Victims of Intimate Partner Violence: An Occupational Justice Perspective

by

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Declaration

I, Tanya La Cock, declare that the master's degree research dissertation that I herewith submit for a Master's Degree qualification in Occupational Therapy at the University of the Free State is my independent work, and that I have not previously submitted it for a qualification at another institution of higher education.

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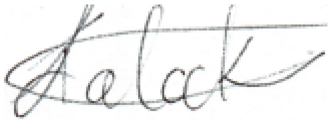

Tanya La Cock

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List of Acronyms

CEDAW	Convention on the Elimination of All Form of Discrimination against Women
COVID-19	Coronavirus Disease 2019 outbreak
DoH	Department of Health
DSD	National Department of Social Development
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
MOHO	Model of Human Occupation
OTASA	Occupational Therapy Association of South Africa
RSA	Republic of South Africa
UN	United Nations
USA	United States of America
USPSTF	United States Preventative Service Task Force
WFOT	World Federation of Occupational Therapy
WHO	World Health Organisation

Concept Clarification

Occupation: Activities that people need to do, want to do, or are expected to do which occupy time, bring meaning to an individual's life and are seen by an individual as part of their identity; occupations include, but are not limited to, self-care, productivity and/or leisure activities that people do as individuals, within their families and within their communities (Creek, 2006, p. 205; Hammell, 2009, pp. 9–10; World Federation of Occupational Therapists, 2016).

Cognitive-behavioural frame of reference: A theoretical framework that is used within occupational therapy which is influenced by a combination of the psychological approaches of behavioural and cognitive therapy. Cognitive behavioural theory focuses on five factors of experiencing life, namely: thoughts, behaviours, emotions, physiological responses and the environment (Duncan, 2011b, p. 155). The theory proposes that "changes in any factor can lead to improvement or deterioration in other factors" (Duncan, 2011b, p. 155).

Collage Technique: This refers to an enabling technique that can be used in research, where research participants create rough collages using visual material, such as magazines, to represent something related to the research topic (The Association for Qualitative Research, 2013).

Gender Based Violence: An overarching term used to refer to violence that results from normative gender roles and unequal power relationships in a society. It is the general term used to capture violence that occurs as a result of the normative role expectations associated with each gender, as well as the unequal power relationships between the genders within the context of a specific society (Centre for the Study of Violence and Reconciliation [CSVR], 2016a, p. 4). For females, gender based violence includes female genital mutilation, human trafficking, rape, intimate partner violence among other forms of violence against women (Garcia-Moreno et al., 2013, p. 11; Republic of South Africa [RSA], 2020, p. 11).

Intimate partner violence: Behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm. Such behaviours can, include physical aggression, sexual coercion, psychological abuse and controlling behaviours (World Health Organisation [WHO], 2012, p. 1).

Intimate Partner: "A person with whom one has a close personal relationship that can be characterised by the following: emotional connectedness; regular contact; on-going physical contact; and/or sexual behaviour; identity as a couple; familiarity and knowledge about each other's lives. The relationship need not involve all these dimensions. Examples of intimate partners include current or former spouses, boyfriends or girlfriends, dating partners, or sexual partners" (Briedling, Basile, Smith, Black & Mahendra 2015, p. 11).

Occupational Alienation: A prolonged experience of isolation, disconnectedness and estrangement from society, associated with powerlessness, frustration, and a sense of meaninglessness as a result of engagement in occupation that does not satisfy occupational needs (Durocher, Gibson, & Rappolt, 2014, p. 422; Wilcock, 2006, p. 343)

Occupational Deprivation: A state of being unable to engage in occupations due to circumstances beyond the control of the individuals (Durocher et al., 2014, p. 421; Wilcock, 2006, p. 343).

Occupational Imbalance: A balance between occupations, including but not limited to: a balance between strenuous and restful occupations; between chosen and obligatory occupations; as well as between productivity, pleasure, and restoration (Wilcock 2006, p. 243). Thereby occupational imbalance refers to disproportionate time spent occupied on one life area at the expense of another area (Durocher, Gibson & Rappolt, 2014, p. 422).

Occupational Justice: :The promotion of fair socio-economic and political conditions on an individual and population level that, in recognising people's occupational wishes and needs, will result in all people having the resources and

opportunities to become healthy and flourish through engagement in occupations (Durocher et al., 2014, p. 420; Wilcock, 2006, p. 248).

Occupational Marginalisation: Exclusion from participation in occupations based on informal norms, such as habits, traditions, and expectations, about who should participate in what occupations, how, when, where, and why (Durocher, Gibson & Rappolt 2014, p. 422).

Occupational therapy: The Occupational Therapist Association of South Africa has adopted the following definition of occupational therapy from the World Federation of Occupational Therapists (2017, p. 57): "A client-centred health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement".

Psychodynamic frame of reference: A theoretical framework that is used within occupational therapy which acknowledges the impact of our emotions and unconscious instincts on our actions (Daniel & Blair, 2011, p. 165).

Summary

Background: One in three women in South Africa report being affected by IPV. Every eight hours, a woman dies at the hands of her intimate partner, making South Africa the country with the highest rate of intimate partner homicide. Experiencing IPV affects all aspects of health including physical, intellectual, social, emotional, and spiritual well-being. IPV should therefore be considered a public health priority in South Africa.

Occupational therapists are likely to encounter people affected by IPV and are equipped to provide interventions for people affected by IPV. However, literature on this topic from an occupational therapy perspective is scarce. In South African occupational therapy literature specifically, there are no publications relating to IPV. The silence in literature indicates that occupational therapists may not be aware of the holistic needs of their clients, who, if they are female, have a 33% chance of being affected by IPV. This topic should be explored in order for occupational therapists in South Africa to respond appropriately to clients affected by IPV.

Accordingly, the researcher conducted a study that purposed to explain how women affected by IPV experience and adapt to occupational risk factors. The study describes IPV from an occupational justice perspective to advocate for an improved response among occupational therapists toward the plight of people affected by IPV.

Methods: The study is positioned in the constructivist and feminist paradigms, utilising aspects of a phenomenological design. Data was collected from eleven participants who had been affected by IPV and were residing at women's shelters in Gauteng using a collage technique with in-depth, unstructured interviews. The interviews were manually analysed using inductive content analysis. The coded data were grouped into categories and synthesised into three emerging themes. Rigour was enhanced during this process by utilising investigator triangulation.

Discussion: The first theme “perpetrators of occupational rights violations”, illuminates how coercive control, family attitudes, community institutions, and cultural attitudes contributed to an environment that allows for IPV to be perpetrated continuously. The second theme, “experience occupational rights violations” describes how the participants experienced restricted activity participation, feeling unsatisfied in activities, lost/changed identity, feeling dehumanised, and had challenges in areas of occupation. The last theme “changes and adaptations within the women affected by IPV” describe how the participants responded to IPV through mental changes, emotional adaptations, behavioural adjustments, spiritual changes, and leaving the relationship.

Conclusion: This study firstly illustrates that IPV is perpetrated on a relational, community, and societal level. These are largely attributed to societal stigmas, patriarchal beliefs, and ignorance surrounding IPV. Occupational therapists in all settings can influence all these contexts. However, their first responsibility is to be cognisant of the prevalence of IPV and reflect on how their own beliefs may contribute to the perpetration of IPV. Secondly, the study describes the adversaries women affected by IPV face from an occupational perspective, as well as the resilience they displayed by adapting to these adversaries. This allows therapists who are confronted with IPV to be aware of the holistic needs of their clients and respond in ways that support the occupational well-being of their clients.

Word Count: 508 words

Preface

The Little Plant

In the heart of a seed,
Buried deep, so deep,
A dear little plant
Lay fast asleep.

Wake! said the sunshine,
And creep to the light
Wake! said the voice
Of the raindrops bright.

The little plant heard
And rose up to see
What the wonderful outside
World might be.

Kate .L. Brown

I could never imagine the growth that embarking on this research journey would bring. The “little plant” asleep in me was a feminist, an advocate, and a person who is willing to talk about and listen to the difficult, dark sides of human existence that often are swept under the carpet. ‘Racism’, ‘paternalism’, ‘patriarchy’, ‘colonialism’, ‘abuse’, ‘power imbalances’, ‘societal structures perpetrating injustices’ are all concepts that I shielded away from, believing that these topics were reserved for philosophers or activists - people that made their statement through wearing T-shirts and attending protests. I never realised that conversations hold the potential of being platforms for difficult topics to be brought to light. I never realised that listening and authentically engaging in these conversations, was also activism. I never realised these topics were for me.

The first time I cried while reading an academic piece of literature was when I read one of Kate Joyner’s articles. It was qualitative and included excerpts of the experiences of women affected by IPV. I grew up in a beautifully sheltered environment. I was in shock and deeply saddened to learn that such stories existed. Resultantly, a part of my worldview that believed the world was a good, safe place began to shatter– never in my life could I have dreamed that *this* is the reality for

some women. The shattering of my worldview was the best thing that could happen to me. It was like hard soil being ploughed, preparing the soil so that a seed can be planted and something new could grow.

This research provided me with a platform to increase conversation regarding IPV. Not only did I talk to the eleven participants who have experienced IPV, but also in my personal, social circles I had conversations with women about their experiences of IPV – it was sad to hear that each story was similar. Initially the statistic that one in three women had been affected by IPV seemed inflated to me. That is until, every time people asked me what my topic of research was, both in a professional and personal capacity, immediately, without hesitation, I would *always* hear a story of how they themselves, their mother, their sister, or their friend was also affected by IPV or other forms of more subtle abuse – sometimes I was the first person they spoke to openly. I already knew what their story was going to sound like, they all have similar patterns, yet I listened with an open heart. I found that there was an underlying sense of relief that suddenly, because I was already familiar with the topic, that the person talking felt this topic was not taboo. A friend who offered to proofread my dissertation had a similar experience. During a dinner gathering, she was telling how ignorant she had been on the topic of IPV – immediately women started sharing how they or a loved one had been affected by IPV. I realised that this is a conversation people *want to* talk about, yet, often, they have never been offered the platform.

