THE INCIDENCE AND CORRELATES OF INTIMATE PARTNER VIOLENCE IN A SAMPLE OF SOUTH AFRICAN UNIVERSITY STUDENTS

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DEDICATION

I would like to dedicate this study to all the rape survivors I have counselled. Witnessing such strength has been my inspiration to learn more, be more and do more.

ABSTRACT

This study aimed to obtain an indication of the incidence (past 12 month) of intimate partner violence (IPV) in a South African student sample, and to explore the association between exposure to intimate partner violence and psychological adjustment. Study participants were 146 undergraduate students, aged 18-25years old, registered for psychology modules on the Howard College campus of the University of KwaZulu-Natal. The incidence of IPV was assessed using the physical assault and sexual coercion subscales of the revised Conflict Tactics scale, with exposure to emotional abuse being assessed using scores on the Women's Experience of Battering Scale. The impact of exposure to IPV was assessed using the depression and anxiety subscales of the Hopkins Symptom Checklist and scores on the Brief Screening Instrument for PTSD. Past 12 month incident rates for exposure to any form of IPV were high (92.5%), with incident rates for specific forms of IPV being: physical assault (31%), sexual coercion (14%), and emotional abuse (41%). Although females were significantly more likely than males to report sexual coercion (18.2% versus 5.6%), there were no significant gender differences in incidence rates for exposure to physical assault or emotional abuse. A series of regression analyses indicated that exposure to: (a) emotional abuse was associated with significantly higher scores on the measures of depression and PTSD, (b) sexual coercion was associated with significantly higher scores on the measure of depression, and (c) physical assault was not associated with scores on any of the clinical measures used in the study. Study findings are discussed with respect to their implications for practice and for further research.

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CHAPTER ONE

INTRODUCTION

1.1 Introduction and background to the study

The first study of intimate partner violence (IPV) in dating relationships was published by Makepeace in 1981. This study was conducted with college students, and found that more than one in five students had direct personal experience of intimate partner violence (Makepeace, 1981). Since the time of that ground breaking work, researchers have continued to present an eye-opening picture of the extent to which violence occurs, not only in marital, but also in dating relationships (Iconis, 2013).

Intimate partner violence (IPV) is a global public health problem that is increasingly cited as a risk factor for adverse physical and behavioural health outcomes among women. Characterised by behaviour within an intimate relationship that causes physical, psychological, or sexual harm to a partner, IPV has reached globally epidemic proportions. The lifetime prevalence of experiencing IPV is estimated to be between 15% and 71% among women worldwide (Gass, Stein, Williams & Seedat, 2010). A review of more than 50 population-based studies from 35 nations on the global prevalence rates of IPV found that 10%-52% of females reported that they had been physically abused, and that 10%-30% had experienced sexual violence from an intimate partner at some point in their lives (Spencer, Haffejee, Candy & Kaseke, 2016). The reported IPV prevalence of 20%-71% in sub-Saharan Africa has been thought to be an underestimate due to under-reporting and poor standardisation of methods (Spencer et al., 2016).

IPV is one of the most common forms of violence against women, with IPV occurring across settings, and among all socioeconomic, religious, and cultural groups. The overwhelming global burden of IPV is borne by women (WHO, 2013), with IPV being regarded as a social vice common to all ages, races, ethnic groups, social classes, and religious groups (Wusu, 2015).

Intimate partner violence is one of the leading causes of poor health, disability, and death among reproductive age women (Coker, 2007), with IPV having been found to be associated with significant physical, mental health, and social consequences. Health consequences of IPV include chronic gynaecological, central nervous system, and stress-related health problems (Campbell et al., 2002b; Kernic et al., 2002) as well as depression, post-traumatic stress disorder, substance abuse, and suicidality (Campbell, 2002a; Dutton et al., 2006; Woods et al., 2005).

1.2 The context of the study

South Africa has amongst the highest rates of IPV in the world. Although prevalence estimates of IPV vary, rates have been found to be consistently high. A nationally representative study found a 19% lifetime prevalence of victimisation among female respondents and a study on physical violence among South African men found that 27.5% reported perpetration in their current or most recent relationship (Spencer et al., 2016).

In South Africa, interpersonal violence has been the second highest contributor to the burden of disease after HIV/AIDS. Interpersonal violence, including IPV, negatively affects the daily lives of South African women and accounts for 10.9% of all disability adjusted life years (Groves et al., 2015), with IPV accounting for 62.4% of the total interpersonal violence burden among women in South Africa (Peltzer & Pengpid, 2013).

Previous studies confirm that South Africa has particularly high prevalence rates of intimate partner violence (Abrahams & Jewkes, 2005). Reports indicate that more than 50% of men disclose that they have physically abused their partners, whilst 40%-50% of women report they have experienced violence from their partners (Seedat, Scott, Angermeyer, Berglund & Bromet, 2009). In a nationally representative study of IPV it was found that one in three South African women had experienced physical IPV at some point in their current relationship (Groves et al., 2015), with nearly 50% of participants reporting emotional abuse or denial of financial support from their partners in the previous year. Moreover, a national study found that at least 7% of women reported being forced or persuaded to have sex against their will (Groves et al., 2015).

IPV is a leading cause of morbidity and mortality for South African women. Over half of female homicide victims are killed by their intimate partners (Gass et al., 2010). Furthermore, a South African study on female homicide indicated that every six hours a woman is killed by her intimate partner (Spencer et al., 2016).

Although much of the research on IPV has been conducted among adult populations, the South African national survey of youth risk behaviour found that intimate partner violence starts early in life, with 12.1% of grade 8 girls reported having been hit, smacked, or physically hurt by their boyfriends in the past 6 months, and 16.1 % of grade 8 boys reporting that they had hit, smacked, or physically hurt their girlfriends in the past 6 months (Russell et al., 2014).

In summary, available research suggests that within the South African context, there are high rates of IPV, with IPV not only being present within the adult population but also in younger population groups.

1.3 Rationale for study

Although there has been a significant amount of research on IPV within the South African context, there is very little research that focuses on the student population within universities, which constitutes an age group classified as emerging adulthood. Research on IPV has moved from just focusing on adult populations to also looking at adolescence and emerging adulthood, although there are not many of these studies within the South African context and only one other study (Spencer et al., 2016) has focussed specifically on a student population within universities.

Due to trends indicating IPV starting at a much younger age than anticipated (Russell et al., 2014), it was deemed important that this study focus on a younger population, especially a student population, where romantic relationships become an area of focus in early adulthood according to Erikson's (1959) stages of psychosocial development.

Murray & Kardatzke (2007) found that dating violence which includes physical, sexual, and psychological or emotional abuse is common among college students (Iconis, 2013). Similarly, the United States Department of Justice (1997) found that women aged 16-24 experience the highest per capita rate of intimate partner violence.

Straus (2006) and White & Koss (1991) found that the perpetration of intimate partner violence (IPV) is a growing concern on college campuses across the United States of America. With approximately one third of students having experienced violence in their dating relationships in the past year, and with male and female students reporting relatively equal rates of perpetration (Fossos, Neighbours, Kaysen & Hove, 2007).

The following statistics are taken from the National Coalition Against Domestic Violence, 2007:

- 21% of college students report having experienced dating violence by a current partner. And 32% reporting dating violence by a previous partner.
- 13% of college women report they were forced to have sex by a dating partner.
- Over 13% of college women report they have been stalked. Of these, 42% were stalked by a boyfriend or ex-boyfriend.
- Nearly one third of college students report having been physically assaulted by a dating partner in the previous 12 months (Break the Cycle, Inc., 2005).
- As many as one quarter of female students experience sexual assault over the course of their college career (Break the Cycle, Inc., 2005).

A study conducted by Forke, Myers, Catallozzi & Schwarz (2008) found that of 910 participants (who were college students within the ages of 17-22 years old), a total of 407 (44.7%) reported experiencing partner violence, 383 (42.1%) reported victimization, and 156 (17.1%) reported perpetration.

A study conducted in Nigeria (Umana, Fawole & Adeoye, 2014) with female university students found a life-time prevalence for IPV of 42.3%; while a study conducted in Atlanta United States of America (Amar & Gennaro, 2005), involving 863 college women between

18 and 25 years of age, found almost half (48%) reported IPV and, of these, 39% reported more than one form of IPV.

These high rates of IPV, reported by various studies in different countries, suggest further research is necessary among the South African university population group (i.e., the emerging adult age group), in order to (a) establish the incidence of IPV among this emerging adult population and (b) explore the psychological adjustment of those individuals who report having experienced IPV. Due to IPV having many effects on the individual, it would be important for research to measure the type of psychological effects experienced by this particular age group.

This study could potentially add to the body of research regarding IPV within university student populations (i.e., an emerging adulthood age group), and establish the need for support services.

1.4 Aims of the study

This study had two main aims:

- To obtain an indication of the incidence (past 12 month) of intimate partner violence in a South African student sample.

- To explore the association between exposure to intimate partner violence and psychological adjustment.

1.5 Structure of the dissertation

Chapter 1 comprises an introduction to the present study and provides a background to IPV both globally and locally. It contextualises IPV within the South African context. Included in this chapter are a rationale for the study, a statement of the research objectives, and an outline of the dissertation.

Chapter 2 begins with the definition of IPV used within this study, before going on to explore the nature and the scope of IPV. Risk factors for IPV are then conceptualised using an integrated ecological framework. Context specific risk factors are then discussed and empirical studies of IPV are reviewed.

Chapter 3 provides information on the research methodology used in the study. That is: the research design, study location, sampling and sampling methods used, instruments used for data collection, data collection procedures, and data reduction methods used.

Chapter 4 presents the major findings that emerged from the study. Findings are discussed and presented in tables in terms of demographic details of participants, the incidence of IPV, and the association between exposure to IPV and psychological adjustment.

Chapter 5 provides a discussion of the findings in the context of the available literature on the topic. The limitations and implications of the study are also addressed.

CHAPTER TWO
LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Definition of intimate partner violence

Intimate partner violence is one of the most common forms of violence against women and includes physical, sexual, and emotional abuse as well as controlling behaviours by an intimate partner. IPV refers to any behaviour within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship (WHO, 2012). IPV has been found to encompass a number of forms of interpersonal violence, including: physical abuse, sexual violence, stalking, and psychological aggression (including coercive acts) by a current or former intimate partner; with an *intimate partner* being defined as someone with whom an individual has a close personal relationship that is characterized by emotional connectedness, regular contact, ongoing physical contact and/or sexual behaviour (Breiding et al., 2014). The three main forms of IPV are:

- *Physical abuse* which is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to, scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, aggressive hair pulling, slapping, punching, hitting, burning, the use of a weapon, and the use of restraints. Physical violence also includes coercing other people to commit any of the above acts (Breiding et al., 2014).

- *Sexual abuse* is defined as a sexual act that is committed or attempted by another person without freely given consent of the victim or in a situation where a person is unable to consent or to deny consent. It includes forced or alcohol /drug facilitated sexual penetration of a victim; alcohol or drug facilitated incidents in which the victim is forced to sexually penetrate a perpetrator or someone else; any unwanted sexual penetration; intentional sexual touching; or non-contact acts of a sexual nature. Sexual violence can also occur when a perpetrator forces or coerces a victim to engage in sexual acts with a third party (Breiding et al., 2014).

- *Emotional (psychological) abuse* includes insults, belittling, constant humiliation, intimidation (e.g. destroying things), threats of harm, and threats to take away children (WHO, 2012).

- IPV also includes stalking, *Stalking* is defined as a pattern of repeated unwanted attention and contact that causes fear and concern for an individual's safety and/or the safety of others. Stalking acts include but are not limited to: repeated and unwanted phone calls, voice messages, text messages and hang ups; repeated and unwanted e-mails, instant messages or messages through a website(e.g., Facebook); watching or following from a distance; leaving cards, presents, letters, flowers when the victim doesn't want them; spying with a listening device, camera or GPS; the perpetrator showing up at places where the victim does not want to see them; leaving strange or potentially threatening items for the victim to find; sneaking into the victims home or car and doing things to scare the victim by letting them know they had been there; damaging the victims personal property, belongings, or pets; harming or threatening to harm the victims pet; and making threats to physically harm the victim. Victims must have experienced one or more of the above experiences on multiple occasions involving the same perpetrator and felt fearful or believed that they or someone close would be harmed or killed due to the perpetrators behaviour (Breiding et al., 2014).

- IPV also includes *controlling behaviour* by the perpetrator, including isolating a person from their family and friends, monitoring their movements, and/or imposing restrictions on the victim's financial, employment, educational, and/or medical resources (WHO, 2012).

2.2 Nature and scope of the problem of intimate partner violence

Intimate partner violence (IPV) is regarded as a serious public health problem that has been found to be associated with deleterious short- and/or long-term effects, including physical injury, poor mental health, and chronic physical health problems (Breiding et al., 2014). The most recent data from the 2011 National Intimate Partner and Sexual Violence Survey

(NISV survey, cited in Breiding et al., 2014) indicate that over 10 million women and men in the United States experience physical violence each year at the hands of a current or former intimate partner; with one in five women and one in seven men having experienced severe physical violence by an intimate partner at some point in their lifetime (these incident rates translate into nearly 29 million women and nearly 16 million men in the United States). The NISV survey also found that nearly 1 in 11 women had been raped by a current or former intimate partner at some point in their lives (Breiding et al., 2014).

Violence against women is not a new phenomenon. What is new is the growing recognition that acts of violence against women are not isolated events but rather form a pattern that violates the rights of women and girls and their participation in society, and that damages women's health and well-being. From the World Health Organisation report (2013), it is clear that violence against women is a global public health problem which affects approximately one third of women globally (WHO, 2013).

Overall 35% of women worldwide have experienced either physical and or sexual intimate partner violence. In some regions, 38% of women have experienced intimate partner violence, with as many as 38% of murders of women globally being committed by intimate partners (WHO, 2013).

