). The emotional effects described by participants illustrated their hurtful feelings related to exposure to emotional abuse; and the anxiety and sadness they experienced. Emotional abuse include the abuser's acts of calling the woman names, humiliating her, making her feel bad about herself and using things that matter to her to hurt her (Olds et al., 2004:173). Although women exposed to physical violence were selected for the study, most of them narrated experiences of emotional abuse that occurred together with the physical violence. Being emotionally abused with humiliating remarks from

the partner was strongly associated with emotional hurt and related to feelings of worthlessness as evidenced in these quotes:

> *"...him calling me names hurts more ...in my mind I start undermining myself. I don't take myself as a person even if he beats me it is much better." and:"I used to cough and he will hurt me with the words, he used to tell me, you cough like you are dying (laughing)".*

Related to the emotional hurt the participants in this study experienced anxiety and sadness as emotional effects of the domestic violence they were exposed to. Anxiety is characterised by an unpleasant, vague sense of apprehension often accompanied by autonomic symptoms such as headache, tightness in the chest, perspiration, palpitations and mild stomach discomfort and restlessness. It can be presented as panic disorders, social phobia, post-traumatic stress disorders, acute stress disorders, and obsessive compulsive disorders (Sadock & Sadock, 2010:579). The category of anxiety is interrelated with other experiences such as insomnia, often related to fear.

Anxiety was revealed by one woman who said: "…sometimes I feel that my chest is full of air". An anxious person might struggle to fall asleep and this was expressed by a woman who said:

> *"I am not feeling well at night, at night I have fear, I am scared straight, how will I sleep? I'm just scared that this person can do something bad to me and run away".*

Sadness is a feeling expressed externally as crying (Johnson, 2009:170). It is often seen in mood disorders such as major depressive disorder (Uys & Middleton, 2010:831). The women were saddened by their experiences of domestic violence as one women stated:

> *"I controlled my emotions because my spirit was very high. I went to the bedroom, cried and fell asleep".*

Crying was not only a sign of sadness but it relieved the hurting:

> *"I was always hurting, I would cry until I feel better".*

Spiritual effects: hopelessness, thoughts of death and suicide

The spiritual environment refers to two interrelated components with an integrated function comprising one's conscience and one's relationship with God (University of Johannesburg, 2009:6-7). The participants' descriptions of hopelessness and thoughts about death and suicide indicated how domestic violence resulted in a loss of meaning and purpose in these women's lives. Hopelessness is an underlying emotion of depression, as the individual might feel hopeless about ever finding meaning or satisfaction in life

again. In hopelessness, the recurrent thoughts of dying or killing oneself commonly occur (Uys & Middleton, 2010:831).

One participant related the hopelessness of her situation in stating that not even the law could help her:

> *"Even the protection order does not help because I report him they arrest him just to release him by tomorrow and repeat the same thing".*

The hopelessness is reflected in this statement:

> *"I feel hurt a lot, that is why I said I don't want to talk anymore because I am dying…"*

The hopelessness experienced by the participants escalated into suicidal ideation which is a symptom of major depressive disorder (Sadock & Sadock, 2010:534) and is seen as a serious indication of cognitive and mood disorders. Suicidal ideations were stated as:

> *"He is abusing my feeling, my mind, it is just because I am strong, if I was someone else I would have killed myself".*

Related to the theme of suicidal ideation is the wish to be dead as described by some women:

> *"Killing myself no, but I wish God can just take my life when I'm asleep, but when this thoughts are coming when I think of my children all this disappears".*

> *"It makes me to think that I must just rest, God must just take me, I think dead people are resting better than me."*

Social effects: distrust and negative attitudes towards men and social isolation

According to the Theory for Health Promotion in Nursing (University of Johannesburg, 2009:7), social resources refer to the woman's human resources such as her relationships with others in the external environment. The inability to trust one's partner in a relationship can cause someone to be overexposed and vulnerable to others (Johnson, 2009:99). The women expressed their distrust and negative attitudes towards their partners by stating:

> *"I do not trust him anymore even when he starts fighting I think he has started with his cheating again".*

They also related how the domestic violence caused negative feelings towards men in general:

> *"Like the way things are I don't think if I separate with him I will ever love someone ever again… Even when I see a man I become bored."*

Social isolation may be experienced by individuals with major depression as the person loses pleasure or interest in usual activities (Uys & Middleton, 2010:834). This participant's social isolation related to a feeling of not being able to associate herself with her former social group:

> *"These things are hurting me because I don't want to be with my friends anymore because they talk about their children; losing weight so that they can be slim. I become bored. They will also say things like if I become sick I will kill myself, you see they are influencing me badly. I tell them not to come at my parent's house; who are they coming to visit because I am always busy".*

Some women related how the domestic violence made them feel alienated, like outcasts in their community:

> *"I undermine myself because people already know that when he is drunk it is "weekend special" [implying violence]. People ask themselves today where she will sleep"*

Survival coping mechanism and relief after talking about the domestic violence

The women in this study used silence, avoidance, perseverance and tolerance as mechanisms only to "survive" on a daily basis and not to resolve the domestic violence. According to Goodman, Smyth, Borgers and Singer (2009:306-309), there are several problem-focused and emotion-focused coping mechanisms, but these authors hypothesised that in the presence of poverty and intimate partner violence women will use survival-focused coping mechanisms. These mechanisms are aimed at surviving in the short term, meeting basic needs, and keeping oneself and one's loved ones as safe as possible. Some participants used avoidance such as a woman pretending to cope for the sake of her children:

> *"I turn around and pretend. I tell myself that I must just stand up for my children. When I see that there's no maize meal I must go around and get them maize meal, even if it means I must loan money to buy this maize meal, I do".*

Another woman used silence to avoid the stress and stated it as follows:

> *"All these things are hurting me, but I told myself I must just keep quiet because I will end up being sick having stress, heart diseases, can you imagine".*

The sense of relief after talking about the domestic violence during the interviews was expressed as follows:

> *"I feel much better now even though I was hurting; it's no longer so heavy".*

One woman realised that talking is better than keeping quiet as she narrated:

> *"I feel relieved; it is not the same like when you keep quiet."*

DISCUSSION

The research results indicated that women, exposed to domestic violence in a low socio-economic area, experienced physical, psychological, spiritual and social health effects and they used different survival coping mechanisms. The mental health effects included symptoms associated with major depressive disorders, anxiety disorders and post-traumatic stress disorders. Coker, Davis, Arias, Desai, Sanderson, Brandt and Smith (2002:260) indicated that higher psychological partner violence scores were strongly associated with poor health, depressive symptoms, and chronic physical and mental illness.

Some interviewed women experienced insomnia, which could be related to the continuous fear of violence as described by Lowe, Humphreys and William (2007:549-56) who found that abused women restrict their sleep although they realise that the lack of sleep affects their ability to cope. The participants voiced their awareness of their partners' violent behaviour and the consequences of the domestic violence; they would phone the police, some considered going back to their parents, but their social circumstances often prevented them from making final decisions.

The women experienced regret. Fry and Barker (2001:342) also discovered that women exposed to domestic violence regretted that they made little effort to escape from their constrained environment. A South African study (De Beer, Poggenpoel & Myburgh, 2005:86) found that women exposed to domestic violence experienced anxiety as well as fear in relation to the perceived dangerous situation and the effects it might have on them and on their children.

Hopelessness was expressed by the women as they reflected on the desperateness of their situations and their own helplessness. De Beer et al. (2005:88) indicated that women who experienced domestic violence were hopeless about the situation and this could lead to personal breakdowns. Hopelessness is seen as a spiritual experience where a person has no hope for the future.

The women in this study did not trust their partners and they experienced social isolation related to a belief that others would not understand them. A qualitative study (Crawford, Liebling-Kalifani & Hill, 2009:71-3) discovered that women exposed to domestic violence feared to enter into new relationships as they doubted their ability to choose a good man, they feel stigmatised and silenced by the community who might appear to be conspiring with the abuser, aggravating the women's sense of shame and self-blame.

The participating women in this study used silence, avoidance, perseverance and tolerance as mechanisms only to "survive" on a daily basis and not to resolve the domestic violence. The participants expressed relief after talking about the violence.

CONCLUSION

Women, in a low socio-economic area exposed to domestic violence, experienced symptoms associated with mental disorders such as major depressive disorders, anxiety disorders and post-traumatic stress disorders. These symptoms affected their physical, psychological, spiritual and social functioning to such an extent that some of them verbalised suicidal ideas during the interviews. They attempted to cope by using survival coping mechanisms.

The PHC system might be the only hope for these women with limited resources. By utilising the recommendations proposed by this study, PHC nurses could intervene and promote the mental health status of women caught up in the cycle of domestic violence.

RECOMMENDATIONS

PHC practice should have guidelines for the management of domestic violence. This should include screening for domestic violence in an empathetic way, providing supportive interventions, including appropriate referral guidelines and adequate resources.

Nursing education programmes should ensure that all categories of nurses are knowledgeable about and skilful in identifying and managing women exposed to domestic violence.

The use of psychiatric rating scales, to determine the prevalence of specific psychiatric conditions among women exposed to domestic violence, could yield useful results for planning and implementing psychiatric services.

LIMITATIONS OF THE STUDY

Although the study findings generated insights and an in-depth understanding of the mental health effects of domestic violence in a specific low socio-economic area, participants could have been subjected to both recall and social desirability bias during the semi-structured interviews that relied on self-reports only.

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