As much as I would like to separate how the topic of IPV affected me as an occupational therapist, a citizen of South Africa, and in my personal capacity, I cannot. As a person, in all these capacities, the slumbering seed inside of me has awakened – and it is growing. The joy is that, with my awakening, my friends, family, and colleagues have also been awakened. I often hear a sentiment of the sort: "I don't know if it's because gender-based violence (GBV) is a more popular topic, or because I am more aware of it since hearing about your research – but GBV is truly everywhere, isn't it?"

Now that the seed is awakened, I am hearing and seeing these conversations. People's worldviews are being shifted and people are realising that there are stories that are deeper than what meets the eye. I realise that if people are willing to talk and listen without judgement, then there is room for understanding and reconciliation. My shattered worldview has had the opportunity to reconstruct. My new, adjusted worldview includes hope for a wonderfully just society.

CHAPTER 1: Introduction and Orientation

Gender equality is not a women's issue. It is a human issue. It affects us all.
- unknown -

1.1 Introduction

South Africa is considered one of the most dangerous places in the world to be a woman (Republic of South Africa [RSA], 2020, p. 2). Thereby, violence against women is considered a national crisis by the South African government (RSA, 2019). In September 2019, the rape and murder of university student Uyinene Mrwetyana in a post office began the #AmINext movement on social media (Kiunguyu, 2019; Raborife, 2019). The hashtag was used in social media to highlight the prevalence of gender-based violence (GBV) in South Africa. In a Johannesburg exhibition against GBV held in December 2019, the Republic of South Africa (RSA) has satirically been dubbed the Republic of Sexual Abuse by the association, People Opposing Women Abuse (Tonisi, 2019). A well-known GBV campaign globally is the United Nations's (UN) '16 Days of Activism'. Since 1998, it has been recognised annually in South Africa (North-West University, 2020, para. 2) between 25 November (International Day for the Elimination of Violence against Women) and 10 December (International Human Rights Day). These dates intentionally link violence against women violates to human right violations (Center for Women's Global Leadership, n.d., para. 2). Gender-based violence (GBV) is the overarching term used to describe violence against women. GBV includes female genital mutilation, human trafficking, rape, intimate partner violence among other forms of violence against women (Garcia-Moreno et al., 2013, p. 11). Male intimate partners are the most common offenders making IPV the most prevalent form of GBV worldwide. One will find that the term 'intimate partner violence' is commonly associated with and sometimes used interchangeably with the term 'domestic violence'. Domestic violence refers to violence against any member of a house and includes abuse of partners, children or elders (RSA, 2020, p. 10). 'Intimate partner violence' more

specifically refers to violence inflicted by anyone that the victim is or was in an intimate relationship with (WHO, 2012, p. 1). Although both men and women can be affected by IPV, however IPV is more likely to be perpetrated by men against women (WHO, 2013, p. 11, 2017). Therefore, in the study a 'victim' of IPV refers to a woman.

South Africa is considered to be one of the most violent places in the world, which considering that South Africa is not a war zone, is alarming (RSA, 2020, p. 23). The roots of the violence in South Africa are theorised to be buried deep in the collective trauma of the apartheid era during which violence was used as a means to assert control (RSA, 2020, p. 25). Not only was violence normalised during this period but also institutionalised (RSA, 2020, p. 25). In this context of violence, GBV is especially prevalent in South Africa. Although GBV is a complex issue cannot be ascribed to a single causing factor (Chester & DeWall, 2018, p. 57; Jewkes, 2002; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002, pp. 12–13), we do know, that all forms of GBV, including IPV, are firmly rooted in power imbalances and patriarchal practices (Jewkes, 2002, p. 1424; WHO, 2012a, p. 5; Centre for the Study of Violence and Reconciliation [CSVR], 2016a, p. 8). Therefore, although IPV takes place in a domestic setting, it is very much a societal issue (CSVR, 2016a, p8).

Rates of GBV in South Africa are generally higher than global averages. South Africa has be dubbed 'the rape capital of the world' (Stats SA, 2018, p. 14) because the country has some of the highest rates of reported rape cases (Steinbrenner, Shawler, Ferreira, & Draucker, 2017, p. 2) with more than 52 000 cases of reported rape in 2019 (RSA, 2020, p. 27). Following global trends, it is estimated that one of three South African women have experienced some form of IPV in their lifetimes (Garcia-Moreno et al., 2013, p. 2,16; WHO, 2017). However, these numbers may be higher. In 2011 it is estimated that more than 50% of women living in Gauteng have experienced IPV while and 80% of men living in Gauteng report to have been violent against their imitate partners (CSVR, 2016a, p. 3)(Centre for the Study of Violence and Reconciliation, 2016b, p. 3) .The most tragic outcome of GBV is death/ The

most recent statics available on femicide in South Africa indicate that in 2009, femicide at the hands of an intimate partners accounted for fifty-six present of femicides, and one of every five rape cases end in femicide(RSA, 2020, p. 25). A woman is killed by her intimate partner almost every eight hours in South Africa, distinguishing South Africa as the country with the highest global rate of intimate partner femicide (Abrahams et al., 2009, p. 552; Khumisi, de Waal, & Van Wyk, 2015, p. 370).

Reports of violence against women are flooding South African newspaper headlines and communicating to women and girls that they are equally unsafe in private and public spaces (Sibanda-Moyo, Khonje, & Brobbey, 2017, p. 11). Oscar Pistorius[1], Christopher Panayiotou[2], DJ Donal Seboli[3], Rameez Patel, Monero[4] Clayton Lee[5], Niresh Singh[6], Sandile Mantsoe[7], and Warrant Officer Phike Abel Moyana[8] are all men who have been convicted of murdering their intimate partners. These cases have received public attention at the time of the research in mainstream media as well as social media. However, there are many lesser-known and unnamed South African women who have died at the hands of their intimate partners.

IPV has become an increasingly important topic during the COVID-19 pandemic . With an estimated 243 million women globally having been exposed to IPV in the year 2019, home is clearly an unsafe place for many women (United Nations [UN] Women, 2020, p. 1).. Ironically in the year 2020 people were encouraged to lockdown -at-home- to prevent the spread of the viruses associated with COVID-19 (United Nations [UN] Women, 2020, p. 1). Home is clearly an unsafe place for many

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[1]Convicted of killing his girlfriend Reeva Steenkamp on Valentine's Day in February 2013.
[2] Convicted of having his wife, school teacher Jane Panayiotou kidnapped and murdered in April 2015.
[3] Convicted of murdering his girlfriend Dolly Tshabalala in June 2015
[4] Convicted of murdering his wife Feroz Patel in April 2016
[5] Convicted of killing his wife Mitashja Lee in August 2016 by stabbing her 23 times while she was holding her grandchild
[6] Convicted of murdering his girlfriend Tisha Naidoo by setting her alight in December 2018, despite his pleas of innocence.
[7] Convicted of killing his ex-girlfriend Karabo Mokoena in April 2017
[8] Convicted of killing his wife, Sergeant Yvonne Moyana in front of her three children in November 2019.

women, yet ironically half of the planet's population were subject to lockdown-at-home measures to stay safe from contracting the virus (UN Women, 2020, p. 1). IPV rates almost doubled at a hospital in Boston (Gosangi et al., 2020), and reports of IPV nearly tripled in France, Cyprus and Singapore, while they increased by 25% in Argentina (UN Women, 2020, p. 2). Anecdotally in South Africa calls to GBV hotlines almost doubled during South Africa's lockdown period (Brown-Luthango, 2020; Dartnall, Gevers, Gould, & Pino, 2020).

The first policy guidelines on responding to IPV published by the WHO in 2013 (WHO, 2013), established that IPV is a research topic that requires collaboration to improve IPV services (Joyner, 2013, p. 23). Occupational therapists have a unique approach to health that is concerned with human occupation. Occupational therapists approach people with the belief that humans are occupational beings and that their unique, goal-directed activities are intrinsically linked to well-being (Hammell & Iwama, 2012, p. 388). Based on this belief, occupational therapists approach issues concerning social justice with a focus on occupation. Occupational justice thereby focuses on the distribution of resources and social opportunities in such a way that will result in every person participating in meaningful and rewarding occupations (Durocher et al., 2014, p. 420). There are four types of occupational injustices which are known as occupational risk factors, namely: occupational deprivation, occupational alienation, occupational marginalisation, and occupational imbalance (Durocher et al., 2014; Peters & Galvaan, 2017, p. 2).

Consider the following excerpts from a qualitative study on IPV by Joyner and Mash (2014):

> *He also hit and kicked her, insulted her, and controlled all financial decisions including refusing her permission to work. When she found a job, he burnt her clothes and official documents and even set light to her shack (home) while she and her son were inside it (p. 657).*

> *…verbal abuse is worse—he uses strong words, always blaming me. That makes me feel worthless, stupid . . . I hate myself most of the time." Also, her husband does not allow her to meet people, not even neighbours—no friends, no work (p. 657).*
>
> *…he becomes extremely verbally abusive if she refuses him sex. Sometimes, he wants it three times a night. He also has tramped on and kicked her with safety boots to gain her compliance (p. 658).*

These excerpts show how in abusive relationships women do not have autonomy in whether to work, socialise or have sex with their partners. Therefore, women affected by IPV have their occupational rights violated and experience occupational injustice.