Women who have been physically or sexually abused by their partners report high rates of a number of problems. For example, they are 16% more likely to have a low birth weight baby. They are more than twice as likely to have an abortion, almost twice as likely to experience depression, and in some regions 1.5 times more likely to acquire HIV/AIDS as compared to women who have not experienced intimate partner violence (WHO, 2013).

Intimate partner violence is one of the leading causes of poor health, disability, and death among reproductive age women (Coker, 2007), with IPV having been found to be associated with significant physical, mental health, and social consequences. IPV has also been found to be associated with sexual risk taking, inconsistent condom use, having

unplanned pregnancy or induced abortion, the presence of sexually transmitted infections, and sexual dysfunction (Coker, 2007).

These findings send a powerful message that violence against women is not a small problem that only occurs within some pockets of society but instead is a global public health problem of epic proportions.

Much of the extant literature on IPV has been conducted in the United States of America and in other developed countries (Wusu, 2015), with researchers utilising survey measures that have been standardised for developed countries. As such it is not clear whether available findings can be generalised to developing countries (such as South Africa) with any degree of confidence.

IPV has been identified as a significant public health and human rights problem across the globe, with South Africa being no exception (Groves et al., 2015). In South Africa, interpersonal violence has been found to be the second highest contributor to the burden of disease after HIV/AIDS (Groves et al., 2015).

In a nationally representative study of IPV, it was found that one in three South African women reported physical IPV at some point in their current relationship (Groves et al., 2015), with nearly 50% of participants reporting emotional abuse, or denial of financial support from their partners, in the previous year. Moreover, a national study found that at least 7% of women reported being forced or persuaded to have sex against their will (Groves et al., 2015).

In another nationally representative study, conducted among 1,229 married and cohabiting women in South Africa, the prevalence rate for IPV was found to be 31% (Gass et al., 2010) with findings from a recent study of sexual violence among South African men indicating that 27.5% of participants reported acts of sexual violence directed at a current, or most recent, partner (Peltzer et al., 2013a).

The South African national survey of youth risk behaviour found that intimate partner violence starts early in life, with 12.1% of grade 8 girls reported having been hit, smacked, or physically hurt by their boyfriends in the past six months, and 16.1 % of grade 8 boys reporting that they had hit, smacked, or physically hurt their girlfriends in the past six months (Russell et al., 2014). Furthermore a South African study found that 42% of females aged 13-23 years reported experiencing physical dating violence (WHO, 2012).

According to Peltzer & Pengpid (2013), more women are killed in South Africa by a current or previous intimate male partner than in any other country (Peltzer & Pengpid 2013), with the South African femicide rate (8.8 per 100,000 women) ranking among the highest in the world (Groves et al., 2015). Mortality from intimate partner violence has been found to be elevated among women aged 14 to 44 years, with the proportion of women under the age of 40 years reporting physical violence being double that for women over 40 years of age (Abrahams & Jewkes, 2009).

In sum, available research suggests that in the South African context, IPV is not only common but also constitutes a major health and social problem, with further research on the topic being strongly indicated.

2.3 Risk factors for intimate partner violence

a) Risk Factors

The most widely used model for understanding violence is the ecological model, which proposes that violence is a result of factors operating at four levels: individual, relationship, community, and societal (WHO, 2012):

Individual factors

Some of the most consistent factors that have been associated with a man's increased likelihood of committing violence against his partner are: (WHO, 2012)

- Young age

- Low level of education
- Witnessing or experiencing violence as a child
- Harmful use of alcohol and drugs
- Personality disorders
- Acceptance of violence (feeling it is acceptable for a man to beat his partner)
- Past history of abusing partners

Factors consistently associated with a women's increased likelihood of experiencing violence by her partner across different settings are: (WHO, 2012)

- Low level of education
- Exposure to violence between parents
- Sexual abuse during childhood
- Acceptance of violence
- Exposure of other forms of prior abuse

Relationship factors

Factors associated with both the victimization of women and perpetration by men are: (WHO, 2012)

- Conflict or dissatisfaction in the relationship
- Male dominance in the family
- Economic stress
- Men having multiple partners
- Disparity of educational attainment (for example, women having a higher level of education than her male partner).

Community and societal factors

The following risk factors for IPV have been identified across studies: (WHO, 2012)

- Gender inequitable social norms (especially those linked to concepts of manhood and to male dominance and aggression)
- Poverty

- Low socio-economic status of women
- Weak legal sanctions of intimate violence within marriage
- Lack of women's civil rights, including restrictive or inequitable divorce and marriage laws
- Weak community sanctions against intimate partner violence
- Broader social acceptance of violence as a way to resolve conflict
- Armed conflict and higher levels of general violence in society

Widely held beliefs about gender roles that have been found to be associated with IPV include (WHO, 2012):

- A man has a right to assert power over a woman and it is considered socially superior
- A man has a right to physically discipline a woman for "incorrect" behaviour
- Physical violence is an acceptable way to resolve conflict in a relationship
- Sexual intercourse is a man's right in marriage
- A woman should tolerate violence to keep her family together
- There are times when a woman deserves to be beaten
- Sexual activity (including rape) is a mark of masculinity
- Woman are responsible for controlling a man's sexual urges

A systematic review of risk factors for intimate partner violence (Capaldi, Knoble, Shortt & Kim, 2012), which reviewed 877 articles, found that an older age for women is associated with decreased risk for IPV with the peak risk age occurring in late adolescence and young adulthood. This trend is similar to the pattern for crime and violence generally (which peaks in adolescence and then declines) (Blumstein, Cohen, Roth & Visher, 1986; Wiesner, Capaldi & Kim, 2007).

Capaldi et al. (2012) found that deprivation, including unemployment and low income, was predictive of IPV, and that minority group membership was also predictive of IPV. The study also found that acculturation stress was predictive of IPV, as were other kinds of stress such as financial and work related stress (Capaldi et al., 2012).

In recent years, more attention has been paid to the possible contribution of larger community contextual factors in IPV, with studies of neighbourhood/community and school factors having provided somewhat mixed findings (Capaldi et al., 2012). Exposure to violence between parents in the family of origin and experiences of child abuse have been much researched as risk factors, with study findings indicating that there is a low to moderate significant association between these two childhood experiences of violence and later IPV perpetration or victimization. However much of the evidence is based on retrospective reporting and therefore needs to be treated with some caution (Capaldi et al., 2012).

Studies of protective family of origin factors include parental factors such as positive involvement in the adolescent's life and the encouragement of non-violent behaviour (Capaldi et al., 2012).

Similar to findings for crime and violence more generally, there is evidence that involvement with aggressive peers is a relatively robust and strong predictor of involvement in dating aggression during adolescence. The quality of friendships has also been found to be associated with adolescence IPV; with this risk factor having been found to be related to both *selection* and i*nfluence*: that is, youth with higher levels of problem behaviour select friends with similar characteristics and the friends' behaviours influence their behaviour (Dishion & Patterson, 2006; Kupersmidt, DeRosier & Patterson, 1995).

A factor that has been hypothesized as an important protective factor for IPV victimization is social support, with social isolation being regarded as a risk factor (Dutton & Goodman, 2005). Studies that have examined this issue, indicate that social support and tangible help are protective for both perpetration and victimization and that parental support is protective for adolescents (Capaldi et al., 2012).

Areas of psychopathology that have received attention as risk factors for IPV, particularly in developmental studies conducted within the last decade, include both externalising and

internalising symptoms. Conduct problems or antisocial behaviour have emerged consistently as a substantial risk factor for men and women who later perpetrate IPV, and have frequently found to be a mediator for early risk factors such as harsh parental treatment. In contrast, for the internalising domain, depressive symptoms are indicated as being associated with IPV perpetration and victimization, although this association has not been found to be robust in multivariate analysis. A particularly interesting finding is that depressive symptoms may be a stronger risk factor for IPV perpetration for women than for men. These findings indicate that depressive symptoms may be a risk factor, perhaps, because of the effects of symptoms such as irritability and negative affect (i.e., the associations between depressive symptoms and IPV may be reciprocal (Capaldi et al., 2012).

Findings in the area of substance use are particularly interesting. Conventional wisdom holds that alcohol use is a major risk factor for IPV. But available evidence suggests that this association may be weak. However, there is evidence that there could be a strong association between drug use and IPV. These findings, along with findings that alcohol use could be a stronger risk factor for women's than for men's perpetration, suggest the need for further studies which are designed to explore the co-occurrence of substance use with antisocial behaviour (Capaldi et al., 2012).

Regarding relationship factors, relationship status (i.e., married, cohabiting, or separated) has been found to be related to IPV. Married individuals are at lowest risk whereas separated women are particularly vulnerable. Low relationship satisfaction and high conflict are proximal predictors of IPV, with high conflict in particular being a robust predictor (Capaldi et al., 2012).

A notable finding of this review (Capaldi et al., 2012) is that regardless of any differences in frequency and/ or severity of engagement in IPV by girls/women and boys/men, there are more similarities than differences in risk factors. The main area where there is relatively robust evidence for gender differences, is with respect to internalising problem behaviours, including depressive symptoms and low self-esteem, where there is relatively

consistent evidence that internalising behaviours are risk factors for women but not for men. The second area where there seemed to be emerging evidence for gender differences in relation to IPV, is the finding that alcohol abuse is a greater risk factor for IPV for girls/women than for men. This could be due to several possible factors, such as alcohol having a disinhibitory effect on aggression for women rather than for men, the association of alcohol use to other psychopathologies in women (including antisocial behaviour), men's reactions to women's drinking, or the characteristics of male partners selected by women who are higher users of alcohol. However, further research would be needed to test such explanations. (Capaldi et al., 2012)

Risk factors for college student dating violence

Researchers have identified a number of individual risk factors for college student dating violence. The categories under which the risk factors fall include family history, peer influences, personal attitudes, beliefs, and perceptions, alcohol use and abuse, and psychological factors (Murray & Kardatzke, 2007).

- Family history factors include observing violence between one's parents or having a personal history of child abuse (Hendy et al., 2003).

- The influence of peer group norms has been found to increase the likelihood of experiencing college student dating violence (Capaldi, Dishion, Stoolmiller, & Yoerger, 2001). An examination of perceptions of peer relationships found that children who overestimated or underestimated their social competence with their peer group were more likely to have increased aggression. Personal attitudes and beliefs that justify the use of aggression during conflict have been useful predictors of dating violence. Hostile attitudes and acceptance of violence against women have been found to be a significant predictor of sexual aggression in relationships (Carr & Van Deusen, 2002).

- In their investigation into the attitudes of college students toward dating violence, West and Wandrei (2002) presented 157 college students with videotaped situations

depicting victims of dating violence. They found that male students, as compared to female students, were "*somewhat more likely to hold generally violence-condoning, victim-blaming attitudes*". College students' attitudes influence their likelihood of being involved in a violent dating relationship and people involved in abusive relationships tend to believe that dating violence is more common than it actually is (Murray, Wester, & Paladino, 2008).

- Men's perception that the relationship is in jeopardy has been linked to the physical abuse of their partner. Lloyd and Emery (2000) found that 70% of abused women mentioned a "perceived threat to the relationship" as the reason for violence against them by their partners.

- Alcohol use and abuse has been linked to dating violence, and specifically, to incidents of sexual violence. Alcohol is involved in the overwhelming majority (80%) of cases of unwanted sexual activity (Murray & Kardatzke, 2007). Lundeberg, Stith, Penn & Ward (2004) in a comparison of nonviolent, psychologically violent, and physically violent college men who were dating found that physically violent men reported more problems with alcohol than did men in the other two groups.

- In their review of the literature concerning psychological and emotional factors that seem to be linked to dating violence, Murray and Kardatzke (2007) report that factors such as low self-esteem, antisocial behaviour, high levels of jealousy, and angry temperament have all been shown to relate significantly to college dating violence.

These identified risk factors are very similar/ consistent to risk factors found in previous studies involving samples drawn from the general population. Therefore the combined risk factors will be conceptualised according to the integrated ecological framework.

b) Conceptualisation of risk factors: An integrated ecological framework

In this study, IPV is conceptualised using an integrated ecological framework. According to Heise (1998), an ecological approach conceptualises violence as a multifaceted phenomenon which is grounded in an interplay between personal, situational, and sociocultural factors. As such, the ecological model provides a comprehensive theoretical perspective on the perpetration and consequences of IPV, with influences on IPV being conceptualised as operating at one or more of four levels: the individual level, the relationship level, the community level and the societal level (Wusu, 2015).