Nevertheless, literature from an occupational therapy perspective regarding IPV is scarce and outdated, leaving the occupational therapy profession largely silent regarding this prevalent injustice. No publications could be located about IPV within the occupational therapy professional discourse in South Africa. The available literature agrees that occupational therapists are likely to encounter women affected by IPV (Johnston, Adams, & Helfrich, 2008, p. 38), have a role to play in facilitating disclosure of violence (Johnston et al., 2008, p. 38; Twinley & Addidle, 2012, p. 203) and should support the recovery of people affected by IPV (Humbert, Bess, & Mowery, 2013, p. 248), especially related to pragmatic issues such as employment, housing, and childrearing (Gorde, Helfrich, & Finlayson, 2004, pp. 703–704; Helfrich, Badiani, & Simpson, 2006, p. 327; Helfrich & Rivera, 2006, p. 23; Humbert, Engleman, & Miller, 2014, p. 235,238). Occupational therapists also have a role in supporting children who have been exposed to IPV (Waldman-Levi & Bundy, 2015, p. 8), and creating violence prevention programmes (Canique Brown, 2016, p. 43). Published literature acknowledges that women affected by IPV, especially those who have disabilities, experience occupational injustice (Smith & Hilton, 2008, pp. 168–169). However, no studies could be located where women affected by IPV describe their experience with occupational injustice. Occupational justice is the

framework that occupational therapists use to advocate for occupational issues on a societal level. IPV is a complex societal issue, however the current occupational therapy literature largely refers to managing IPV on an individual client level. Thereby, occupational therapists who do respond to IPV, may be addressing the surface level symptoms and effects of IPV on their clients and not the deeply rooted societal issues that prevent women affected by IPV from participating in meaningful and rewarding occupations. To effectively respond to IPV, occupational therapists need to address both the deeply rooted societal issues, as well as the clients' individual needs.

1.2 Problem Statement

Women affected by IPV likely experience occupational injustice, indicating that occupational therapists have an ethical obligation toward this population. However, the occupational injustices that people affected by IPV experience, have not been described in literature. Studies on IPV, especially those that are qualitative in nature, indicate that women affected by IPV experience restrictions (both internally and externally) in their ability to engage in activities that would contribute to their health and well-being. Examples of this include: not being able to choose what to wear, having restrictions on when and with who to socialise with, not being allowed to earn an income, being forced to do domestic chores, and being forced to engage in sexual activities (Flasch, Murry, & Crowe, 2015, p. 14; Joyner & Mash, 2014, pp. 657–658; Nagae & Dancy, 2010, pp. 759–760; Taherkhani, Negarandeh, Simbar, & Ahmadi, 2014, p. 264).

Legislation such as the National Policy Guidelines on Victim Empowerment acknowledges the impact of GBV and resounds with the ontology of occupational therapy in that it aims to restore the well-being of victims following traumatic incidents (National Department of Social Development [DSD], n.d., p. 2). Considering the prevalence of GBV in South Africa in comparison to global trends, one would expect that South African occupational therapists would spearhead the discussion on issues related to GBV in the occupational therapy profession globally.

Yet, published occupational therapy South African literature is mostly silent on this topic. On a global platform, therapy literature on the topic of IPV is scarce and largely outdated and does not address the occupational injustices that the women affected by IPV experience on a societal level. Literature thereby indicates that although occupational therapists may be responding to IPV on an individual level, they may not be responding to IPV on a societal level.

Occupational therapists in all settings are ethically obliged to consider how they could enable occupational justice in practice (Peters & Galvaan, 2017, p. 64). The amount of occupational therapy literature published on IPV and other issues of GBV, does not reflect the scale of the issue. Occupational therapists may have, albeit subconsciously, been proverbially turning a blind eye to the highly prevalent issues of GBV and IPV. More concerning, if the silence in literature were to be reflective of an ignorance and passivity concerning IPV, occupational therapist professionals could be contributing to and perpetuating the experience of IPV. It is important to open theoretical discussions within the profession by describing how women have experienced and adapted to IPV. In so doing occupational therapists could be made aware of their responsibility to a large and vulnerable part of our society.

Outside of the occupational therapy profession, it is important to provide a fresh theoretical perspective and new terminology to literature related to IPV. Occupational therapists have a unique role to play in the collaborative response toward IPV. Research that provides an occupational justice perspective, will allow not only occupational therapists to respond to IPV, but it will also encourage other sectors and professionals to invite occupational therapists to join in their initiatives in responding to IPV.

1.3 Research Question

The problem outlined above leads to the research question:

How do women affected by IPV experience and adapt to occupational injustice[9]?

1.4 Research Objectives and Aim

The following aim and four objectives were identified to answer the research question:

1.4.1 Research Aim

To identify and describe how victims of IPV, who reside at women's shelters in Gauteng, experience, and adapt to occupational risk factors.

1.4.2 Research Objectives

- To identify and describe how victims of IPV who reside at women's shelters experience and adapt to occupational imbalance.
- To identify and describe how victims of IPV who reside at women's shelters experience and adapt to occupational alienation.
- To identify and describe how victims of IPV who reside at women's shelters experience and adapt to occupational deprivation.
- To identify and describe how victims of IPV who reside at women's shelters experience and adapt to occupational marginalisation.

1.5 Significance of the study

Considering the recent events concerning GBV in South Africa, this study is particularly timely. Given that data was gathered in 2018 before the COVID-19 pandemic, its continued relevance exposes the deeply entrenched fault line of GBV and associated IPV, not only on a global scale, but also very much in South Africa. Acts of IPV are often written off as 'domestic issues', however, the existence of IPV points to societal issues related to power imbalances and patriarchy. This study

[9] Occupational injustice is the umbrella term to describe four type of occupational injustices which are also referred to as occupational risk factors (cf. 2.2.4).

describes the resultant injustices experienced by women affected by IPV from an occupational perspective. Describing the occupational injustices could influence many levels of society.

On an individual client level, the study has the potential to increase awareness of IPV among occupational therapists, especially in South Africa where GBV is prevalent. This has the potential to result in increased dialogue with clients and colleagues on the topic and thereby creates an environment that allows for increased violence disclosure by people experiencing IPV. Disclosing violence and seeking help are crucial to overcoming IPV.

On a community level, the study will highlight the ethical responsibility of occupational therapists towards people affected by IPV by describing the occupational injustices they experience. The study could inspire critical self-reflection within therapists to challenge the extent to which they have normalised violence or have victim-blaming mindsets. The fruit of such self-reflection is that occupational therapists can then influence the communities in which they live and work to be better informed on IPV.

On a societal level, the study contributes a fresh perspective to the topic of IPV among people already working in IPV. It encourages occupational therapists and people involved in IPV to cooperate in determining how this perspective can be applied to improve responsiveness and service delivery to people affected by IPV. Further, this study provides an initial platform to establish a body of literature on the topic of GBV in occupational therapy and possibly lead the profession, especially in South Africa, to more contextually responsive practice considering prevalent issues such as IPV.

1.6 Research design and Methodology

This qualitative study is positioned both within a constructivist paradigm as well as a feminist paradigm (cf. 3.2) to describe the experiences of the participants who had been affected by IPV.

After obtaining permission from the necessary stakeholders and informed consent from the participants, who were recruited by using criterion sampling as a means of purposive sampling (Etikan, Abubakar Musa, & Sunusi Alkassim, 2016, p. 22), a two-part data collection procedure was conducted with eleven participants at four women's shelters in Gauteng, South Africa. Part one of the data collection procedure consisted of a demographic questionnaire and a prompted collage technique. Part two consisted of unstructured interviews that were informed by the collage made in part one. The interviews were recorded and transcribed by the researcher and a professional transcriber and were then de-identified for confidentiality. The data was analysed by the researcher and two co-coders using inductive thematic analysis (cf. 3.3.6). Data was independently coded by each of the coders using inductive descriptive coding. The codes were grouped into categories and subcategories and then synthesised into themes. The results were reported using verbatim quotes and rich descriptions. Negative case analysis was performed as well as literature triangulation to enhance the rigour of the study (Creswell & Poth, 2018, p. 413).

The details of the research methods are discussed in Chapter 3 including the research paradigm, study design, research context, study population, data collection, data management and data analysis methods, and the strategies for rigour.

1.7 Ethical considerations

The research proposal was approved by the Health Sciences Research Ethics Committee of the UFS (Ethics number: HSREC 159/2017 (UFS-HSD2017/1434)) (cf. Appendix A). Informed consent for conducting the study was obtained firstly from the Gauteng DSD for permission to access the shelters, secondly from the managers of the four shelters from which the participants were recruited, and lastly from the

eleven participants[10] of the study. The data collected was kept confidential and the participants remained anonymous to the reader and co-coders as they were de-identified by the researcher. A detailed discussion of the ethical considerations of this study can be found in Chapter 3.

1.8 Dissertation style and outline

With regards to referencing throughout this dissertation, I utilised automated referencing through the *Mendeley Cite-O-Matic* plug-in on the *Microsoft Word 2013* program with the style “American Psychological Association 6th edition”. Page numbers were included where relevant to ease tracking of literature sources.

The content of each of the chapters in this dissertation are as follows:

Chapter 1: Introduction and overview – This chapter provides an overview of the study and includes an introduction, problem statement, purpose statement, research questions, and the significance of the study. In this chapter and throughout the dissertation, the researcher purposefully refrains from using the term “victims of IPV” and rather use the term “people/women affected by IPV”. This terminology aligns with the feminist paradigm that is utilised in the study. People are presented in a way that emphasises that IPV is only a part of their person-hood as opposed to being completely defined by experiencing IPV.

Chapter 2: Literature Overview – This chapter discusses information related to the topic of the study, as well as literature required for interpreting its findings. IPV is a multi-disciplinary topic and sources from various professions were consulted including occupational therapy, nursing, social sciences, and family violence work. This chapter includes information on the fundamentals of occupational therapy and occupational justice. Furthermore, core concepts related to IPV and shelters are

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[10] Initially twelve participants consented, however one participant withdrew leaving eleven participants.

described and an overview of occupational therapy literature related to IPV and domestic violence is provided.

Electronic literature searches were conducted to obtain journal articles using EBSCOhost® electronic databases, which include CINAHL® and Medline®. Google Scholar® was used to access frequently cited sources relevant to the topic and Google Search® to obtain access to policy documents, as well as documents and statistics from relevant governing bodies. Books relevant to the study were sourced privately or through libraries.

An effort was made to ensure that the sources consulted represented the most current knowledge in the fields of IPV and occupational therapy. Older sources are quoted in the case of seminal work and also older sources related to IPV and occupational therapy due to the limited publications available. This study was carried out before the COVID-19 pandemic and therefore the literature does not include details of violence against women that surged in this time. It acknowledges how much this global event emphasises the societal fault lines of responding to people affected by IPV.