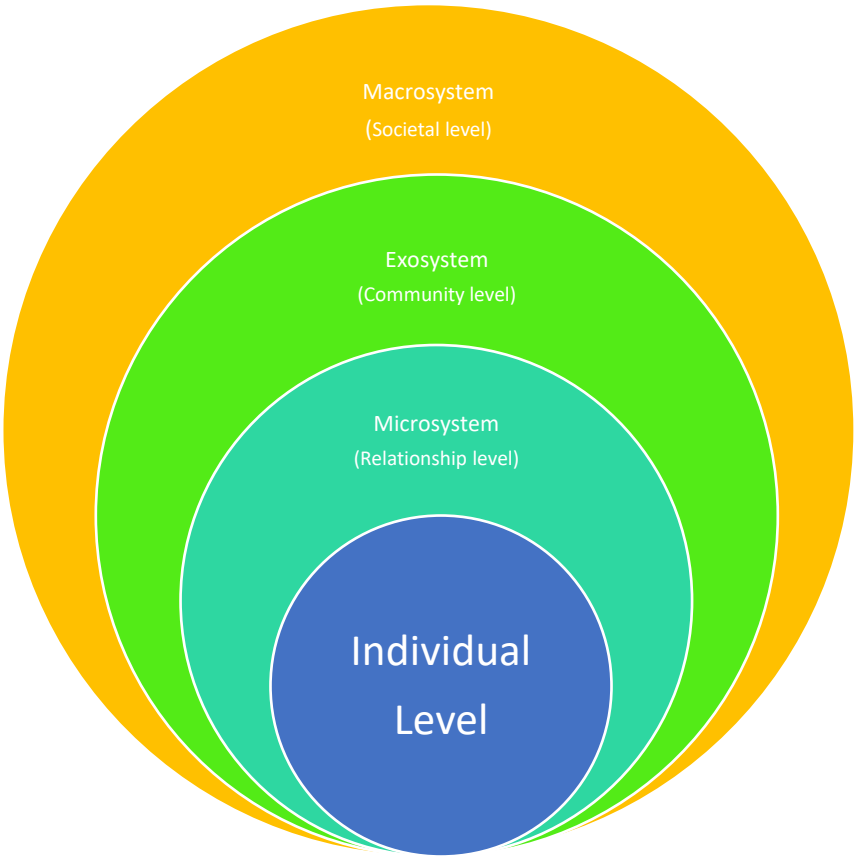
Bronfenbenner's (1979, 1986, 1995) ecological theory of human developmental and conceptualisation shaped the theoretical model developed by Heise (1998). According to Bronfenbenner: (a) *individual level* influences comprise the bio-psycho characteristics of the person, (b) *microsystemic* influences involve direct interpersonal interactions between individuals and members of their immediate environment such as families, friends and peers, (c) the *mesosystem* comprises interconnections and linkages between individuals, and between individuals and systems, (d) the *exosystem* includes organisations and social systems (medical, legal, and mental health services), (e) the *macrosystem* includes societal norms, expectations, and beliefs that form the broader social environment, and (f) the c*hronosystem* encompasses the changes that occur over time between the individual and their multiple environments (Campbell, Dworkin & Cabral, 2009).

The integrated ecological framework used in this study (Heise, 1998), was specifically developed for conceptualising violence; with Heise's model containing four levels of systemic influence (see Figure 1.1). The individual level of the model includes biological and personal characteristics that may be implicated in the perpetration of IPV, with individual level influences including: age, education, income, substance use, history of abuse, and history of aggressive behaviour (Wusu, 2015).

The next level of influence is the microsystem, which represents the immediate relationship context in which violence or abuse takes place. This relationship context is defined with respect to a range of relationship types (including: the family, friends, acquaintances, intimate partners, and peers) and focuses on the social contexts in which

violence is most likely to occur. For example, women who belong to social circles where women are encouraged to challenge the dominance of their partner or husband have been found to face a greater risk of being exposed to IPV (Wusu, 2015).

Figure 1.1: The integrated ecological framework proposed by Heise (1998)



The third level of influence in Heise's (1998) model is the exosystem, which encompasses both formal and informal institutions and social structures, including: the work world, the neighbourhood, social networks, and identity groups (Heise, 1998). This level is also referred to as the community level (i.e. exosystem influences involving social settings in which relationships occur), with characteristics of different settings being assumed to have the potential to either increase or decrease the likelihood of IPV taking place (Heise, 1998). For example, in a neighbourhood where social support for women who are abused by their intimate partner is available, the occurrence and consequences of IPV are likely to be lower than in neighbourhoods where social support is not available (Wusu, 2015).

Finally, the fourth level of influence (the macrosystem) represents the general views and attitudes that permeate the culture at large (Heise, 1998). This level, which is referred to as the societal level, encompasses broad social and cultural norms that influence the prevalence and consequences of IPV (Wusu, 2015).

Several theorists emphasise an additional level of influence (the mesosystem) that represents the interplay between various aspects of a person's social environment. The mesosystem includes linkages between an individual's family and place of work and/or peers. The mesosystem also includes linkages with social systems such as police, court and social services (Heise, 1998).

<u>Risk factors for IPV at each systemic level:</u>

Both the Centre for Disease Control and Prevention (CDC) and World Health Organization (WHO) have adapted this approach (ecological framework/theory) to address and develop multilevel models for the prevention of gender based violence (Campbell et al., 2009); with risk factors for IPV having been identified at each of the systemic levels defined by Heise's (1998) model:

- *Individual/ Ontogenic Factors:*

Ontogenic factors refer to those features of an individual's developmental experience or personality that shape his or her response to microsystemic and exosystemic stressors. For

female victims, a risk factor that has consistently been found to be associated with being a victim of IPV is having witnessed violence between parents or caregivers during childhood (Heise, 1998). For males who are violent towards their female intimate partner, two developmental experiences have emerged to be predictive of future violent behaviour and serve as risk factors, namely: witnessing domestic violence as a child and experiencing physical or sexual abuse as a child. A third factor which has emerged as a possible risk factor for IPV is having a rejecting or absent father (Heise, 1998), with a number of studies having found an association between heavy alcohol use and sexual and physical violence against women (Heise, 1998).

Alcohol consumption has also been found to be associated with an increased risk for all forms of interpersonal violence (Jewkes, 2002). South Africa has one of the highest levels of alcohol consumption per drinker in the world and is now ranked as one of the top 20 biggest drinking nations in the world, putting it on a similar level to countries such as the United Kingdom and the Ukraine (Rehm, Room, Monteiro, Gmel & Graham, 2004).

- *Microsystem (Situational Factors):*

The microsystem refers to those interactions in which a person directly engages with others as well as to the subjective meanings that are assigned to such interactions. For the violent perpetrator and partner the most salient element of the microsystem is the family, which is generally the site and context in which violent episodes take place. In cases where IPV takes place outside of the home, the relevant microsystem is likely to be the immediate context in which violence takes place (Heise, 1998).

A variety of microsystemic risk factors have been found to be associated with IPV, including: male dominance in the family, male control of wealth in the family, and marital conflict; with a cross-sectional study conducted by Levinson (1989) finding that male economic and decision-making authority in the family was one of the strongest predictors in societies that demonstrate high levels of violence against women. In Levinson's (1989) study, the most violent male partners tended to make most of the financial decisions and strictly controlled when and where their partner could go.

A study by Yllo and Straus (1990) suggests that the relationship between patriarchal family structure and violence may be in part fuelled by macro level norms that approve or support male dominance within the family or relationship; with the authors identifying a significant linear association between patriarchal norms and the extent of violence against women. There is also considerable evidence that men raised in patriarchal families are more likely to be violent towards their intimate partner than are men raised in egalitarian homes (Heise, 1998).

Additional studies have identified an association between IPV and the degree of economic dependency of women (Heise, 1998) and/or the frequency of verbal disagreements in a relationship (Straus, Gells & Steinmatz, 1980); with Coleman and Straus (1986) having suggested that when conflict occurs within a patriarchal relationship structure there is a much higher risk of violence than when conflict occurs within an egalitarian relationship. Moreover, a number of qualitative studies have identified sexual jealousy as a common source of conflict, and accusations of infidelity as a predictor of IPV (Heise, 1998).
The frequency of verbal disagreements and high levels of conflict have also been found to be associated with physical violence. In South Africa, conflict within intimate relationships has been found to arise in situations where the women: has other partners, drinks alcohol, and argues about their partner's drinking (Jewkes, 2002).

- *Exosystem Factors*

The following factors have been identified as risk factors for violence within the exosystem: unemployment or low socioeconomic status, the social isolation of women and of the family, and delinquent peer groups (Heise, 1998).

Although intimate partner violence occurs in all socioeconomic classes, there is strong evidence that the abuse of women is more common in families characterised by poverty and unemployment. According to Heise (1998), poverty is likely to generate stress, frustration, and a sense of inadequacy in some men for failing to live up to a culturally

defined role as provider; which could serve as a trigger for increased relationship conflict and abuse (Heise, 1998).

Poverty and associated stress have been identified as key contributors to intimate partner violence. Recent statistics indicate that 21.7% of South Africans live in extreme poverty (not being able to pay for basic nutritional requirements); 37% of people do not have enough money to purchase both adequate food items and non-food items; 53.8% of people can afford enough food and non-food items but fall under the widest definition of poverty in South Africa, surviving on less than R780 per month (Nicolson, 2015).

In a South African study (Jewkes, 2002), physical violence was not found to be associated with socio-economic status. However, the circumstances under which women worked were found to constitute a risk factor for exposure to violence. Taken together, these findings suggest that economic inequality within a context of poverty may be more important than the absolute level of income as a risk factor for exposure to violence (Jewkes, 2002).

It has also been postulated (Jewkes, 2002) that the link between violence and poverty could be mediated through masculine identity; with men who live in poverty not being able to live up to notions of 'successful manhood', resulting in a climate of stress. Violence against women is thus not seen as just male dominance or as an expression of male power but also as being rooted in male vulnerability stemming from social expectations of manhood that are unattainable within a poverty stricken nation (Jewkes, 2002).

A number of researchers have discussed intimate partner violence as a learned social behaviour for both men and women (Jewkes, 2002); with an intergenerational cycle of violence having been documented in many settings (Jewkes, 2002).

IPV has also been found to be associated with a strong desire to be held in high esteem in peer or social identity groups. In a study of men who reported forcing their intimate partner to have sexual intercourse, peer group influences appeared to provide a 'culture' in terms

of which sexual access to women was regarded as being of paramount importance in the maintenance of self-esteem (Heise, 1998).

Cross-cultural studies of intimate partner violence suggest that learnt aggressive behaviour is much more frequent in societies characterised by high levels of violence (Jewkes, 2002).

Within South Africa, there has been a history of violent state repression and community insurrection, but violence has also been frequently used in many situations such as disputes between neighbours and within the work place. Verbal and physical violence between staff and patients within health settings is also common, which contributes to violence becoming an accepted social norm; with such a norm constituting a macrosystemic risk factor for IPV (Jewkes, 2002).

Clinical and research data suggest that social isolation is both a cause and consequence of intimate partner violence. For example, battered women have been found to be more likely than their non-battered counter-parts, to be isolated in terms of frequency of interactions with friends, family, and neighbours (Heise, 1998).

Conversely, one of the strongest predictors of societies with *low* levels of violence is whether family and community members would intervene if a woman is being beaten or harassed. In *low violence* societies, the family and community feel it is their right and obligation to intervene in private family matters, whereas in cultures with *high violence* against women, families tend to be isolated, with marital and intimate partner relationships considered to be outside of public scrutiny (Heise, 1998).

- *Macrosystem Factors*

Macrosystem factors operate through their influence on factors and structures lower down in the system. For example male supremacy on a macro level could influence the organisation of power in community institutions, as well as the distribution of decision-making authority within intimate relationships (Heise, 1998).

Most feminist theories and discourses on violence against women have focused on macrosystemic factors such as patriarchy. The ecological approach acknowledges the centrality and importance of macro level factors such as male supremacy, but tends to emphasise the interrelationship between patriarchal beliefs and risk factors at other systemic levels (Heise, 1998).

One of the most enduring macrosystem factors that promotes violence towards women is a cultural definition of manhood that is linked to dominance, toughness, or male honour. The dominant style of men within rape prone societies is the macho-personality of hypermasculinity. Hypermasculine men have callous sexual attitudes towards women, seeing violence as both manly and desirable. It has been found that in societies with high rape rates, the macho-personality is more likely to be endorsed as the appropriate one for males (Heise, 1998).

At a macrosystemic level, IPV has also been found to be associated with rigid gender roles at both a societal and individual level (Heise, 1998); and with a cultural ethos that condones violence as a preferred method for settling interpersonal disputes (Levinson, 1989).
Many cultures within South Africa also condone the use of physical violence by men against women within certain circumstances and within certain boundaries of severity (Jewkes, 2002).

Women empowerment has also been identified as a risk factor for IPV. The relationship between intimate partner violence and women empowerment through education is complex. According to Jewkes (2002), this relationship is a U-Shape with some protection from violence existing at the highest and lowest educational levels. The most likely explanation for this U-shape relationship is that some education empowers women to challenge aspects of traditional sex roles, but that such empowerment carries an increased risk of violence until it reaches a high enough level for the protective effects to

predominate. Therefore during periods of transition in gender relations, women may be at an increased risk of violence (Jewkes, 2002).

South Africa's past has been characterised by immense brutality, which reflected extraordinary state-directed structural, as well as physical, violence. The combination of a patriarchal culture with a legacy of violence gives rise to a society that raises boys who grow up with a sense that they are entitled, and expected, to control girls, and that it is legitimate to use force to do so. Such socio-cultural norms of male superiority, combined with notions that violent conduct is acceptable, constitute potentially preventable exosystem or community level and macrosystem risk factors influencing intimate partner violence (Russell et al., 2014).

2.4 Context specific risk factors within South Africa

Over the past several decades South African societies have been characterised by multiple forms of violence. Until the country's transition to democracy in 1994, state-perpetrated abuse of human rights, such as detention without trial, torture, and politically motivated assaults were endemic. While democracy brought a reduction in politically motivated violence, some reports indicate that a post-apartheid South Africa continues to be characterised by high rates of violent crime and high rates of, sexual, and domestic violence (Kaminer, Grimsrud, Myer, Stein & Williams, 2008). For example, recent survey data suggest that the contemporary South African context is characterised by incidence rates for murder, armed robbery (Shaw, 2002), rape (Bollen, Artz, Vetten & Louw, 1999) and intimate partner violence (Abrahams, Jewkes, Laubscher & Hoffman, 2006) that rank amongst the highest in the world. These high prevalence rates may be a legacy of South Africa's socio-political history of apartheid and violent repression combined with ongoing socio-economic inequality and deprivation (Fajnzylber, Lederman & Loayza, 2002; Shaw, 2002).

The first democratic elections took place in South Africa in 1994, which marked the end of a history spanning over 350 years of racial oppression and discrimination. South Africa's transition from apartheid to political democracy has been marked by a sudden and intense

disruption of norms and identities. Challenges to previously held values made their way into the personal and private domains of people's lives, making intimate relationships sites of contestation. In the aftermath of the transition to democracy, sexual violence became an unprecedented focus of public concern and debate, with the relational and sexual practices of men in particular being increasingly interrogated (Smith, Lobban & O'Loughlin, 2013).