Chapter 3: Research methodology – In this chapter a comprehensive overview of the research methodology is provided, including an explanation of the research paradigm, the method of enquiry, data collection procedure, data analysis strategies, considerations for validity and reliability as well as ethical considerations.

Chapter 4: Presentation and discussion of findings – This chapter includes a description of the study participants. Research results are then presented by describing the themes categories and codes that emerged from the results, as well as discussing the findings.

Chapter 5: Conclusions – In this chapter conclusions are based on the findings of the study. The findings from the data analysis are compared to theoretical findings to draw the final conclusions. The limitations of the study are discussed and

recommendations for practice and future research are offered. The dissertation is concluded with final reflections.

1.9 Conclusion

In this first chapter the background of the study and key concepts related to it were briefly introduced. The research problem and significance of the research were argued and the research purpose and aims were presented. From this introduction, the researcher argued the research problem and presented the research question, purpose, and objectives, as well as a synopsis of the research design and methodology employed in this study. The following chapter is a review of the relevant literature related to the key concepts of this study.

Chapter 2: Literature Overview

2.1 Introduction

In Chapter 1, the following were presented: an overview and introduction to this study with the problem statement, research question and study aim, significance of the study, ethical considerations, as well as a summary of the methodology. In Chapter 2, I will review literature concerning the main concepts of the study. These concepts will be discussed in three parts, namely: 1) occupational therapy and related concepts, which include context, how occupation relates to health and occupational justice; 2) IPV and related concepts, which include coercive control, roots of IPV, consequences of IPV and the response toward IPV; 3) occupational therapy and IPV, which includes the potential role of the occupational therapist.

2.2 Occupational Therapy and Related Concepts

Traditionally, the profession of occupational therapy has not been involved in addressing IPV. To explain the relevance of occupational therapy to the topic of IPV, it is necessary to elaborate on profession-specific core concepts related to this study. Subsequently, this will provide a platform from which to discuss the relationship between occupational therapy and IPV throughout this chapter. This section will provide a brief history of occupational therapy, the relationship between occupation and health, as well as clarify the profession-specific terms of occupational well-being, occupational rights, and occupational justice.

2.2.1 Historical influences on Occupational Therapy

Occupational therapy as a profession was established in 1917 and has its roots in working in situations and with individuals who have undergone or are undergoing a struggle in some area of their lives. In the early 1900s occupation, or meaningful activity, was used in rehabilitating soldiers from the world wars (Molke, 2009, p. 81). Occupation was also used among people struggling with mental illness in the early

part of the 18h century, as well as individuals and communities with scarce monetary resources, whose lives had changed with the industrial revolution (Molke, 2009, p. 81).

By the time occupational therapy was introduced to post-colonial South Africa in 1942, the relationship between health and occupation was apparent. Occupational therapy was introduced to South Africa towards the end of World War II to aid in rehabilitating injured soldiers (Davy, 2003). At that time South Africa was ruled by an apartheid government. Until the end of apartheid in 1994, only white South Africans were able to study occupational therapy. Furthermore until 1994, the occupational therapy curriculum and scope of practice were overtly controlled by the South African Medical and Dental Council. The board of this council did not include occupational therapists and consisted primarily of white males (Joubert, 2010, p. 25). The implication is that for the first formative fifty years of occupational therapy, the curriculums that were developed and the practice of occupational therapists were subjected to forced oppression and discrimination under the apartheid government, as well as having strong patriarchal influences. The consequences of these formative years still have an impact on practice today. Joubert uses the example or occupational therapy assessment which regards normalcy, for example a "normal" pencil grip, a "normal" work-life balance, or a "normal" range of motion (2010, p. 22), to suggest that occupational therapists may uncritically accept an ideology of normality as determined by those in positions of power. Occupational therapists are encouraged to be culturally sensitive in their practice (Joubert, 2010, p. 22) and toward a more Africanised epistemology (Joubert, 2010, p. 26).

2.2.2 Health and occupational well-being

Occupational therapy is based on the assumption that there is a positive relationship between occupation and well-being (Hammell & Iwama, 2012, p. 388). For more than seventy years the WHO has defined health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948). Ramugondo (2017, p. 34) identifies five aspects of health that

compliment this holistic understanding of health. They are namely: physical (integrity and functioning of a person's body), intellectual (the ability to carry out simple and cognitive functions such as decision-making, problem solving and critical reasoning), social (feeling cared for, loved, and accepted within a social unit), emotional (feeling a full range of emotions, as well as developing psychological resilience) and lastly spiritual health. Spiritual health is understood in terms of four domains (Ramugondo, 2017, p. 34): personal (relating to yourself as a human being), communal (quality and intimacy of interpersonal relationships within a community), environmental (connectedness to a physical environment and nature), and lastly transcendental (connectedness with a higher spiritual Being). Mary Reilly (1962, p. 2) introduces an occupational perspective of health when she proposes, "that man, through the use of his hands as they are energized by mind and will can influence the state of his own health". Ultimately occupational therapists aim to facilitate people and communities engaging in occupations that will allow them to achieve health and well-being.

To highlight the importance of an occupational perspective on health, Ramugondo (2017, p. 40) emphasises occupational well-being and eudemonic occupations. Occupational well-being as defined by Doble and Santha (2008, p. 185) measures "the extent to which the occupations that people choose, engage in, and have orchestrated into their occupational lives generate meaning and satisfaction." They propose seven occupational needs, namely accomplishment, affirmation, agency, coherence, companionship, pleasure, and renewal (Doble & Santha, 2008, p. 186). These needs are described in Table 2-1. Occupational needs of agency, coherence, and companionship are closely related to eudemonic-well-being, the result of pursuing meaning and purpose in life beyond gratification of basic personal needs (Ramugondo, 2017, p. 40). Eudemonic occupations are therefore occupations that allow centring of self (free an individual of nervous energy and allow being present) and contemplation (such as prayer and mindfulness exercises), creativity, and contribution (Ramugondo, 2017, p. 41). Considering that people experiencing IPV, have restricted choice over their activity participation, they likely are unable to

engage in occupations that meet their occupational needs (cf. 1.1). Occupational well-being and eudemonic occupations are perspectives that could be harnessed by occupational therapists to assess and address health beyond a pathogenic view, in the promotion of complete well-being.

Table 2-1 : Occupational Needs for Occupational Well-Being

(Doble and Santha, 2008, p. 186; Ramugondo, 2017, p. 40)

Occupational Need	Description
Accomplishment	Addressed when individuals generate evidence indicating that they are learning and mastering skills, meeting performance expectations, and achieving goals.
Affirmation	The need for individuals to recognise and to have others recognise that their occupational choices and occupational performances are important, worthwhile, and valued and thus, contributes to their self-worth. When individuals do things with and for others, they are more likely to receive affirmation
Agency	Addressed when they perceive that they exert influence or control in important or valued aspects of their occupational lives. Agency may be experienced when individuals choose what occupations they do, and how, when, where, how often, and with whom they perform occupations.
Coherence	Experienced when individuals' occupational experiences are aligned with their values, personal desires, goals, and the occupations they engage in generate evidence that confirms who they are and want to become.
Companionship	Fulfilled when individuals engage in occupations with others who share common experiences, interests, values, or goals. Such occupations enable individuals to feel a sense of belonging and sometimes even intimacy.
Pleasure	This ranges from the simple satisfaction derived from small daily rituals to the intense pleasure people feel in pursuing their driving passions and thus includes contentment, happiness, and joy.
Renewal	Experienced when individuals engage in occupations that provide a sense of inner peace, abandon, relief, and mental clarity, and leave them feeling refreshed, re-energized, and rejuvenated.

2.2.3 People as occupational beings

Occupational therapists look at people through an occupational lens. They consider internal and external factors which influence whether they engage in certain activities, what activities people engage in, and the effect of these activities on their well-being. When considering people as occupational beings, conceptual occupational therapy models are useful tools to organize theory and concepts to better explain the process and practice of occupational therapy in a way that is clear, concise and applicable (Duncan, 2011a, p. 45). The Model of Human Occupation (MOHO) (Kielhofner 2008 as cited in Forsyth & Kielhofner, 2011, p. 53; Turpin & Iwama, 2011, p. 128) is the first published model in occupational therapy. The MOHO, depicted in Figure 2-1 provides main concepts to explain occupation and occupational problems. The MOHO has been found valuable in assessing and understanding people affected by IPV from an occupational perspective (Abelenda & Helfrich, 2003, p. 31).

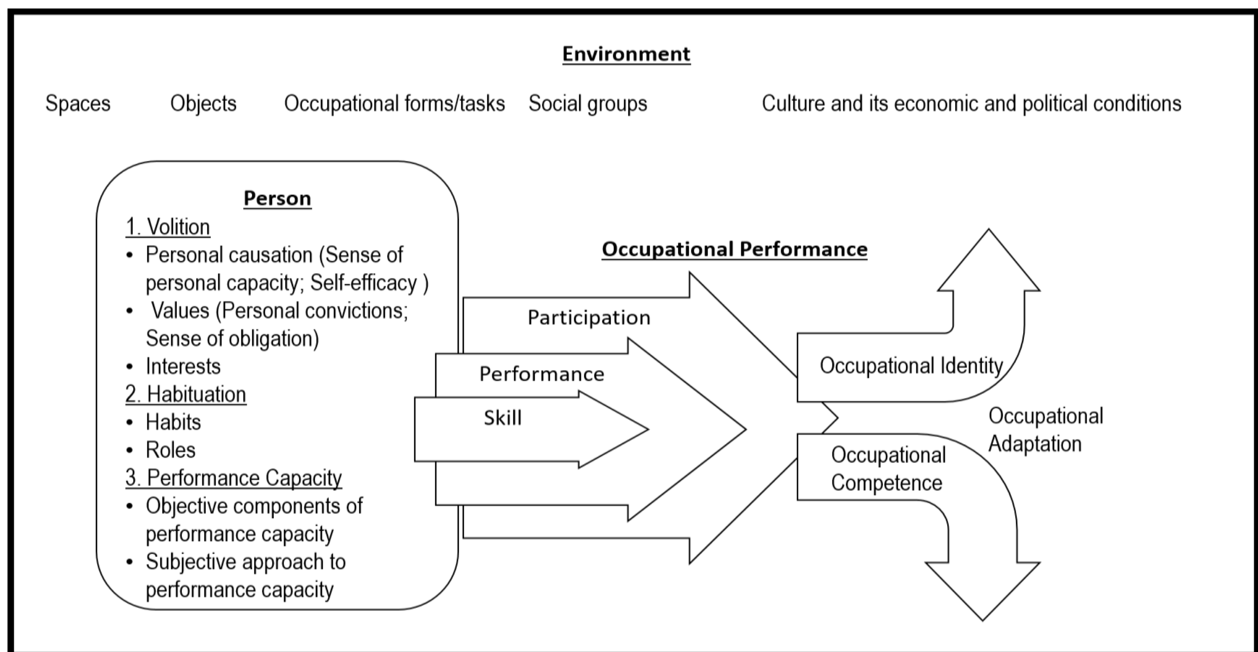

***Figure 2-1*. Components in MOHO** (*Reproduced from Kielhofner 2008 as cited in Forsyth and Kielhofner 2011, p. 53*).

The model consists of three parts, namely the components of a person, occupational performance, and the environment. Each of these parts have their own respective components. The parts and their components are summarised in Table 2-2.