The predictors of intimate partner violence which have been highlighted in previous studies are largely rooted in gender power relations and culture. In Africa, gender has been seen to affect the power to act and influence others (Wusu, 2015).

Against a background of the constitutional endorsement of gender equality and accompanying legislation, research was conducted to explore the association of masculinity and domestic violence. There was ample evidence to demonstrate that within the new diverse South Africa, men are grappling with change. Masculinity is contested and dynamic. The challenges to the gender order, that have accompanied the political transition seen in South Africa, have resulted in the emergence of a new and diverse understandings of masculinities and masculine practices (Smith et al., 2013).

The new constitutional order in South Africa endorses gender equality, although neither the structural foundations of inequality nor the ideology that make access to power an ideal have been dismantled. Therefore, for many men gender rights tend to evoke feelings of potential loss. The current social conditions, particularly economic marginalisation, can result in what seems to be feelings of envy among men, of what may be viewed as women's privileged access to the benefits of political transformation (Smith et al., 2013).

Social and institutional practices, in particular within the apartheid state, legitimised male dominance over women and children. Thus, even if the father worked away (for example migrant miners), the image of the father's role as head of the family was kept alive. The consequences of such virulent forms of racial domination and class exploitation for men's sense of themselves in public life gave domestic life significance as a site for successful

manhood. Polarised notions of masculinity and femininity dominated the cultural content of gender categories at the time.

The social and political changes within South Africa resulted in women taking on and performing what were previously assumed to be masculine roles. Studies have then looked at the consequences of what can be described as the destabilisation of masculinity and reveal the problematic implications for individual men.

One of the least expected outcomes of human rights and political transformation in South Africa has been the challenge posed to the legitimacy of men's privileged status over women. The new democratic state's recognition of women as equal legal persons, combined with the presence of growing numbers of successful women within the public domain, has been said to reveal men's vulnerability. To recognise women as independent subjects with equal rights, belies having to protect them as the weaker ones. This recognition confronts men with their dependence on women, who are then repositioned as independent and beyond "omnipotent" control. If men are not provided with any support for negotiating this encounter, their anxieties could be provoked. As a defence, men may view women as the people who could be blamed for men's insecurity (Smith et al., 2013).

Studies reviewed above clearly depict the unique contextual factors, as well as changes that have taken place within South Africa, which can be attributed to factors operating at a macrosystemic level. Such changes impact on and permeate through all system levels right down to the individual level, as well as suggesting a well-founded explanation of the perpetration of intimate partner violence within our country.

2.5 Empirical research

The research and literature relating to intimate partner violence is vast, and therefore, in order to narrow it down, the focus of this review will be on recurrent themes from South African based studies, as well as findings from recent literature in the field of intimate partner violence and how they inform the current body of knowledge.

Abrahams et al. (2004) conducted a study of sexual violence against intimate partners in Cape Town, looking specifically at the prevalence of IPV and risk factors for perpetration reported by men. This cross-sectional study was conducted with 1,368 randomly selected working men within three Cape Town municipalities. In this study, it was found that 15.3% of men reported perpetrating sexual violence against their partners in the past 10 years. With 80.9% of the men who reported sexual violence also reported perpetrating both emotional and physical violence against their partners. Within this study none of the demographic and childhood variables were independently associated with sexual violence (Abrahams et al., 2004).

With regard to risk factors, the association between reported sexual violence and problematic alcohol use was consistent with other studies. There was a positive relationship between sexual violence and verbally abusive tactics used during conflict. Besides the above mentioned risk factors, the risk of being sexually violent was also associated with using violence in other settings and with having more than one current partner. It was also associated with particular types of conflict stemming from ideas of male sexual entitlement and dominance (Abrahams et al., 2004). A recommendation from the study was that prevention programmes should be focused on gender issues and non-violent conflict resolution among men and youth (Abrahams et al., 2004).

A study conducted in the Eastern Cape in rural areas (with a sample of young men aged 15-26 years) found the following results in terms of intimate partner perpetration. Nearly a third of the men (31.8%) reported perpetrating intimate partner violence. Among these men, 71.9% reported perpetrating physical violence only, 11.3% reported perpetrating sexual violence only and 16.8% reported perpetrating both types of violence (Dunkle et al., 2006).

South African research studies reveal the alarming reports by men of perpetrating intimate partner violence within their relationships, even if it was just one incident in their lifetime. Specific risk factors have been identified with the core need appearing to be attempts to address gender inequalities or roles as well as masculinity and conflict resolution. Studies

recommend culturally tailored interventions addressing violence perpetration, as well as interventions that engage communities in transformative dialogue around ideals of masculinity (Dunkle et al., 2006).

With high rates of men reporting perpetrating intimate partner violence, the impact of intimate partner violence cannot be ignored. This leads to the exploration of the effects of intimate partner violence and how these effects constitute a public health burden.

IPV affects women's physical and mental health through direct pathways such as injury and indirect pathways such as chronic health problems that arise from prolonged stress. A history of experiencing violence is therefore a risk factor for many diseases and health conditions. Current research suggests that the influence of abuse can persist long after the violence has stopped. And the more severe the violence, the greater the impact on a woman's physical and mental health. The impact over time of different types and multiple episodes of abuse appears to be cumulative (WHO, 2012).

The WHO (2012) has reported the following physical and mental health effects of IPV. The physical damage resulting from IPV can include: bruises, welts, lacerations and abrasions, abdominal or thoracic injuries, fractures and broken bones and teeth, sight and hearing damage; head injury; attempted strangulation; and back and neck injury. However in addition to injury, and possibly far more common, are ailments that often have no identifiable medical cause or are difficult to diagnose. These are often referred to as functional disorders or stress related conditions and include irritable bowel syndrome or gastrointestinal symptoms; fibromyalgia; various chronic pain syndromes, and exacerbation of asthma. In the WHO multi-country study, the prevalence of injury among women who had been physically abused by their partner ranged from 19% in Ethiopia, to 55% in Peru. Abused women are also twice as likely as non-abused women to report poor health and physical and mental health problems, even if the violence occurred years prior (WHO, 2012).

Evidence suggests that women abused by their partners suffer higher levels of depression, anxiety, and phobias than non-abused women. In the WHO multi-country study, reports of emotional distress, thoughts of suicide, and attempted suicide were significantly higher among women who had experienced physical or sexual violence than those who did not. In addition IPV has been linked to alcohol and drug abuse, eating and sleep disorders, physical inactivity, poor self-esteem, post-traumatic stress disorder, smoking, self-harm, and unsafe sexual behaviour (WHO, 2012).

IPV may lead to a host of negative sexual and reproductive health consequences for women, including: unintended or unwanted pregnancy, abortion and unsafe abortion, sexually transmitted infections including HIV, pregnancy complications, pelvic inflammatory disease, urinary tract infections, and sexual dysfunction. IPV can have a direct effect on women's sexual and reproductive health (including sexually transmitted infections through forced sexual intercourse), or through indirect pathways (for example, making it difficult for women to negotiate condom or contraceptive use with their partner) (WHO, 2012).

Studies from a range of countries have found that 40%-70% of female murder victims are killed by their husband or boyfriend, often in the context of an abusive relationship. In addition evidence suggests that IPV increases the risks of women committing suicide and may also increase the risk of contracting HIV, and thus of AIDS related deaths (WHO, 2012).

Studies have found substantial levels of physical IPV during pregnancy in settings around the world. The WHO multi-country study, found prevalence rates of physical IPV in pregnancy ranging from1% in urban Japan to 28% in provincial Peru, with prevalence rates in most sites of 4%-12%. Similarly a review of studies from 19 countries found prevalence ranging from 2% in settings such as Denmark, Australia and Cambodia, to 13.5% in Uganda, with the majority ranging from 4%-9%. A few facility based studies have found even higher prevalence rates (one in Egypt with a prevalence rate of 32%) while a review of studies in Africa found prevalence rates as high as 40% in some settings. Violence

during pregnancy has been associated with miscarriage, late entry into prenatal care, stillbirth, premature labour and birth, foetal injury and low birth weight, or small for gestational age infants. IPV may also account for a proportion of maternal mortality (WHO, 2012).

In a national intimate partner and sexual violence survey conducted in the United States in 2011, an estimated 27.3% of women who had reported experiencing contact sexual violence (rape, sexual coercion, or unwanted sexual contact), physical violence, or stalking by an intimate partner during their lifetimes had experienced at least one negative impact from it. Specifically an estimated 23.7% of women were fearful, 20.7% were concerned for their safety, 20.0% experienced one or more post-traumatic stress symptoms, 13.4% were physically injured, 6.9% needed medical care, 3.6% needed housing services, 3.3% needed victim advocate services, 8.8% needed legal services, 2.8% contacted a crisis hotline, 9.1% missed at least one day at work or school, 1.3% contracted a sexually transmitted infection, and 1.7% became pregnant as a result of the violence experienced by an intimate partner (Breiding et al., 2014).

Those who experience intimate partner violence are at greater risk for a range of long-term health consequences. Therefore secondary prevention is also of great importance in order for victims of intimate partner violence to be able to readily access the services they require. Research suggests that nearly half of female victims who indicate a need for services do not receive any of the services needed (Breiding et al., 2014).

A national epidemiological study conducted in South Africa focused on the mortality of women from intimate partner violence. This was the first national study of female murders in South Africa that has been able to describe the mortality rate from intimate partner violence. The overall rate of female homicide (24.7 per 100 000) found in this study is the highest in published literature and is six fold higher than the global rate (4.4 per 100 000 female population) estimated in the World Health Organisation's Global Burden of Disease project in 2000. The female homicide rate found in this study, 8.8 per 100 000, far

exceeds rates reported in the United States, Australia, Canada, and the United Kingdom (Abraham & Jewkes, 2009).

The demographic profile of age and race for both victims and perpetrators found in the study by Abrahams and associate (2009), is similar to the findings reported for prevalence and risk factors in other South African studies. The proportion of women under 40 years old reporting physical violence in the past year was nearly double that of women over the age of 40. And the proportion of coloureds reporting it was 66% higher than that of African women (the race group with the next highest prevalence rate). This suggests that mortality from intimate partner violence can be better understood as an extension of the problem of intimate partner violence and not just as part of the general homicide problem (Abrahams & Jewkes, 2009).

The study conducted by Abrahams and associates suggests a number of findings that have important implications for prevention. In South Africa, the randomised controlled trial evaluation of the HIV behaviour change intervention has proved to be effective in reducing men's perpetration of intimate partner violence at 2-year follow-up (Jewkes et al., 2008). These kinds of interventions are said to be critical in reducing intimate partner violence. Controlling access to firearms, interventions to reduce alcohol abuse, and improving mental health services were identified as having an impact on female homicide. The recommendation from the study by Abrahams and associates is that prevention of intimate partner violence should take place through reducing gender power inequalities - and that this should be a public priority for the country (Abrahams & Jewkes, 2009).

A study conducted in Vhembe district in South Africa, examined the mental health consequences of intimate partner violence (Peltzer et al., 2013a). Only a few studies of battered women include multidimensional assessments of physical assault, sexual coercion, psychological abuse and stalking. One of the aims of this study was to assess the contributions of the different forms of intimate partner violence to symptoms of post-traumatic stress disorder and depression (Peltzer et al., 2013a). This study found that in a sample of women with protection orders, there was a higher severity of overall, and

different types of, intimate partner violence than has been documented in previous studies. The results suggest that a significant number of women who experience intimate partner violence also experience post-traumatic stress disorder and depression. In a study of primary care in South Africa, both post-traumatic stress disorder and major depression were significantly more common in patients with a history of domestic violence, with prevalence rates of 35.4% and 48.2% respectively. Post-traumatic stress disorder and depression tended to be highly comorbid, which increases the likelihood of debilitating outcomes. In this study, physical and sexual violence contributed to the prediction of post-traumatic stress disorder. Study findings suggest that psychological abuse contributes to the onset of depression. The clinical implications from this study justify the assessment of women reporting partner violence for post-traumatic stress disorder and depression (Peltzer et al., 2013a). Recent research also points to the intergenerational impact of abused women's mental health on the functioning of their children (Peltzer & Pengpid, 2013).

The recommendations of the study by Peltzer and associates are: early assessment and intervention of women reporting IPV, as well as the use of assessments which are able to measure different forms of IPV, in order to prevent negative outcomes such as mental dysfunction and psychological distress of children (Peltzer et al., 2013a; Peltzer & Pengpid, 2013).

A study conducted by Katz and Rich (2015) looked at co-victimisation in intimate partner violence and the consequences of a relational break up in a sample of United States college women. Many researchers assess multiple forms of intimate partner violence, but very few specifically focus on the outcomes related to experiencing multiple forms of intimate partner violence. Co-victimisation is defined as experiencing both physical and sexual forms of intimate partner violence.

In a study of college women, 64% reported being co-victimised since the start of adolescence but not necessarily by the same partner. Co-victimised women also report experiencing more severe forms of physical and sexual intimate partner violence. Because co-victimising partners use more severe forms of intimate partner violence, they may be

more likely to enact post break up intimate partner violence. The available research data suggests that intimate partner violence prior to a break up predicts, repeated fear-inducing pursuit after a break up. Research on post separation violence suggests that women are at an increased risk for intimate partner violence soon after leaving a relationship (Katz & Rich, 2015).