Table 2-2: MOHO Concepts

(Forsyth and Kielhofner, 2011; Turpin and Iwama, 2011)

Concept	Description
Person	
1. Volition	The processes that motivate people to do what they do. The volitional processes consist of a cycle of anticipation, choice-making, experience, and interpreting actions.
Personal Causation	People's sense of their current and potential abilities to act with purpose and produce outcomes. It includes personal capacity, people's thoughts on their capabilities and self-efficacy, and a sense of the extent to which they can control outcomes.
Values	The beliefs that people have about what is good, right, important, and worth doing. Values include personal convictions, a person's view of what matters in life, and a sense of obligation, which is a drive to act in accordance to one's values.
Interests	Attraction to certain activities based on anticipated enjoyment.
2. Habituation	This is a readiness to behave in a consistent way according to what is fitting for the time, place, and social situation.
Habits	Patterns of behaviour that are often performed automatically. Habit formation decreases the conscious effort to perform a task and frees up cognitive capacity.
Roles	Taking on an identity, outlook, and activities related to your position in society and relationship with others. Society has expectations of what is expected of a person in a particular role. Examples of roles include, wife, mother, student, and friend.
3. Performance Capacity	The way the systems in your body interact that allows you to do things.
Objective Components	Capacities of bodily systems such as the musculoskeletal and cardiovascular systems, as well as cognitive capacities.
Subjective Experience	How persons experience their performance in specific activities.

Table 2-2 (continued)

Concept	Description
Environment	
Environment	People and their environments cannot be separated. The environment affects the opportunities people have available for occupation. Similarly, people affect their environments through their choice of activities.
Occupational Performance	
Skill	Quality of discreet purposeful actions during an activity such as reaching for a key and then manipulating it in your hand.
Occupational Performance	Ability to successfully complete a task or activity.
Occupational Participation	Engaging in occupations that are part of a person's context and contribute to well-being
Occupational Identity	A person's sense of who they are and who they want to become as influenced by what they do.
Occupational Competence	The extent to which a person can participate in occupations that reflects their occupational identity.
Occupational Adaptation	Constructing an occupational identity and achieving competence in that identity over time.

The MOHO acknowledges that there are factors within people, namely their volition, habituation, and performance capacity that influence their activity participation as well as aspects in persons' physical and socio-cultural environments that influence the availability of activities and the consequences of participating or not participating in activities. Thereby when considering the effect of IPV on a person's occupational performance, it is important to consider both personal factors and environmental factors.

2.2.4 Occupation: a justice issue

A common approach in World Health Organisation (WHO) directives for health promotion is through prevention of known risks (see for example Prüss-Ustün, Wolf, Corvalán, Bos & Neira 2016; WHO 2009; WHO 2010). Likewise, when assessing people's situations or environments to assess health from an occupational perspective, occupational therapists can look for the presence of occupational risk factors. These include occupational alienation, occupational deprivation,

occupational imbalance and occupational marginalization as risks to health and well-being. In the seminal work of Townsend and Wilcock (2004, p. 80), each of these occupational risk factors have been linked to their juxtaposed state in the form of occupational rights.

2.2.4.1 *Occupational alienation*

Occupational alienation (Wilcock, 2006, p. 343), refers to the sense of powerlessness, isolation and frustration that results from a person not engaging in occupations that satisfy their inner needs. It is "demeaning, soulless, tiresome, coercive participation in occupations they find meaningless (Townsend & Wilcock, 2004, p. 81)". Alienation is appropriately juxtaposed with the occupational right of people to "experience occupations as meaningful and enriching (Townsend & Wilcock, 2004, p. 80)". A violation of this right is associated with an individual feeling empty, disconnected, a loss of identity, and isolated. The following excerpt from Thaggard and Montayer's (2019, p. 221) research on shame in IPV is an example of occupational alienation.

> *…so I really did start to lose myself. Yep I had to stay invisible, keep my mouth shut only speak when spoken to. I couldn't really express myself. … and I wasn't who I used to be, as carefree as I used to be. My needs and wants were what he needed and wanted and if I ever did try to bring it up then I would get a hiding.*

Despite an individual experiencing feelings of 'emptiness' and loss of identity,, occupational alienation is not a psychological state but rather highlights an underlying condition of injustice where there is a lack of opportunities available to engage in occupations that provide meaning and enrichment (Townsend & Wilcock, 2004, p. 80).

Hammel and Beagan (2017, p. 60) critique occupational alienation as difficult to differentiate from occupational deprivation and occupational marginalisation. Attempting to differentiate whether a scenario is an example of one occupational risk

factor or another is complicated. Occupational risk factors may and do co-exist (George & Stanley, 2018, p. 10). For this study, I will differentiate occupational alienation from occupational deprivation and occupational marginalisation by considering that occupational alienation is an internal state whereas occupational deprivation and occupational marginalisation point to factors in a person's environment that are outside of their control.

2.2.4.2 *Occupational deprivation*

Occupational deprivation (Wilcock, 2006, p. 343) refers to a prolonged lack of choice and diversity in occupations due to circumstances outside the control of a person. The associated occupational right is "to develop through participation occupations for health and social inclusion (Townsend & Wilcock, 2004, p. 80)". People who are incarcerated, in refugee camps or who are institutionalised are examples of people who experience social exclusion from some occupations (Stadnyk, Townsend, & Wilcock, 2010, p. 339). Women experiencing IPV have described how their partners have prevented them from leaving the house or finding a job (Taherkhani et al., 2014). Depriving someone of something to do is a way of controlling people. Deprivation becomes a justice issue if you consider that it is by 'doing' that people get to exercise health, citizenship and social inclusion (Townsend & Wilcock, 2004, p. 81). Hammel and Beagan (2017, p. 84) critique the current understanding of occupational deprivation to lack specific parameters and to lack guidelines for assessment. Thereby for the purposes of this study I will consider that the following factors need to all be present to identify occupational deprivation: it is lack of occupational choice; it is caused by factors outside of a person's control; it results in social exclusion.

2.2.4.3 *Occupational marginalisation*

Occupational marginalisation is described as an invisible force of normative societal expectation of when, how and where a group of people should participate in certain occupations (Townsend & Wilcock, 2004, p. 82). Concepts related to occupational

marginalization are discrimination, stigmatization, and exclusion. Groups of people are typically occupational marginalized when the ideas that influence policies, laws, funding and built environments cater for the ‘standard’, ‘typical’ and majority type of people group and not for people groups who are in the minority, are ‘different’ or who have less power to influence decisions on a macro level (Townsend & Wilcock, 2004, p. 82). Many groups of society experience occupational marginalisation in some form including migrants, women and people of colour (Hammell & Beagan, 2017, p. 62). In addressing occupational marginalisation, it is necessary make the invisible norms and expectations visible so that they can be addressed.

Women affected by IPV report having experienced negative responses towards their victim status from informal sources such as friends and family as well as from formal agencies including police and healthcare workers. Reported responses that they reported include lack of empathy, blame, insensitivity and scepticism (Menaker & Franklin, 2015, p. 10). The fear of anticipated victim-blaming from members of society result in reduced help-seeking (Menaker & Franklin, 2015, p. 10). Normative society has discriminated against them and made unsolicited decisions on their behalf on what their relationship should look like, whether what they are experiencing is abusive or not, whether their reasons for staying are valid, and how they should respond to their abusive partner. Occupational marginalisation highlights the social and contextual elements of occupational injustices further supporting that IPV is not a domestic issue but a societal issue.

Townsend and Wilcock (2004, p. 80) related occupational marginalisation to the occupational right of people to “exert individual or population autonomy through choice in occupations”. In that regard occupational marginalisation is less about participation in occupations but rather empowering all individuals with the *choice and control* of whether or not to participate.

2.2.4.4 *Occupational imbalance*

Wilcock (2006, p. 243) explains how a balance between occupations brings well-being, including a balance between strenuous and restful occupations; between chosen and obligatory occupations; as well as between productivity, pleasure and restoration. Any imbalance in activities results in the experience of occupational imbalance (Wilcock, 2006, p. 243) and contributes to decreased well-being. At the societal level, occupational imbalance is described as situations where some individuals are offered many opportunities for occupation while others are afforded few, resulting in individuals being over, under, or even un- occupied (Stadnyk et al., 2010; Townsend & Wilcock, 2004). The following verbatim example from the study on IPV by O'Doherty, Taft, McNair, & Hegarty (2016, p. 232) illustrate the pressure that the abusive partner was placing on his wife to stay busy:

> *Yeah, when it comes to cooking, and when he comes home and if he sees the house a mess, he just can't take it. He is like, "what are you here for?" With the kids he wants me to do certain responsibilities which he feels I don't fulfil. He expects that, "oh you're supposed to be doing this and you're so educated, why aren't you doing that also?"*

Townsend and Wilcock (2004, p. 80) related occupational imbalance to the occupational right of people to "benefit from fair privileges for diverse participation in occupations". Hammel and Beagan (2017, p. 84) critique the current understanding occupational imbalance as making it difficult to assess. They ask who is able to decide whether a person works too much or rests too much. They also question how it would be possible to create a normative standard as balance would be different according to a person's role, culture and environment. In the example I provided the person affected by IPV clearly felt there was too great a demand on her too be productive. She instinctively knew that she was experiencing occupational imbalance. For this study I consider that a person's subjective experience of their occupational balance is the best determinate of whether if a person is experiencing occupational imbalance.

2.2.4.5 *Evolving concepts of occupational justice and occupational rights*

The occupational risk factors described above are seen as types of occupational injustices (Durocher et al., 2014, p. 423; Peters & Galvaan, 2017, p. 2). Occupational injustice is best understood in the light of occupational justice. Occupational justice is understood as a type of social justice and described as a justice of difference that focuses on equal opportunities despite people's individual differences (Nilsson & Townsend, 2014, p. 65). Wilcock (2006, p. 248) coined the term occupational justice and defines it as

> *...the promotion of just socio-economic and political conditions to increase individual, population and political awareness, resources and opportunity for people to participate in doing, being and becoming healthy through engagement in occupations that meet the prerequisites of health and every person's different natures capacities and needs.*

From this definition we see that occupational injustice is thereby an outcome of misused power that is exercised in a way that restricts populations and individuals from the opportunity to participate in everyday occupations (Nilsson & Townsend, 2014, p. 65). From this perspective Townsend and Wilcock (2004, p. 83) explained that occupational therapists are primarily concerned with populations who are vulnerable to injustices because their participation in occupation has been restricted by injury, mental illness, age or other circumstances. Occupational justice is thereby seen as a unique way that occupational therapists can contribute to the greater cause of social justice. However, the concept of occupational justice remains vague in literature.

Hammel has done extensive work critically investigating and critiquing the use of the term 'occupational justice' and its associated terms (Hammell, 2017a, 2017b; Hammell & Beagan, 2017; Hammell & Iwama, 2012). I will discuss three of her arguments that are relevant to occupational justice as it pertains to IPV. First, Hammel and Iwama (2012, p. 386) argue that occupational therapists should

promote occupational rights as an outcome rather than occupational justice. Although the term 'occupational rights' were first used by Townsend and Wilcock in 2004, Hammel was the first to define it as "the right of people to engage in meaningful occupations that contribute positively to their own well-being and the well-being of their communities." She states that occupational rights provide occupational therapists with a clearer mandate to advocate for people. Second Hammel and Iwama (2012, p. 386) explain that the concept of rights can be found in every cultural tradition as a statement how all humans ought to be treated and what all people are entitled to expect. Hammel explains that rights demonstrate how people are entitled to be treated whereas justice is more idealistic (Hammell, 2017a, p. 51). Justice requires a human judgement to be made regarding what is fair and is therefore subject to moral relativism (Hammell & Iwama, 2012, p. 386).

These arguments made by Hammel and Iwama (2012, p. 386) and later Hammell (2017a, p. 51) are valid and crucial to consider considering the nature of IPV. First, issues around GBV and IPV are societal issues. Thereby advocacy is cardinal to prevent becoming stuck in our ability to progress in social issues. However, it is possible to encourage advocacy with both occupational rights and occupational justice. Literature published on issues occupational justice regularly calls for therapists to address problems on a systematic level by partnering with community stakeholders and policy makers (Galvaan et al., 2015, p. 46; George & Stanley, 2018, p. 11; Marshall et al., 2019, p. 15; Rivas-Quarneti, Movilla-Fernández, & Magalhães, 2018, p. 16). Second, violence is perpetrated by humans, often as a result of a power imbalance (RSA, 2020, p. 27). It could therefore be dangerous if the same humans decide what is fair and unfair. However, the term 'occupational rights' does not solve the problem of moral relativism as the concepts of 'rights' is deeply imbedded in power and has been critiqued as not necessarily universally applicable (David, 2020, p. 1,5). Occupational therapists thereby have to practice reflectively to ensure that they are abiding by the 'golden rule' of ethics and ensuring that others are being treated in a way that they themselves would like to be treated.

Hammel and Iwama's arguments appear to place the concepts of occupational rights and occupational justice in a dichotomy to each other. However, this dichotomy is possibly false. Occupational rights have been used as a core concept in explaining occupational justice. As seen in the preceding parts of this subsection (cf. 2.2.4.1 – 2.2.4.2) the presence of occupational risk factors indicate occupational rights is being violated. Similarly, it can be said that the violation of occupational rights indicates the presence of occupational injustice. I thereby argue that occupational rights and occupational justice cannot be separated from each other and occupational therapists should advocate for the occupational rights that people are entitled to as a vehicle to achieving the idealistic vision of an occupationally just society. Recent authors on topics of occupational issues continue to use the term 'occupational injustice' when highlighting the ethical responsibility occupational therapists have toward specific population groups (see for example George & Stanley, 2018; Marshall et al., 2019; Rivas-Quarneti et al., 2018). In this study I opted to use the term 'occupational justice' as it inherently includes occupation rights and calls for occupational therapists to assume advocacy role. Further using the preferred terminology by authors in the field the study, contributes to the greater discussion on how occupational therapists can address occupational issues in society.

2.2.5 Summary

Occupation is a fundamental part of being human. Consequently, occupational therapists advocate that all people have the right to engage in meaningful occupations. To assess if people's right to occupation is being violated, occupational therapists have identified risk factors, namely occupational alienation, occupational deprivation, occupational marginalisation, and occupational imbalance. The presence of these risk factors indicate that the well-being of individuals and communities are at risk because their occupational rights are being violated. When occupational therapists respond to violations of occupational rights, they align themselves with global strategies for health promotion and function within the core

mandate of the profession. Occupational therapists thereby have the responsibility to proactively seek out and respond instances where occupational rights are being violated. One such instance is with women affected by IPV. The next section will focus on this topic.

2.3 Intimate Partner Violence and related concepts

This study seeks to contribute to the existing understanding if IPV as well as advocate for improved services for women affected by IPV. Thereby in this section, I will discuss coercive control in IPV, the roots of IPV, the consequence of IPV and the response toward IPV.

2.3.1 Coercive control in intimate terrorism

Many studies on IPV (Beck & Raghavan, 2010; Crossman, Hardesty, & Raffaelli, 2016; Eckstein, 2017) refer to Johnson's (1995) differentiation between two main types of violence in heterosexual relationships (although there are four in total theorised[11]), patriarchal terrorism, and common couple violence. More recently Johnson changed these terms to intimate terrorism and situational couple violence. The primary difference in these two terms is that the latter refers to conflict that gets out of hand, it is seldom life-threatening and control of the partner is not the purpose (M. P. Johnson, 2006, p. 1005). On the other hand, with intimate terrorism, men use tactics such as physical abuse, financial abuse, threats (verbal abuse), and isolation as tactics to control 'their' woman (M. P. Johnson, 2006, p. 1005). Although intimate terrorism has a higher risk of recurring and having fatal outcomes, as Eckstein (2017, p. 16) argues, situational couple violence should still be addressed, especially by researchers, and not be written off as poor communication. Such an attitude supports the normalisation of violence in society. Intimate terrorism is more likely to

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[11] For an elaboration on the four types of IPV, See (M. P. Johnson, 2006). In this article Johnson differentiates between situational couple violence, intimate terrorism, violent resistance, and mutual violent control. He argues that in heterosexual relationships, intimate terrorism is perpetuated primarily by men, violent resistance primarily by women and the remaining two are gender symmetric.

occur against women (Eckstein, 2017, p. 14; M. P. Johnson, 2006, p. 1004; Stark, 2007, p. 6), although it can also occur against men[12]. Due to the participants in this study being female (cf. 3.3.3), the topic will be elaborated on in this literature review.

Coercive control in intimate terrorism shares dynamics with crimes such as kidnapping, stalking, and harassment (Stark, 2007, p. 6). Perpetrators of intimate terrorism treat their intimate partners as hostages by depriving them of money, food, transport, contact, and relationships with support systems. However, intimate terrorism is unique from all other crimes in that it extends over a much longer time, the perpetrator targets the same victim and it is especially impactful due to gender inequalities present in society. Men establish control by micro regulating stereotypical female roles, such as how they think a woman should dress, clean, cook, work, socialise, and behave sexually. Thereby they disregard gender equality that women have, and are still fighting to achieve (Stark, 2007, p. 5).

The terms 'IPV' as well as 'domestic violence' mask the underlying dynamics behind coercive control in a relationship. The reason for Johnson's (1995) original choice of using the terminology 'patriarchal terrorism' was to highlight that historical and cultural roots of coercive control are largely ascribed to patriarchy and the idea that men have ownership of their female partners (M. P. Johnson, 1995, p. 224). Intimate terrorism is effective because of the existence of gender inequalities and is thereby not a 'domestic' or 'intimate' problem. It rather points to a societal and political issue of women's position in the larger society (Stark, 2007, pp. 10,14; UN, 1995, p. 49). Further, the term "violence" does not sufficiently account for the invisible yet devastating chronic oppression that victims experience. Stark (2007, p. 13) found that women whom he had dealt with in his psychology practice are less devastated by the violent acts that their partners have committed against them and are more devastated by what their partners have prevented them from doing, by taking away

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[12] For research on intimate terrorism against men, see Hines et al, 2007. *Characteristics of callers to the domestic abuse helpline for men*.

their resources and social support. IPV is thereby better described as a crime of freedom rather than a crime of violence.