The results of the study by Katz and Rich, suggest that one quarter of the sample reported co-victimisation prior to their most recent break up, and that two-thirds of the sample reported some kind of ongoing pursuit after the break up. Compared to women who reported either physical or sexual intimate partner violence before a break up, co-victimised women reported elevated rates of ongoing intimidation and threats after a break up. These findings further support previous research suggesting that co-victimised women report greater partner intimidation behaviours. These findings, as well as findings from past research, suggest that, intimidation and threats commonly occur with partner co-victimisation and that such behaviours can occur repeatedly even after a break up. There was clear support for the prediction that partner co-victimisation before a break up predicts intimate partner violence after a break up. Results showed that pre-break up physical intimate partner violence predicted post break up physical intimate partner violence, and that pre-break up sexual intimate partner violence predicted post break up sexual intimate partner violence. Compared to women who had partners that did not assault them, women whose partners were physically assaultive before the break up showed a greater ongoing surveillance pursuit after the break up. The results extend previous findings by showing that physical intimate partner violence predicts post break up pursuit, which was defined as repeated behaviour for at least two weeks. The findings that sexually coercive partners showed higher levels of ongoing approach or contact pursuit following a break up adds to past research which links pre-break up sexual intimate partner violence to repeated pursuit that elicits fear in a partner.

Generally, current results linking sexual intimate partner violence to ongoing pursuit supports past studies in which women who were stalked during a relationship were also more likely to report sexual intimate partner violence during that same relationship. The

results of this study add to the broader literature by suggesting that pre-break up sexual intimate partner violence predicts a pattern of unwanted approach or contact behaviours after a break up. This research also suggests that different types of ongoing pursuit can be predicted by different types of intimate partner violence pre-break up. Different types of ongoing pursuit are also associated with post break up intimate partner violence. Present studies help clarify the relationship between threats and actual violence, with the results of this study demonstrating that threats and intimidation are often accompanied by post break up intimate partner violence (Katz & Rich, 2015).

In conclusion, ending a dating relationship which was characterised by intimate partner violence does not necessarily mean the end of violence. Unfortunately for many women, intimate partner violence involves a pervasive pattern of intrusiveness, disrespect, and aggression that persists even after the relationship has ended. Partner co-victimisation places women at a higher risk for continued intimidation and violence following a break up (Katz & Rich, 2015).

The findings by Katz and Rich have a number of implications, namely: (a) the need to assess pre-break up experiences of both types of intimate partner violence, which could improve the prediction of risk for ongoing pursuit, and (b) the need for those working with co-victimised women to prepare such women for the probability of ongoing pursuit and intimate partner violence after a break up. Katz and colleagues recommend that safety planning and education about effective responses to such ongoing pursuit would benefit co-victimised women (Katz & Rich, 2015).

A study that conducted a systemic review of 40 years of published research, examined physical intimate partner violence and the effects on sexual health. Rates of intimate partner violence were found to be high among women seeking medical care, with a lifetime prevalence of 44%, and with 15% of women currently experiencing intimate partner violence (Thompson et al., 2006). Both physical and psychological intimate partner violence have been found to have significant mental, physical, sexual and social

consequences, with symptom severity increasing as a function of the duration of abuse exposure.

A growing literature has addressed the effects of intimate partner violence on sexual health (Coker, 2007). Physical intimate partner violence may reduce sexual pleasure or desire which in turn can lead to sexual dysfunction. Physical trauma from chronic physical or sexual intimate partner violence may directly result in unexplained pelvic pain, pain during intercourse, menstrual bleeding or other menstrual irregularities, infertility or eventually hysterectomy (Coker, 2007).

Chronic intimate partner violence is characterised by the sense of a loss of power and control over one's own life. Intimate partner violence can influence a woman's ability to take control and make informed decisions about her sexual health regarding issues such as: when and whether to use contraceptives or whether to become pregnant. Abusive partners could have multiple sexual partners outside of the relationship and this is something the woman will have no control over or little knowledge of. Factors which are outside of the women's control could influence rates of unplanned pregnancies, sexually transmitted infections, and urinary tract infections; while repeated sexually transmitted infections could result in infertility (Coker, 2007).

Physical, sexual, and psychological intimate partner violence is known to influence perceived stress, anxiety, and depression rates. This increase in stress in turn affects the immune system which indirectly affects sexual health and physical health. Increased stress may also influence sexual dysfunction, cervical neo-plasia risk, endometriosis, or fertility rates (Coker, 2007).

The results of the study by Coker suggest that physical intimate partner violence, which includes both sexual and psychological abuse, is consistently associated with most sexual health indicators. All studies that have explored intimate partner violence and sexual pleasure found that victims were significantly more likely to report a lack of sexual desire and pleasure within their intimate relationships. The majority of studies that addressed

sexual risk taking behaviour, such as inconsistent condom use or partner monogamy, found that intimate partner violence victimisation was associated with sexual risk taking by the women or by the partner. Intimate partner violence is associated with unplanned pregnancy, or an induced abortion, in the majority of studies which addressed this sexual health outcome. In almost 80% of studies addressing intimate partner violence, sexually transmitted infections, and urinary tract infections evidence was found of an association between IPV and STIs, and IPV and UTIs. In 17 of 18 studies that addressed intimate partner violence and sexual pain, a significant association was found. In all studies exploring a link between IPV and painful menses, an association was found. In studies addressing intimate partner violence and hysterectomy, a positive association was found (Coker, 2007).

A study conducted in Nigeria regarding the prevalence and implications of intimate partner violence against young married female youths, found a number of effects correlated with intimate partner violence (Wusu, 2015). Most of the research regarding intimate partner violence, and sexual and reproductive health consequences among youth, are based on studies carried out in the United States. Therefore the study by Wusu sheds light on consequences that may be unique to a specific context. The findings of the study by Wusu indicate that intimate partner violence is positively associated with unwanted pregnancy or childbirth, which correlates with findings from previous studies (Silverman, Gupta, Decker, Kapur & Raj, 2007; Okenwa, Lawoko & Jansson, 2011). The study also found a statistically significant association between intimate partner violence and the incidence of sexually transmitted infections, which is consistent with previous studies which found sexually transmitted infections as one of the main consequences of intimate partner violence (Wusu, 2015).

Intimate partner violence does not have restrictive boundaries and is found during pregnancy and in the postpartum period. A study conducted by Peltzer (2013b) among new mothers found that 6.2% had reported experiencing physical and or sexual partner violence, with 11.9% reporting emotional abuse in the past 12 months. Similar, and higher, rates of intimate partner violence in new mothers have been reported in previous studies

(Gielen, Lawoko & Jansson, 1994; Hedin, 2000; Koenig et al., 2006; Saito, Creedy, Cooke & Chaboyer, 2012). The study by Peltzer suggests that routine screening for intimate partner violence by maternity services should be implemented and encouraged (Peltzer, 2013b).

Groves et al. (2015) conducted a similar study which examined prevalence rates of intimate partner violence among South Africa women during pregnancy and in the postpartum period. The study found that almost half of all women (42.25%) reported experiencing at least one act of physical, psychological, or sexual intimate partner violence either during pregnancy or in the first nine months postpartum. Just over one fifth of women (21.35%) experienced at least one act of intimate partner violence during pregnancy, with the prevalence of psychological intimate partner violence (16.63%) being nearly double that of physical intimate partner violence (8.76%). This suggests that pregnancy and the postpartum period are times when women are at high risk for intimate partner violence. These findings illustrate the importance of intimate partner violence screening and intervention both during pregnancy and in the postpartum period; periods which are regarded as being vital, as women engage with health care settings during this time. The recommendations of the study suggest that women need to be screened not only for physical violence but also for psychological violence, as psychological violence has been found to be the most prevalent type of violence during pregnancy and in the postpartum period (Groves et al., 2015).

In addition to screening, Groves and associates recommend that appropriate interventions need to be implemented in order to reduce levels of intimate partner violence. The study by Groves and associates suggests that interventions beyond the healthcare sector are also needed to address intimate partner violence during pregnancy and the postpartum period, with the suggestion being the implementation of specific community based intervention programmes, directed at both pregnant partners and male perpetrators during this time (Groves et al., 2015).

Recent research (Groves et al., 2015; Peltzer, 2013b) has identified pregnancy and the six months after pregnancy (postpartum) as critical or sensitive periods for particular vulnerability in relation to intimate partner violence. These periods call for timely intervention in order to prevent the dire consequences of the possible effects that intimate partner violence could have during pregnancy and in the aftermath of delivery.
Intimate partner violence has also been found to be associated with HIV/AIDS. Due to HIV/AIDS being the highest contributor to the burden of disease in South Africa (Groves et al., 2015) it is important to examine the association and relationship between intimate partner violence and HIV/AIDS. Research conducted in the United States, has consistently shown that experiences of intimate partner violence lead to increased HIV risk behaviour. Studies conducted in Tanzania, Rwanda, and South Africa have found that HIV positive women are more likely than HIV negative women to report a history of physical or sexual abuse. Results of a South African study suggest that women who have experienced intimate partner violence are more likely to be HIV positive, even after controlling for a range of associated risky behaviours. Such findings suggest that experiencing intimate partner violence may be an independent risk factor for HIV infection among women. A possible explanation for the above finding is that men who perpetrate intimate partner violence are more likely than other men to engage in HIV risk behaviours and are therefore more likely to be HIV positive (Dunkle et al., 2006).

The relationship between intimate partner violence, HIV/AIDS, and other sexually transmitted infections is bidirectional. Several different pathways may explain the link between intimate partner violence and HIV infection. Forced sex as part of intimate partner violence, increases the risk of direct transmission. Key drivers of intimate partner violence and HIV are gender inequalities, which may also mediate the relationship between abuse and HIV transmission. Social norms that give power to men over women increase the risk of violence against women, which in turn gives rise to a reduction in women's and girls' ability to negotiate safe and consensual sex, and to seek protection from abuse (Wagman et al., 2015).

Research on women's experiences suggests that intimate partner violence is an important risk factor for HIV infection (Dunkle et al., 2006). Women who experience intimate partner violence and men who perpetrate intimate partner violence have an added clustering of factors that increase their risk of contracting HIV (Wagman et al., 2015).

Norms, which are related to, masculinity often encourage men to engage in more risky sexual behaviour. Available evidence suggests that men who perpetrate abuse are more likely to: (a) be HIV positive or carrying another sexually transmitted infection, (b) engage the services of female sex workers, and (c) report concurrent sexual partners, problematic alcohol and substance abuse, and/or inconsistent condom use (Wagman et al., 2015).

A study conducted in a rural area of the Eastern Cape on a sample of young men aged 15-26 years, found that the perpetration of intimate partner violence was associated with a higher numbers of lifetime and past year sexual partners, more recent sexual intercourse, a greater likelihood of reporting casual sex partners (overall and in the past year), transactional sex, substance use, and a greater likelihood of reporting sexual violence against women other than their girlfriends. Men who reported more severe intimate partner violence also reported significantly higher levels of HIV risk behaviour. These finding provide clear support for the hypothesis that men who perpetrate intimate partner violence also engage in high levels of HIV risk behaviours; further suggesting that more severe intimate partner violence is associated with higher levels of risky behaviour (Dunkle et al., 2006).

Cross-sectional studies have shown that intimate partner violence and gender inequality in relationships is associated with the increased prevalence rates of HIV in women (Jewkes, Dunkle, Nduna & Shai, 2010). A longitudinal study conducted in the Eastern Cape with women aged 15-26 years (Jewkes et al., 2010), found that women who experience intimate partner violence and gender inequality within their relationships have an increased incidence of HIV infection (however, this risk of incidence of HIV was not associated with rape by a non-partner). These findings of IPV being associated with an increased incidence

of HIV infection, are consistent with previous finding obtained in cross-sectional studies (Dunkle et al., 2004).

The incidence of HIV infection in Jewkes et al. (2010) cohort study was 6%, which is similar to the national rate that is estimated at 6.5% in women aged 15-24 years. In conclusion, these findings suggest that exposure to physical and sexual intimate partner violence and low relationship power equity increases the incidence of HIV in young women in rural areas of South Africa, accounting for a substantial proportion of HIV infections. This study by Jewkes et al. (2010) recommends that programmes and interventions focusing on empowering women and changing the ideals of masculinity are both important and necessary. Jewkes et al. findings suggest that already running successful programmes – such as Stepping Stones, Sexto Sentido from Nicaragua, Program H from Brazil, the Intervention with Microfinance from AIDS and Gender Equity (IMAGE) from South African, and Better Options for Boys from India – could benefit from further research designed to assess and refine these programmes (Jewkes et al., 2010).

The study by Jewkes and associates further recommends that organisations that are driving HIV prevention, such as UNAIDS and WHO, need to ensure that policies, programmes, and interventions designed to build gender equity and prevent partner violence are developed and widely implemented (Jewkes et al., 2010).

Because HIV/AIDS is one of the highest contributors to the burden of disease in South Africa, and interpersonal violence is the second highest contributor to disease, it is important to examine how the two are linked and the directional relationship between the two.

Research findings have shown that IPV is not limited to adult populations, but, unfortunately, is also quite common among adolescents and young adults. Exposure to intimate partner violence is now being documented at younger and younger ages. The Center for Disease Control and Prevention (CDC) has estimated that between 12% and 20%, or nearly one-fifth, of middle and high school students experience physical or

psychological abuse in dating relationships (CDC, 2006). The prevalence of dating violence among adolescent samples has been shown to vary by racial and ethnic subgroups, with African American female adolescents facing the highest risk of being victimised (Malik, Sorenson & Aneshensel, 1997; Rickert, Wiemann, Vaughan & White, 2004). As has been found for adult victims, experiences of dating violence among adolescents have been associated with increased participation in health risk behaviours, including sexual intercourse, attempted suicide, episodic heavy drinking, and physical fighting (CDC, 2006; Williams et al., 2008).

Intimate partner violence and sexual violence is widespread among adolescents, which (when experienced) can place individuals on a lifelong trajectory of violence, either as perpetrators or victims. A report estimating intimate partner violence based on data from 81 countries, shows that the lifetime prevalence of physical and or sexual intimate partner violence among girls' age 15 to 19 years, is 29.4%, and, among young women ages 20 to 24 years is 31.6%. In some countries such types of violence affect as much as half of girls and young women aged 15 to 24 years (Lundgren & Amin, 2015).

A national intimate partner and sexual violence survey conducted in the United States in 2011, among female victims of contact sexual violence, physical violence, or stalking by an intimate partner, found that an estimated 71.1% of participants first experienced these or other forms of intimate partner violence before the age of 25 years (Breiding et al., 2014), with 23.2% having reported experiencing IPV before the age of 18 years and an estimated 47.9% having experienced IPV between the ages of 18 and 24 years. An estimated 20.7% first experienced intimate partner violence at age 25-34 years, an estimated 5.9% at age 35-44 years and an estimated 2.3% at an age older than 44 years (Breiding et al., 2014).

It is estimated that approximately one in four adolescents reports dating violence each year (Center for Disease Control, 2014); and 23%-38% of emerging adults (19-23 years) report violence in their intimate relationships. During adulthood, which is from ages 27-31 years, national surveys reveal rates of physical intimate partner violence in the region of 17%-

39%; with the modal age for victimisation being late adolescence and young adulthood (Lohman, Neppl, Senia & Schofield, 2013).

Recent evidence suggests that rates of intimate partner violence peak during young adulthood with one third (32%) of young adults reporting being victimised, and one quarter (24%) reporting perpetration of such violence (Johnson, Manning, Giordane & Longmore, 2015b). Entry into the dating world or world of romantic relationships begins in adolescence. As adolescents transition into adulthood, these romantic relationships begin to increase in duration, deepen in meaning, and normally follow a pattern of increased trust, intimacy and commitment. But these relationships can be complicated by a number of different factors and discord, along with negative conflict styles, can result in outcomes such as intimate partner violence.

Physical assault or the use of bodily violence is common among young dating couples. Straus (2004) showed that between 17-49% of college students, at each of 31 sites worldwide, reported perpetuating physical assault against a dating partner in the past year. Rhatigan and Street (2005) found that 29% of undergraduate women in a United States college, reported assault by a male dating partner in the past year (Katz & Rich, 2015).

Coerced sex within heterosexual dating relationships – defined broadly to include verbal threats, pressure and force – is, also common, with prevalence rates ranging from 29%-33%. Using this broad definition, 32% of undergraduate males at a United States college reported coercing sex from a female partner (Katz & Rich, 2015).

Taken together, these findings suggest that primary prevention of intimate partner violence should take place at an early age. For example school based programmes, such as a safe dating programme which focuses on enhancing conflict management skills, would appear to be indicated in order to change norms that are supportive of dating violence. Such programmes have been shown to prevent perpetration of physical and sexual violence as well as psychological aggression in teen dating relationships (Breiding et al., 2014).

A study conducted by Russell et al. (2014) examined intimate partner violence among adolescents in Cape Town. Russell states that much of the research on intimate partner violence has been conducted on adult populations. However, a South African national survey of youth risk behaviour found that intimate partner violence starts early in life, with 12.1% of Grade 8 girls reported being hit, smacked, or physically hurt by their boyfriends in the past 6 months. In addition, 16.1% of Grade 8 boys reported having hit, smacked, or physically hurt their girlfriends (Reddy et al., 2010; Russell et al., 2014).
In the study by Russell and associates (2014), emotional intimate partner violence was reported by one third of both girls and boys, and sexual intimate partner violence was reported by 10% of both girls and boys, whereas physical intimate partner violence victimisation was reported by almost twice as many girls than boys. It was also found that girls were significantly less likely than boys to agree with dating abuse and rape myths. Most learners tended to disagree with statements that suggested that it was okay for a boy to hit a girl under certain circumstances (dating abuse) but fewer disagreed with other attitudinal statements that were supportive of male superiority and violence. Heavy drinking was also reported by 16.5% of the learners. More frequent use of negative styles in order to resolve conflict was reported by 16.6% of students. Higher rates of intimate partner violence were found to be associated with an endorsement of ideologies supportive of male ideology and violence. There was also an association found between heavy drinking and the use of negative styles to resolve conflict. These negative styles of resolving conflict predicted higher rates of emotional and sexual intimate partner violence by boys, while negative styles of resolving conflict among girls predicted higher rates of emotional intimate partner violence (Russell et al., 2014).

The study by Russell and associates found a high prevalence rate of intimate partner violence among Grade 8 learners in Cape Town. These high rates of intimate partner violence reported by adolescents provided an opportunity to model the relationship of preventable risk factors of intimate partner violence victimisation among girls, as well as intimate partner violence perpetration among boys. Ideologies of male superiority and violence were found to be associated with reduced levels of intimate partner violence. In

addition, a negative style of resolving conflict when disagreeing with partners was found to increase the risk of intimate partner violence (Russell et al., 2014).

Analysis of the data in the study by Russell and associates revealed a strong relationship between heavy alcohol use and higher risk of intimate partner violence. However the structural equation model indicated that the contribution of heavy alcohol use to an increased risk of intimate partner violence was mediated by negative conflict styles to resolve conflict. Heavy drinking also decreases sensitivity to social cues (Clements & Schumacher, 2010), which, coupled together with negative styles of resolving conflict, could increase the risk of intimate partner violence. In the study by Russell and associates it was found that girls were as likely to report heavy drinking as boys in this Grade 8 population (Russell et al., 2014). Older adolescent boys' drinking was found to exceed that of girls but it is not uncommon for girls' drinking to exceed boys' drinking among younger adolescents (Russell et al., 2014).

The study by Russell and associates notes that the derived statistical model would appear to be valid for both girls and boys; thus suggesting that interventions to prevent intimate partner violence, which challenge ideologies of male superiority and violence, encourage the use of positive conflict resolution styles, and discourage heavy alcohol consumption will be appropriate for both girls and boys (Russell et al., 2014).

Research findings suggest that parent to child psychological violence during adolescence is a key predictor of later intimate partner violence. Multiple risk factors have been found to significantly increase intimate partner violence during emerging adulthood (19-23 years) and adulthood (27-31 years), such as negative emotionality and number of sexual partners in adolescence. Academic difficulties have also been found to be associated with increased levels of violence in samples of emerging adults (Lohman et al., 2013).

Recent studies have revealed greater variability than stability with regard to intimate partner violence across adolescence and young adulthood for both men and women. Consistent with previous studies, results from the study by Johnson and associates revealed

intimate partner violence is prevalent among youth. The factor of age demonstrated a curvilinear pattern, which increased during late adolescents (in proportion to the increase in relationships) and begins to decrease in young adulthood (Johnson, Giordane, Manning & Longmore, 2015a).

Due to the above findings of IPV being prevalent among youth, there has been an increasing interest in understanding developmental patterns of intimate partner violence. It is assumed that intimate partner violence peaks during an individual's early twenties. The hypothesised pattern for the age intimate partner violence curve is an increase during adolescence, peaking during the early twenties, and then a subsequent decrease (Johnson et al., 2015a).

The results of a recent study, conducted with male youth, found that, intimate partner violence perpetration increased from 13% (at ages 13-16 years), to 19% (at ages 17-20 years). This was then followed by subsequent decreases, 15% at ages 21-24 years, and a further decrease to 10% at ages 25-28 years (Johnson et al., 2015a).

The pattern for female youth was similar but with somewhat higher rates, with a peak rate of 29% at ages 21-24 years. These results confirm the predicted probability that intimate partner violence peaks during early twenties and subsequently declines in the latter half of the twenties. The risk of intimate partner violence perpetration was similar for adolescent boys and girls. The predicted probability of intimate partner violence perpetration was higher for female youth beginning at age 17 and continuing to the oldest observed age which was 28 years. The gender gap of reported intimate partner violence perpetration was highest during the peak period of the early twenties (Johnson et al., 2015a). This gender gap is in contrast to previous studies that reveal higher rates of male perpetrated intimate partner violence, although it should be noted that such studies used an adult sample which could account for differences, although future research is needed to confirm or disconfirm such patterns (Johnson et al., 2015a).

Connolly and McIsaac (2009) found that romantic involvement increased from 25% at age 12 years, to 50% at age 15 years, to 70% at age 17 years, in a sample of youth who had reported romantic involvement. This increased involvement comes with the potential for greater volatility, mismatches of commitment, and expectations. This increase is a contributing factor to the increase of IPV during adolescence and young adulthood (Johnson et al., 2015a).

2.6 Conclusion

The key findings from the review indicate, that, within South Africa, there is a high rate of perpetration of IPV reported by males. Such perpetration involves both adult males and boys, and includes all forms of IPV (i.e., physical abuse, sexual abuse and emotional/psychological abuse.

Risk factors for IPV identified by the studies within the South African context are; gender inequalities, masculinity, conflict resolution and alcohol abuse.

The studies reviewed indicated that the following effects are significantly associated with IPV: physical and mental health effects, depression, anxiety, PTSD, sexual and reproductive health effects, unwanted pregnancies; and increased infection rate of HIV, sexually transmitted diseases, and urinary tract infections. In a South African study, physical and sexual forms of IPV were found to be significantly associated with PTSD, whereas psychological/emotional forms of IPV were found to be significantly associated with depression. Besides the physical and mental health effects, the mortality rate of women in South Africa from IPV has been found to be higher than the global rate.

A number of South African studies have proposed interventions for IPV, including: the need for early assessment and intervention, the need for adequate assessment tools that measure all forms of IPV, measures to reduce gender power inequalities, and the promotion of non-violent forms of conflict resolution.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This chapter includes a detailed description of all the elements of the research study and the procedural steps that were followed with regard to the research design, study location, sampling and sampling methods used, instruments used for data collection, data collection procedures, data reduction methods used, as well as issues relating to the validity of the study findings.

3.2 Research design

This study employed a quantitative approach, with a cross-sectional survey research design which made use of a self-administered structured questionnaire. The use of a structured questionnaire allowed for specific data to be collected in order to explore associations between IPV and participants clinical status. A quantitative approach, using a relatively large sample, was considered appropriate as it enabled the researcher to systematically explore intimate partner violence within this student sample in a manner that permitted generalisation to other comparable samples (Terre Blanche, Durrheim & Painter, 2006).

3.3 Location of study

This study was conducted at the University of KwaZulu-Natal, Howard College campus in Durban. The target sample for the research was first year undergraduate students registered for Psychology modules on the Howard College campus, in 2016. The questionnaires were administered during tutorial classes to enrolled first year psychology students.

3.4 Sampling and sampling method

Purposive sampling was used, as the study was concerned to explore the experiences of individuals who had experienced IPV. In this study the selection criteria were undergraduate students, registered for psychology modules, on the Howard College campus of the University of KwaZulu-Natal. A total of 200 questionnaires were returned,

with 146 participants indicating that they had been involved in an intimate relationship in the past 12 months. These 146 participants constituted the study sample.

Research participants had a mean age of 19.38, with an age range of 18-25 years old. Participants were predominantly female (75.3%) and Black African (79%).

3.5 Instruments

A self-administered, structured questionnaire was used (cf., Annexure A). This type of questionnaire enables sensitive information to be collected, and was deemed to be appropriate given the study aims (Foxcroft & Roodt, 2005). The questionnaire was presented in English, as all participants had an adequate level of proficiency in English.

The questionnaire consisted of 3 sections. The first section included standard items relating to research participants' socio-demographic information in terms of age, gender, race and marital status. Standard demographic questions were used to survey age, race, gender, and marital status; with poverty being assessed using the Poverty subscale of the Developmental Trauma Inventory which was developed using a South African sample (Valjee & Collings, 2015).

Intimate partner violence (IPV) was assessed using two validated measures: (a) the short form of the Revised Conflict Tactic scale (physical and sexual IPV; Straus & Douglas, 2004); and (b) the Woman's experience of battering scale (Smith et al., 1999).

The third section of the questionnaire assessed participants' psychological adjustment using two measures that have been extensively used with South African samples: (a) The depression and anxiety subscales of the Hopkins Symptom Checklist (Derogatis et al., 1974), and (b) the Brief Screening Instrument for PTSD (Brewin et al., 2002).

3.5.1 Independent measures

The following two validated measures were used to assess IPV:

The Revised Conflict Tactic Scale short form (CTS2S). Developed by Strauss and Douglas (2004), the CTS2S is a 20-item measure of IPV. The instrument includes scales to measure three tactics used when there is conflict in the relationships of dating, cohabiting, or marital couples: Negotiation, Physical Assault, and Psychological Aggression. In addition, there are two supplemental scales: Injury from Assault and Sexual Coercion. Items are scored on a scale ranging from 1 (*once a year*) to 8 (*this has never happened*), with authors reporting high levels of concurrent validity and construct validity (Strauss & Douglas, 2004). The two subscales of the CTS2S employed in the present research were the Physical Assault ($\alpha = .73$ in the present study) and Sexual Coercion Subscales ($\alpha = .50$, item-total correlations = .736 and .899 in the present study). Although the alpha level for the sexual coercion subscale is low, this statistic is likely to have been influenced by the fact that there were only two items in the scale. As such, a measure of item-total correlation is likely to produce a more meaningful indication of internal consistency, with item-total correlations in the study sample ranging from .74 to .90. [Taken together, these findings suggest that both the physical assault and the sexual coercion subscales were characterized by adequate levels of internal consistency in the present sample].

Emotional abuse was assessed using the *Woman's Experience of Battering scale* (WEB). Developed by Smith et al. (1999), the WEB is a screening tool for IPV. The WEB is a 10-item measure that assesses for emotional abuse by measuring a women's perception to her vulnerability. Items are scored on a 6-point scale ranging from 1 (*disagree strongly*) to 6 (*agree strongly*), with authors reporting high levels of internal consistency and good construct validity (Smith et al., 1995). In the present sample, the 10 items of the WEB were characterised by a high level of internal consistency ($\alpha = .88$).