Stark's findings support an occupational view in that he finds that the rights violated in a controlling relationship are so basic that they become hard to define. He explains (Stark, 2007, p. 15):

> *What status should we accord Terry Traficonda's right to have toilet paper in the downstairs bathroom* (the only bathroom she was allowed to use) *or to Laura's right to go to the gym without being beeped home? Given the prominence of physical bruising, how can we take these little indignities seriously or appreciate that they comprise the heart of a hostage-like syndrome against which the slap, punch, or kick pale in significance? Most people take it for granted that normal, healthy adults determine their own sleep patterns or how they drive or laugh or make love. The first women who used our home as her safe house described her partner as a tyrant. We thought she was speaking metaphorically.*

Occupational therapists see 'doing' and participating in occupations as a basic human right (cf. 2.2.3). An occupational rights approach to IPV can thereby provide a fresh perspective and unique vocabulary to the existing literature on IPV to describe the violations against women.

2.3.2 Roots of Intimate Partner Violence

When looking at the impact of GBV and IPV while considering its prevalence, the questions arises why GBV is so widespread in South Africa. Violence is a complex issue and WHO (Krug et al., 2002, p. 12) uses this ecological model presented in Figure 2-2 to demonstrate how violence is a result of a variety of individual, relationship, cultural, and environmental factors.

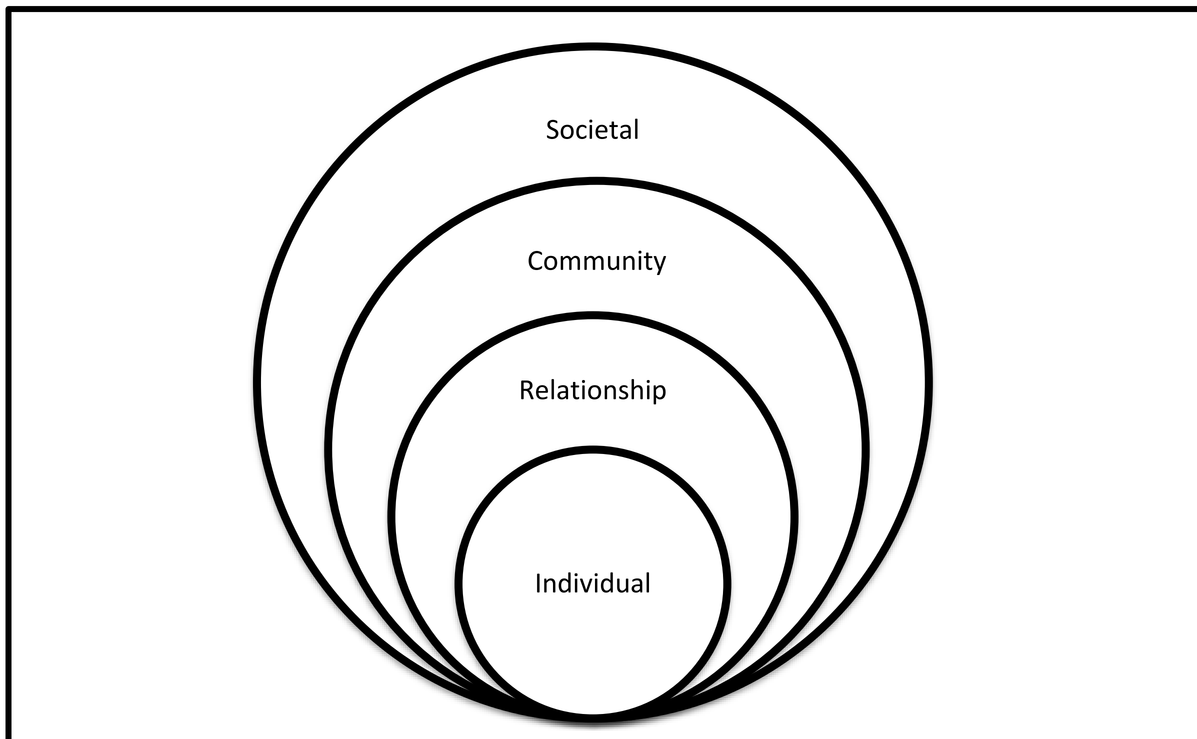

Figure 2-2. **Ecological Model for Understanding Violence.**
(Source: Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002, p. 12)

At an individual level, the ecological model focuses on characteristics individuals possess that increase their likelihood of being either victims or perpetrators (Krug et al., 2002, p. 13). Regarding IPV, women are more likely to experience IPV if they have little education; childhood abuse; exposure to mothers being abused by a partner; personal history of IPV; alcohol abuse; and attitudes accepting violence, male privilege, and women’s subordinate status. On the other hand, men are more likely to perpetrate violence if they have low education, a history of child maltreatment, exposure to domestic violence against their mothers, harmful use of

alcohol, unequal gender norms including attitudes accepting violence, and a sense of entitlement over women (WHO, 2017, para. 8-9).

At the relationship level, the ecological model considers how proximal social relationships increase the risk for violence (Krug et al., 2002, p. 13). IPV is more likely to be present in a relationship where the partners are seeing each other on an almost daily basis or living together, due to the increased opportunity for violent encounters. With regards to relationship dynamics, IPV is more likely to be present in relationships with marital discord, poor communication skills between partners and the males exhibiting controlling behaviours towards their partners (WHO, 2017).

At community level, the ecological model examines the community contexts that relationships are found in and identifies characterising factors within these settings that are associated with IPV. Communities with high levels of violence are associated with poverty, high population density, high levels of unemployment, problems with alcohol and drugs, and widespread social isolation where people do not know their neighbours and do not participate in social events (Krug et al., 2002, p. 13).

The final level of the ecological model is the societal level and considers factors that create an acceptable social climate for violence (Krug et al., 2002, p. 13). I will discuss three aspects that are especially relevant for the South African context. First, the colonial history of South Africa is one of violent oppression and at times a violent struggle for liberation from the apartheid government. It is theorised the violent history has left a scar where violence is seen as an legitimate and effective way to solve political and social conflicts at a community level and family conflicts on a domestic level (Sibanda-Moyo et al., 2017, p. 12). Second, South Africa is plagued by a culture of patriarchy (Ademiluka, 2018, p. 349; Di Napoli, Procentese, Carnevale, Esposito, & Arcidiacono, 2019, p. 4; Sibanda-Moyo et al., 2017, p. 54). The term ‘patriarchy’ originated from a father acting as ruler over his household. With time ‘patriarchy’ as evolved to refer to power relations in society that hold men as superior and puts females in subordination (Igbelina-Igbokwe, 2013, p. 1). Gender

stereotypes in a patriarchal culture establish masculine traits as exuding virility and demonstrating power, strength and control over others. Men are allowed to use violence to enforce this control over their wives and children. Their household role is to earn an income, manage finances, make important decision and enforce discipline (Ademiluka, 2018, p. 346; Di Napoli et al., 2019, p. 4). Feminine traits are to be submissive, gentle, nurturing, obedient and ornamental. Female roles are to manage domestic chores, produce and raise children as well as to support their husbands. (Ademiluka, 2018, p. 346; Di Napoli et al., 2019, p. 4). Such patriarchal ideas buttress GBV in men and encourage women to be tolerate of violence against themselves and their children. Patriarchal ideas continue to be subliminally purported in society through practices such as corporal punishment in homes and schools, the payment of a 'bride price' or 'labola' which some men interpret as 'buying' a women instead of seeing it as a practice to bring families together (Ademiluka, 2018, p. 342; Krug et al., 2002, p. 8), and through poor interpretation of religious scripture (Wood, 2019, p. 2). Third, South Africa has high levels of poverty and associated unemployment, illiteracy, substance abuse and socioeconomic security (Di Napoli et al., 2019, p. 4). These factors exasperate GBV and are associated with men asserting their masculinities through violence (Ademiluka, 2018, p. 346; Di Napoli et al., 2019, p. 4).

2.3.3 Consequences of Intimate Partner Violence

Similarly, to how the root causes for IPV are complex and widespread, the consequences of IPV are also complex and impact not only the health of the victim and children, but also have social and economic impacts. These are discussed, respectively.

2.3.3.1 *Health consequences*

IPV is commonly associated with physical and sexual violence however, it also includes components of emotional, spiritual, and financial abuse (Watson, 2015, p.

1). These various forms of abuse have considerable health outcomes for victims. These outcomes of IPV have been classified as fatal and non-fatal.

The most devastating effect of IPV is death. The fatal outcomes are either indirectly or directly caused by the partner. Indirect outcomes include suicide, maternal mortality, abortions, stillbirths, and diseases resulting from HIV (Joyner & Mash, 2012a, p. 1). Women are also killed directly at the hands of their partners by means of violent homicides (Garcia-Moreno & Watts, 2011, p. 2). South Africa is arguably one of the most dangerous countries for women to live in. This country not only has the highest recorded rate of female homicides globally, but about a third of these homicides are accounted for by IPV (Abrahams et al., 2009, p. 552). This means that more women are killed by an intimate partner in South Africa, than in any other country (Abrahams et al., 2009, p. 552). These horrible statistics emphasise why women who manage to leave abusive relationships are referred to as 'survivors'. The non-fatal consequences of IPV affect women physically, mentally, sexually, and in regard to reproductive health (Garcia-Moreno et al., 2013, p. 5; Watson, 2015, p. 1). Considering that health is understood as physical, mental, and social well-being (WHO, 1948), it is crucial for healthcare practitioners to consider both victims and survivors holistically.

The physical health conditions are typically resultant from physical abuse as well as the impact of prolonged stress on increased cortisol levels in the body. Forty-two percent of IPV survivors report physical injuries such as fractures and soft tissue injuries (Garcia-Moreno et al., 2013, p. 8; WHO, 2017, para. 13). Violent partners may also restrict the victim's access to healthcare and medication, resulting in victims being denied of their healthcare needs (Sprague, Hatcher, et al., 2016, p. 573). Additionally, sustained stress levels are linked to cardiovascular conditions, hypertension, diabetes, and gastrointestinal disorders. Stress also compromises the immune system, which aggravates the spread of infections (Garcia-Moreno et al., 2013, p. 7).