3.5.2 Dependent measures

The following validated measures were used to measure psychological adjustment namely: depression, anxiety and PTSD.

Depression and anxiety were assessed using the Depression subscale (11 items) and the Anxiety subscale (6 items) of the Hopkins Symptom Checklist (HSCL; Derogatis et al., (1974). Items on both of these subscales are scored on a scale ranging from 1 (*not at all*) to 4 (*extremely*), with the authors reporting high levels of internal consistency and test-retest reliability for both subscales (Derogatis et al., 1974).

The 11 items on the measure of depression were characterised by a high level of internal consistency ($\alpha = .84$), with the mean score being 10.25 (*SD* = 6.24). Tests for the normality of distribution of depression scores produced a skewness statistic of .441 and a kurtosis statistic of -.400, suggesting that the score distribution did not differ significantly from what would be expected under the normal curve. Predictors of depression scores were therefore assessed using parametric statistical procedures.

The six items on the measure of anxiety were characterised by a high level of internal consistency ($\alpha = .87$), with the mean score being 4.61 (*SD* = 4.30). Tests for the normality of distribution of depression scores produced a skewness statistic of .849 and a kurtosis statistic of -.102, suggesting that the score distribution did not differ significantly from what would be expected under the normal curve. Predictors of anxiety scores were therefore assessed using parametric statistical procedures.

Post-traumatic stress disorder was assessed using the Brief Screening Instrument for PTSD (TSQ). Developed by Brewin et al. (2002), the trauma screening questionnaire (TSQ) is a 10-item symptom screen that was designed for use with survivors of all types of traumatic stress. Items are scored on a scale ranging from 0 (*never*) to 3 (*more than once*), with authors reporting high levels of sensitivity, specificity and overall efficiency. In this study, the 10 items on the measure of PTSD were characterised by a high level of internal consistency ($\alpha = .84$), with the mean score being 8.28 (*SD* = 5.20). Tests for the normality of distribution of PTSD scores produced a skewness statistic of 3.38 and a kurtosis statistic of .862, suggesting that the score distribution did not differ significantly from what would be expected under the normal curve. Predictors of PTSD scores were therefore assessed using parametric statistical procedures.

3.6 Data collection procedure

Ethical clearance was obtained from the Humanities and Social Science Research Ethics Committee, of the University of KwaZulu-Natal in August 2016. Written permission was obtained from the Dean/Head of School of Applied Human Sciences, to conduct research among psychology undergraduate students registered in the School of Applied Human Sciences during 2016.

First year undergraduate students were addressed at the beginning of one of their Psychology tutorial classes (Howard College, UKZN, 2016 registrations). Initially students were informed of the nature and aims of the study. Thereafter, the study information sheet was presented to the students who were given the opportunity to read through the form and ask any questions they may have regarding participation. Students were then informed of the study inclusion/exclusion criteria (i.e., males and females, regardless of IPV history, and an age of at least 18 years).

A research pack, which included a research questionnaire, information sheet, and consent documentation form, was then distributed to all students who indicated that they wished to participate, with students being told to read the information sheet and the questionnaire before making their final decision to participate. The information sheet (Annexure B) outlined the purpose of the study, as well as indicating to students what their participation would involve.

Written informed consent was obtained from all research participants (Annexure C). Participants were informed that they were free to discontinue their participation at any stage. Participation in the study did not require that participants provided their names or any other uniquely identifying information.

Questionnaires were completed anonymously away from tutorial classes, with completed questionnaires and signed consent documentation forms being returned by “posting” completed questionnaires and consent documentation forms into sealed boxes which were

placed outside the tutorial class venue, as well as outside the Psychology administration office.

As soon as the data analysis phase had been completed, comprehensive verbal feedback was provided to all participants (and non-participants) during a subsequent tutorial class.

3.7 Data reduction methods

Data from questionnaires were coded and then entered into an Excel spreadsheet. These spreadsheets were then transferred into specialized software, namely the Statistical Package for Social Sciences (SPSS version 24) for further analysis and reduction.

3.8 Chapter Summary

This chapter provided a summary of the methodology utilised in this study, which included the research design, study location, sampling and sampling methods used, instruments used for data collection, data collection procedures, data reduction methods used, and issues of validity including internal consistency.

CHAPTER FOUR
RESULTS

4.1 Introduction

In this chapter the major findings that emerged from the analysis of the data are presented. The specific aims of the study were to obtain an indication of the incidence (past 12 month) of intimate partner violence in a South African student sample, and to explore the association between exposure to intimate partner violence and psychological adjustment.

4.2 Sample description

The sample comprised 146 participants. Ages ranged from 18-25 years (M_{age} = 19.38, *SD* = 1.43 years). The sample was predominantly female (75.3%). With respect to race/ethnicity, participants described themselves as: Asian (9.5%); Black African (79.0%); Coloured (2.5%); White (4.5%); or Other (4.5%). In terms of marital status, none of the participants had ever been married.

4.3 Incidence of IPV

One of the main objectives of the study was to obtain an indication of the incidence (past 12 months) of intimate partner violence in a South African student sample. The table below summarises the results regarding this objective.

Table 1

Incidence of IPV

Form of exposure	Total *n* = 146	%	Males *n* = 36	%	Females n = 110	%	χ^2 (1)	*P*
Emotional abuse	60	41.1	17	47.2	42	38.2	1.71	.191
Physical abuse	54	37.0	11	30.6	43	39.1	1.14	.286
Sexual abuse	21	14.4	2	5.6	20	18.2	4.01	.045

Note. 92.5% of participants indicated that they had experienced at least one form of IPV in the past 12 months.

Sixty participants (41%) reported that they had experienced emotional abuse at the hands of their partner in the past 12 months, with there being no significant gender differences in incidence rates.

With respect to physical abuse, 54 participants (37%) reported that they had experienced physical abuse at the hands of their partner in the past 12 months, with their being no significant gender differences in incidence rates.

Finally, with respect to sexual abuse, 21 participants (14%) reported that they had experienced sexual abuse at the hands of their partner in the past 12 months, with incidence rates for females (18%) being significantly higher than incident rates for males (6%, p = .045) .

4.4 Results of exposure to IPV and Psychological adjustment

The impact of exposure to IVP was explored using hierarchical linear regression analyses, with separate regression analyses being conducted for each dependent measure – i.e., depression, anxiety, and PTSD (see Table 2). Control variables entered in these analysis were age and gender.

Table 2

Predicting clinical status: Hierarchical multiple linear regression analyses (N = 146)

		Depression				Anxiety				PTSD		
		β	*t*	*P*		*β*	*t*	*p*		*β*	*t*	*p*
Covariates												
	Age	.027	0.36	.722		.106	1.30	.195		.107	1.36	.176
	Female sex	.257	3.36	**.001**		.056	0.68	.497		.165	2.08	**.040**
Exposure to IPV in past year												
	CTS2S (assault)	.041	0.48	.635		.031	0.34	.738		.094	1.05	.297
	CTS2S (sexual abuse)	.210	2.48	**.014**		.173	1.90	.060		.074	0.85	.399
	WEB	.192	2.30	**.023**		.159	1.78	.077		.297	3.43	**.001**
F (5,140)		7.14				2.53				4.60		
p		<.001				.032				.001		
R^2		.203				.083				.141		
f effect size		0.25				0.09				0.16		
Classification of effect size		medium				small				medium		

Note. According to Cohen (1988), f^2 effect sizes for regression models can be classified as being: small (f^2 =.02-.14, medium (f^2 = .15-.34), or large (f^2 = ≥ .35).

From Table 2 it is evident that the final model accounted for a significant proportion of the variance in depression scores (20%), F (5,140) = 7.14, $p < .001$; with there being significant main effects of exposure to sexual abuse ($\beta = .21$, $p = .014$) and emotional abuse ($\beta = .19$, $p = .023$) but no significant main effect of physical assault ($\beta = .04$, p = .635).

When anxiety scores were entered as the criterion variable, the final model accounted for a significant proportion of the explained variance (8%), F (5,140) = 2.53, $p = .032$. However, there were no significant main effects of any of the clinical measures considered in the study.

Finally, when PTSD was entered as the criterion variable, the final model accounted for a significant proportion of the explained variance (14%), F (5,140) = 4.60, $p = .001$; with there being a significant main effect of exposure to emotional abuse ($\beta = .30$, $p = .001$).

4.5 Chapter Summary

Chapter 4 described the reduction and analysis of the data. Study findings suggest that incidence rates for IPV are high across all forms of IPV assessed, with female participants being significantly more likely to report exposure to sexual abuse than were males. Although scores on measures of depression and PTSD were significantly associated with exposure to IPV, scores on the measure of anxiety were not significantly associated with any of the forms of IPV considered in the study.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter will discuss the study findings in relation to the objectives of the study, which were (a) to assess the incidence of IPV in the study sample, and (b) explore the association between exposure to IPV and psychological adjustment.

5.2 Incidence of intimate partner violence

The findings of the present study indicate that the incidence of intimate partner violence was high, with 92.5% of participants reporting that they had experienced some form of intimate partner violence in the past 12 months.

This finding represents a higher incidence rate than the average incident rate of 41.5% that has been obtained in three recent previous studies (Spencer et al., 2016; Su et al., 2011; Forke et al., 2008); as well as the incident rates of 21%-32% obtained in previous studies which were conducted with university/college students and have employed similar definitions of IPV (Break the Cycle, Inc., 2005; National Coalition Against Domestic Violence, 2007; Straus, 2006; White & Koss, 1991).

A comparative study conducted in the South African context (with university students, using a similar definition of IPV; Spencer et al., 2016), found a prevalence rate for IPV (sexual, physical or emotional abuse) among all respondents of 42.6%. Therefore it seems that the majority of analogous research studies have reported lower rates of IPV than were reported in the present study. However, a comparable study conducted in Brazil among undergraduate students at two universities (Flake, Barros, Schraiber & Menezes, 2013) yielded a prevalence rate of 75.9%, which seems more consistent with the high incidence rate obtained in the present study.

Numerous possible reasons could account for the high incidence rate found in the present study. The first possible reason being the age range of the participants in the present study (Range = 18-25 years). A number of previous studies have found that high rates of IPV are experienced during the ages 16-24 years or before age 25 (e.g., United States Department of Justice, 1997; Lohman et al., 2013; Breiding et al., 2014), with other studies having found that incidence rate for intimate partner violence are high during adolescence and emerging adulthood (Breiding et al., 2014; Johnson et al., 2015a; Katz & Rich, 2015; Lundgren & Amin, 2015; Reddy et al., 2010; Russell et al., 2014; Straus, 2004). South Africa is also characterised by high rates of murder, armed robbery, sexual crime and domestic violence that rank amongst the highest in the world (Abrahams et al., 2006; Bollen et al., 1999; Kaminer et al., 2008; Shaw, 2002;). It is, therefore, not surprising that particularly high rates of IPV were reported by participants in the present study.

There were three forms of intimate partner violence assessed in the present study: emotional abuse, physical abuse and sexual abuse. The table below (Table 3) provides a summary of four comparable previous studies which will be mentioned in this discussion chapter [The nature of comparability is based on the fact that all four studies were conducted using samples of university students, with similar definitions of IPV being used.]

Table 3

Prevalence rates for the different forms of IPV in comparable studies

Type of IPV	Study 1: China (Su et al., 2011)	Study 2: South Africa (Spencer et al., 2016)	Study 3: Russia (Lysova & Douglas, 2008)	Study 4: USA (Forke et al., 2008)
Emotional abuse	33.6%	54.9%	61.6%	27.7%
Physical abuse	18%	20%	25.5%	20.9%
Sexual abuse	5.1%	8.9%	24.1%	24.9%

5.2.1 Emotional abuse

The findings of the present study indicated that 41.1% of the participants reported experiencing emotional abuse by their partner, this making it the most experienced form of IPV in the present study. The four comparable previous studies (Table 3) found an average prevalence rate for emotional abuse of 44.5% which is consistent with the 41.1% found in this present study. For each of these four studies, emotional abuse was indicated as having the highest prevalence rate in comparison to the other forms of IPV. This trend is consistent with findings by Lawrence, BaYoon, MaLanger, & MaRo (2009) who found that psychological victimisation is more prevalent than physical or sexual victimisation (Lawrence et al., 2009).

Many studies within the South African context have a strong focus on physical and sexual forms of IPV (Abrahams et al., 2004; Abrahams & Jewkes, 2009; Coker, 2007; Katz & Rich, 2015). But as indicated by this study, and in previous analogous studies, emotional abuse/psychological violence seems to be the most commonly experienced form of IPV among university students.

5.2.2 Physical abuse

Physical abuse was reported by 37% of participants. Comparing this incidence rate to that of the average prevalence rate of the four comparable previous studies (21.1%), the present study incidence rate of physical abuse is somewhat higher.

Although higher than rates observed in comparable studies, this incidence rate of 37% does seem to fit into the ranges found by other analogous studies. Kaura and Lohman (2007) report a physical abuse incidence rate of between 20%- 47% for males and females; while Amar and Gennaro (2005), found reported rates of physical dating violence for college students ranging from 20% to 45% (Iconis, 2013).

5.2.3 Sexual abuse

Sexual abuse was reported by 14.4% of participants. Comparing this incidence rate to that of the average prevalence rate found in the four comparable previous studies (15.75%), the present study's incidence rate of sexual abuse seems to consistent rates reported in previous studies.

Iconis (2013), found that students experiencing IPV during college were more likely to experience physical and emotional violence and were less likely to experience sexual violence. This seems to be consistent with the present study, as sexual abuse had the smallest incidence rate of all forms of IPV examined.

5.3 IPV incidence rates and gender differences

5.3.1 Emotional abuse

With regard to emotional abuse, although males were more likely to have experienced emotional abuse (47%) than were females (38%), this difference did not reach statistical significance. This is comparable to a previous analogous study (Lysova & Douglas, 2008; which was conducted using university students and which used a similar definition of IPV to that used in this study) which also found no statistically significant gender difference in regard to incidence rates for emotional abuse.

5.3.2 Physical abuse

With regard to physical abuse, there were no significant gender differences in incidence rates. This seems to be consistent with a previous analogous study (Lysova & Douglas, 2008), conducted with university students and applying a synonymous definition of physical abuse, which also found no statistically significant gender difference regarding physical abuse.

5.3.3 Sexual abuse

With regard to sexual abuse, it was found that females were significantly more likely to report one or more instances of sexual abuse than males. This finding is consistent with findings by Murray and Kardatzke (2007) which indicate that sexual dating violence victimisation is experienced by more female than male college students (Iconis, 2013). Present findings are also consistent with Lysova and Douglas' (2008) finding that females are twice as likely to experience sexual abuse than males.

5.4 Exposure to IPV and psychological adjustment

The main finding of this present study indicated that different forms of IPV were associated with different psychological adjustment symptoms. The results indicated that exposure to: (a) emotional abuse was significantly associated with depression and PTSD, (b) sexual abuse was significantly associated with depression, and (c) physical abuse was not associated with any of the clinical measures used in the study.

Depression

The present study found that emotional abuse and sexual abuse were significantly associated with depression. This is consistent with a comparative study conducted in primary care in South Africa (Peltzer et al., 2013a) which found that psychological abuse contributes to the onset of depression. However, previous studies have not reported an association between sexual abuse and depression (see e.g., Breiding et al., 2014; Peltzer et al., 2013a; WHO, 2012).

PTSD

The present study found that emotional abuse was significantly associated with PTSD. This finding extends previous findings which have found that PTSD is associated with sexual abuse (Breiding et al., 2014) or with a combination of both physical and sexual abuse (Peltzer et al., 2013a).

Anxiety

The present study did not find any forms of IPV to be significantly associated with the measure of anxiety. This finding is not consistent with previous findings which have found that IPV is associated with anxiety and phobias (WHO, 2012).

5.5 Limitations

The researcher acknowledges that the present study has a number of limitations. First, in this study a relatively small sample of university students was used, which may have limited the generalisability of research findings. Forke et al. (2008) found that investigations that rely on convenience samples of students in introductory psychology or sociology classes limits the generalisability of the findings. As such further research, based on more representative samples drawn from the general population, are indicated in order to assess the generalizability of findings obtained in the present study.

A further limitation of the present study is that it employed a limited number of measures, which may not have adequately captured the range of deleterious outcomes associated with IPV. Previous studies have, for example, found that IPV is associated with deleterious outcomes not considered in the present study – including suicidal ideation, alcohol and drug abuse, eating and sleep disorders, poor self-esteem and self-harm (WHO, 2012).

5.6 Implications

The present findings would appear to have a number of implications. First, incidence rates for IPV in the present study were significantly higher than rates reported in previous studies, with this finding suggesting the need for more extensive research on the impact of IPV in the South African context, as well as a need for the implementation of effective primary and secondary prevention programmes designed to effectively address the incidence and impact of IPV among South African university students.

Further research is also needed to explore the prevalence of IPV among samples drawn from the general population. Ideally such research needs to employ a broad range of

psychological outcome measures which adequately capture the full range of psychological problems that have been found to be associated with a history of exposure to IPV.

5.7 Concluding summary

Findings from the present study can be summarised as follows:

- The results of the present study suggest that incidences rates of IPV may be high among South African university students.

- The most reported form of IPV was emotional abuse, followed by physical abuse, and lastly sexual abuse.

- The only significant gender difference in exposure to IPV was found in relation to sexual abuse, with females being significantly more likely than were males to report one or more instances of sexual abuse.

- Different forms of IPV were found to be associated with different estimates of psychological adjustment:
    - Sexual abuse was significantly associated with depression;
    - Emotional abuse was significantly associated with PTSD and depression; and
    - Physical abuse was not associated with any of the clinical measures employed in the study.

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APPENDIX A

QUESTIONNAIRE

1. Please answer the following questions about yourself (where appropriate put a X in one block):

Your age: ☐

Your sex: ◯ male ◯ female

Race: ◯ Asian ◯ black African ◯ coloured ◯ white ◯ other

Marital status: ◯ single ◯ married ◯ divorced ◯ separated ◯ widowed

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2. Are any of the following statements true about the family in which you grew up (for each item put an X in one block)?

	No	Yes
Our family was so poor that we did not have enough food to eat	◯	◯
My parents could not afford to send me to the doctor when I was sick	◯	◯
My parents did not earn enough money to support a family	◯	◯

3. How upset have you felt about each of the following during the past 7days including today (for each item put an X in one block)?

	Not at all	A little	Quite a lot	Extremely
Loss of sexual interest or pleasure	◯	◯	◯	◯
Thoughts of ending your life	◯	◯	◯	◯
Poor appetite	◯	◯	◯	◯
Crying easily	◯	◯	◯	◯
A feeling of being trapped or caught	◯	◯	◯	◯
Blaming yourself for things	◯	◯	◯	◯
Feeling lonely	◯	◯	◯	◯
Feeling sad	◯	◯	◯	◯
Worrying about things	◯	◯	◯	◯
Feeling no interest in things	◯	◯	◯	◯
Feeling hopeless about the future	◯	◯	◯	◯
Nervousness or shakiness inside	◯	◯	◯	◯
Trembling	◯	◯	◯	◯
Suddenly feeling scared for no reason	◯	◯	◯	◯
Feeling fearful	◯	◯	◯	◯
Your heart pounding or racing	◯	◯	◯	◯
Having to avoid places or activities because they frighten you	◯	◯	◯	◯

4. In **the past week**, how often have you had the following thoughts or feeling about upsetting or distressing things that have happened to you.

	Never	Once	More than once
Upsetting thoughts or memories about things that have happened in the past have come into my mind against my will	◯	◯	◯
I have had upsetting dreams about things that have happened to me	◯	◯	◯
I have acted or felt like upsetting things that happened in the past were happening again	◯	◯	◯
I felt upset by reminders of things that happened in the past	◯	◯	◯
I had bodily reactions (e.g., fast heartbeat, stomach churning, sweatiness, or dizziness) when reminded of upsetting experiences I have had	◯	◯	◯
I have had difficulty falling or staying asleep	◯	◯	◯
I have felt irritable or had outbursts of anger	◯	◯	◯
I have had difficulty concentrating	◯	◯	◯
I have experienced heightened awareness of dangers to myself and others	◯	◯	◯
I have felt jumpy or been startled at something unexpected	◯	◯	◯

5. Which **ONE** of the following statements is true for you (put an X in one block)?

I am currently in a dating or intimate relationship with a partner	◯
I am not currently in a dating or intimate relationship with a partner but have been in such a relationship in the past year	◯
I did not have a dating or intimate relationship with a partner in the past year but have had such a relationship more than a year ago	◯
I have never been involved in a dating or intimate relationship with a partner	◯

6. Please answer the following questions about **YOUR CURRENT OR THE MOST RECENT** dating or intimate relationship (if you have never had a dating or intimate relationship, go to question 9)

How long has/did this relationship last	Less than 1 month ◯	1-3 Months ◯	More than 3 months ◯
My partner has/had a drinking problem?	Never ◯	Sometimes ◯	Often ◯
My partner has/has a drug problem	Never	Sometimes	Often

	◯	◯	◯
My partner finds/found it difficult to calm down when he/she becomes angry with me	Never ◯	Sometimes ◯	Often ◯
My partner shows/showed respect for my feelings when we disagreed on something	Never ◯	Sometimes ◯	Often ◯
My partner listens/listened to what I had to say when we had a disagreement	Never ◯	Sometimes ◯	Often ◯

7. How many times did each of the following things happen in your **current or most recent relationship** (if you have never had a dating or intimate relationship, go to question 9)

	How many times						
	0	1	2	3-5	6-10	11-20	More than 20 times
My partner shouted or swore or yelled at me	◯	◯	◯	◯	◯	◯	◯
I had a sprain, bruise, or small cut, or felt pain the next day because of a fight with my partner	◯	◯	◯	◯	◯	◯	◯
My partner pushed, shoved, or slapped me	◯	◯	◯	◯	◯	◯	◯
My partner punched, kicked or beat me up	◯	◯	◯	◯	◯	◯	◯
My partner destroyed something belonging to me or threatened to hit me	◯	◯	◯	◯	◯	◯	◯
I needed to see a medical treatment because of a fight I had with my partner	◯	◯	◯	◯	◯	◯	◯
My partner used force (like hitting, holding down, or using a weapon) to make me have sex	◯	◯	◯	◯	◯	◯	◯
My partner insisted on sex when I did not want to or insisted on sex without a condom (but did not use physical force)	◯	◯	◯	◯	◯	◯	◯

8. How strongly do you agree with each of the following statements about your **current or most recent relationship** (if you have never had a dating or intimate relationship, go to question 9)

	Disagree strongly	Disagree somewhat	Disagree little	Agree a little	Agree somewhat	Agree strongly
My partner made me feel unsafe even in my own home	◯	◯	◯	◯	◯	◯
I felt ashamed of the things my partner did to me	◯	◯	◯	◯	◯	◯
I was afraid by what my partner might do to me	◯	◯	◯	◯	◯	◯
I felt programmed to react in a certain way to my partner	◯	◯	◯	◯	◯	◯

I felt like my partner kept me a prisoner	◯	◯	◯	◯	◯	◯
My partner made me feel that I had no control over my life	◯	◯	◯	◯	◯	◯
I hide the truth from others because I am afraid not to	◯	◯	◯	◯	◯	◯
I felt owned and controlled by my partner	◯	◯	◯	◯	◯	◯
My partner could scare me without laying a hand on me	◯	◯	◯	◯	◯	◯
My partner had a look that could scare me	◯	◯	◯	◯	◯	◯

9. Please answer the following questions about your participation in this study by putting a number next to each statement using the following scoring guide:

Disagree strongly	Disagree a little	Undecided	Agree a little	Agree strongly
1	2	3	4	5

I gained something positive from participating in this study	
Knowing what I know now, I would participate in the study again if asked to do so	
The research raised emotional issues for me that I had not expected	
I gained insight about my experiences through participating in the research	
The research made me think about things I did not want to talk about	
I found the questions too personal	
I found participating in this study personally meaningful	
I believe this studies results will be personally meaningful others	
I trusted that my responses would be kept private	
I experienced intense emotions while answering questions in this study	
I believe that the research is for a good cause	
I was treated with respect and dignity by the researchers	
I understood the information sheet given to me at the start of the study	
My decision to participate in the research was made freely	
I found that participating was helpful or beneficial to me	
I was glad to be asked to participate	
I liked the idea that I contributed to science	
I was emotional during the research session	
The study procedures took too long	
It was inconvenient for me to participate in the study	
Participation in the study was a choice I freely made	
If I had known in advance what it would be like to participate, I would still have agreed to participate	
I understood the information that appeared on the consent form	

You have completed the questionnaire (thank you for your participation). When returning the completed questionnaire, please also return the signed consent form

IMPORTANT:

1. If you would like to ask any questions about this research, or if you feel upset because of your participation and would like to discuss these feelings with a counsellor, please contact the researcher or the psychology clinic (contact details are given on the information sheet).

2. As soon as the questionnaires have been analysed, the researcher will provide feedback on the study findings to all students during lectures.

ANNEXURE B

INFORMATION SHEET

Good day

You are being invited to participate in a research study which is entitled: "The incidence and correlates of exposure to intimate partner violence in a sample of South African university students". My name is Michelle Smith (Masters Student in psychology, University of KwaZulu-Natal) and I am conducting this research in order to understand how many undergraduate students are exposed to intimate partner violence, and what the psychological impact of such exposure is.

Who can participate?

You can participate in the study regardless of whether you are male or female, and regardless of whether you have experienced intimate partner violence or not. However, in order to participate in the study you need to be at least 18 years old.

What will you be required to do?

If you agree to participate in the study, you will be asked to complete a 4-page questionnaire which will take about 10-15 minutes to complete. The questionnaire contains questions relating to: who you are (age, gender, etc.), your current psychological well-being, and experiences relating to exposure to intimate partner violence.

Benefits

Although you will not be paid for participating, your participation will provide important understandings that can contribute towards the development of effective prevention and intervention programmes for survivors of intimate partner violence. In addition, all participants (and non-participants) will receive comprehensive feedback on the study findings, which I will present to the class during lectures.

Costs

Questions relating to exposure to intimate partner violence may be experienced as stressful or upsetting by some participants, and you need to carefully consider this before you decide to

participate. If you decide to participate, but feel upset or distressed afterwards, you will be provided with free counselling to assist you to deal with your upset/distress (see contact details below).

Confidentiality and anonymity

You will **not** be required to provide your name, or any uniquely identifying information on the questionnaire and all responses will be anonymously returned. Further, all information provided will be treated in the strictest of confidence.

Voluntary participation

Participation in the study is entirely voluntary and students who decide not to participate will not be disadvantaged in any way. Further, participants who decide to participate are free to withdraw from the study at any stage and for any reason.

Contact details

If you have any questions relating to the study: you can e-mail the researcher at mich.rene@yahoo.com or my supervisor Prof. Collings :collings@ukzn.ac.za or phone him at 031 260 2414 (during office hours).

If you feel you need free counselling: you can contact the researcher (contact details above) or phone the Psychology Clinic (landline: 031 260 7425).

If you want to find out more about your rights as a research participant you can contact Phume in the Research Office (office hours: 031 260 3587)

ANNEXURE C

INFORMED CONSENT

CONSENT DECLARATION

PROJECT TITLE: The incidence and correlates of exposure to intimate partner violence among university students

I hereby confirm that I have read and understood the contents of the information sheet and the nature of the research project, and I consent to participate in the research.

I understand that I am free to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT: DATE:

_____ _____