It has also been found that abusive partners may control the victim's sexual and reproductive health (Garcia-Moreno et al., 2013, p. 7). People affected by IPV are one and a half times more likely to contract HIV and other sexually transmitted diseases (Garcia-Moreno & Watts, 2011, p. 2; Sprague, Woollett, et al., 2016, p. 568; WHO, 2017). This can be contributed to victims not having decisional power in the use of preventative measures (Sprague et al., 2016, p. 574), which is especially critical if one considers the health impact of being HIV positive. Further, women affected by IPV decisions regarding the use of contraceptives, are typically subject to the perpetrator (Sprague et al. 2016:574). IPV accounts for about 80 million pregnancies globally each year, of which at least half are terminated through abortion. Half of these abortions take place in unsafe conditions (Garcia-Moreno et al., 2013, p. 23). Further, due to increased stress levels during pregnancy, women affected by IPV are sixteen percent more likely to give birth to a low birth weight baby or give birth prematurely (Garcia-Moreno et al. 2013, p. 7; WHO, 2011, p. 1) which places the unborn child at increased risk for disability and developmental delays.

The impact on a survivor's mental health of even a single incident of abuse cannot be underestimated. The adverse mental health effects persist long after any physical scars have healed. Prolonged exposure to stress causes permanent structural damage to the prefrontal cortex (Garcia-Moreno et al., 2013, p. 7). This influences cognitive functioning and mental health. Women affected by IPV may experience anxiety disorders, eating disorders, sleep disorders, and attempt suicide (WHO, 2017). They are twice as likely to experience depression (WHO, 2011, p. 8) and struggle with substance abuse in an attempt to manage the adverse outcomes of violence (Garcia-Moreno et al., 2013, p. 7; Garcia-Moreno & Watts, 2011, p. 2).

2.3.3.2 *Impact on Children*

Children who grow up in families where there is violence may suffer a range of behavioural and emotional disturbances (WHO, 2017, para. 14). They tend to have difficulties in their interpersonal relationships including friendships and future

intimate relationships (Callaghan, Alexander, Sixsmith, & Fellin, 2018, p. 1553). For example, they are more likely to become bullies or be bullied (Callaghan et al., 2018, p. 1553). IPV has also been associated with higher rates of infant and child mortality and morbidity, through, for example, diarrhoeal disease or malnutrition (WHO, 2017, para. 14).

2.3.3.3 *Impact on the Health Sector and the Economy*

IPV is a significant contributor to the burden of disease in South Africa (Joyner & Mash, 2014, p. 652). When the mortal and morbid effects of IPV are weighed, it is no surprise to find that women who experience IPV, make use of public healthcare services more often than women who are not exposed to abuse (Gass, Stein, Williams, & Seedat, 2010; WHO, 2013, p. 10). This has economic implications. The estimated economic impact of GBV in the year 2012/2013 is at least between R28.4 billion and R42.4 billion. This represents 0.9% to 1.3% of South Africa's Gross Domestic Product (KPMG Human and Social Services, 2014, p. 10). Evidently IPV should then be addressed as a public health priority (Garcia-Moreno & Watts, 2011, p. 2) by putting measures in place to prevent IPV and to ensure people affected by IPV receive the necessary services.

2.3.4 Response towards Intimate Partner Violence

The "domestic violence revolution" has only been in force as recently as the 1970's (Stark, 2007, p. 25). Violence against women, more especially IPV, is deeply rooted in the history of mankind. It is a sign of unequal power relations between men and women, resulting in men dominating women and men preventing women from fully advancing in and participating in society (UN, 1995, p. 49). The global response toward violence against women started when governing bodies started to identify and define the vague issue of injustices toward women.

The response was birthed with the UN's first world conference on women in 1975, in Mexico City (UN, 1975). At this conference, for the first time, governments were encouraged to become more aware of violence against women (UN, 1995, p. 78)

and to improve legislation that protects women against violence. Shortly after this, in 1979, a major milestone was achieved when the UN General Assembly adopted the Convention on the Elimination of All Form of Discrimination against Women (CEDAW) (UN, 1979). At this convention, “discrimination against women” was defined for the first time and CEDAW also legally obligated member states (of which South Africa was not part) to report on commitments to protect women against all forms of discrimination (UN, 1979; Sprague, Hatcher, Woollett & Black, 2017, p. 1593).

Post-1975, three more UN World Conferences on Women were hosted in 1980, 1985 and 1995. Concern regarding the welfare of black women and children in southern Africa under the discriminatory *apartheid* regime, featured on the agenda of all the UN conferences (UN, 1975, p. 75; UN, 1980, p. 108; UN, 1985, p. 60; UN, 1995, p. 9). Of special interest, the 1985 conference is described as the ‘birth of global feminism’ (UN, n.d.) and for the first time, shelters for victims of ‘gender-specific violence’ as well as victims of ‘family abuse’ and their children were recommended (UN, 1985, pp. 54,70). The fourth conference in 1995 (UN, 1995) was the first that South Africa was able to participate in after being suspended in 1974 from participation in UN affairs as a result of the apartheid regime (South African History Online, 2017, para. 42). This conference is a landmark in South Africa’s foundation for the response to violence against women that we know today. For the first time violence against women was recognised as a critical concern and a deep understanding of the cause, nature, and effects of violence against women was displayed (UN, 1995, p. 37). Also, “violence against women” as a form of GBV was defined and the term “domestic violence” was used and defined for the first time (UN 1995, p. 37). The conference produced the ‘Beijing Declaration and Platform for Action’ (UN, 1995, p. 3), a document that is described as “the most progressive blueprint ever for advancing women’s rights (UN Women, 2015, para. 2)”. In this declaration, member states of the UN committed to “eliminate all forms of violence against women and girls” amongst other items (UN, 1995, p. 4).

The second shift in the foundational response to IPV occurred when it was recognised as a government concern by global governing bodies. As recently as 2002, the WHO extended the evidence base on the topic of violence against women, when they released the first-ever ‘World Report against Violence and Health’. This highlighted the adverse effects of partner and sexual violence and emphasised the role of health systems in addressing IPV when victims seek treatment (Sprague, Hatcher, et al., 2016, p. 1594). Today the topic of IPV has been included in the United Nations Development Program (UNDP)’s Sustainable Developmental Goals (UNDP, 2016, p. 3). The fifth of the seventeen Sustainable Developmental Goals is aimed at achieving gender equality and empowering all women and girls. The prevalence of IPV is used as an indicator to measure progress in this regard (UNDP, 2016, p. 8). As a UN member state, South Africa is expected to comply to global recommendations and actively seek ways to eliminate all forms of violence against women. The only way to achieve success in this, is through a multi-sectoral response.

2.3.4.1 *Role of the legal sector*

IPV has become illegal in most countries. This resulted in well-defined responsibility of police and justice systems in response to complaints of domestic violence (Sprague, Hatcher, et al., 2016, p. 1594). WHO recommends that countries address GBV by enforcing legislation and policies that: end discrimination in marriage and divorce; end discrimination regarding ownership of assets; improve women’s access to earn an income through employment, as well as to develop and fund policies that address GBV (WHO, 2017 para. 20).

Nationally, in the past, the attitude of the South African government in addressing GBV has been protective in nature. The approach has been to caution women, through invoking a sense of fear, and advising against engagement in activities in certain places at certain times. Inherently, a “good woman” will adhere to these rules and be safe (Watson, 2015, p. 3). This patriarchal approach – partly a product of embedded patriarchal cultural values, as well as of a long history of slavery,

colonialism and apartheid (Thompson, 2001; Van Der Westhuizen, 2016, p. 7) - has been deeply ingrained in society, to the extent that it appears common sense that a woman should not walk alone in the streets at night.

Such an attitude, however, is ineffective, and from a discursive point of view, may perpetuate the normalisation (Foucault, 2000, p. 259) of GBV. The reality remains that the majority of GBV is inflicted by an intimate partner (WHO, 2012, p. 1) and violent acts against women are committed by perpetrators known to women, behind closed doors, within the safety of their own homes (Watson, 2015, p. 3). Therefore, despite a protective attitude towards women, IPV is a battle that many women have to fight on a daily basis. The South African government has acknowledged this issue in theory, and this reflects in legislation and subsequent policies.

The South African government has responded to the endemic of IPV by seeking to develop a legislative and policy framework aimed at combating GBV as well as IPV and supporting the victims thereof. These include (from Watson, 2015, p. 2):

- The Domestic Violence Act (Act No. 116, 1998)
- The Criminal Law Sexual Offences and Related Matters Amendment Act (Act No. 32, 2007);
- Firearms Control Act (Act No. 60, 2000);
- National Policy Guidelines on Victim Empowerment;
- National Instructions on Domestic Violence;
- National Policy Framework on the Management of Sexual Offences;
- National Instructions on Sexual Offences; and
- National Directives and Instruction on Conducting a Forensic Examination on Survivors of Sexual Offences in terms of the Criminal Law Sexual Offences and Related Matters Amendment Act (Act No. 32, 2007).

Documents that are of specific relevance to occupational therapists, especially those working in the government sector are: the National Policy Framework on the Management of Sexual Offences (Department of Justice and Constitutional

Development, 2012) and the National Policy Guidelines on Victim Empowerment (DSD, n.d., p. 2).

The National Policy Framework on the Management of Sexual Offences states that, amongst other departments, the Department of Health has the responsibility to refer victims of GBV to appropriate psycho-social services (Department of Justice and Constitutional Development 2012, p. 33). Despite occupational therapists not being specifically mentioned as stakeholders, this policy has implications for occupational therapists working in the public health sector, because occupational therapists are well equipped to play a role and therefore should form part of the team that offers psycho-social services to these victims. This is especially relevant given a renewed focus by government, as discussed in the ANC Policy Conference, to "strengthen the capacity of rehabilitation services in the public sector with a focus on ... gender-based violence" (African National Congress, 2017, p. 23).

Regarding the National Policy Guidelines on Victim Empowerment (National DSD n.d., p. 33), in its essence, it resounds with occupational therapy. Considering the effects of violence on a victim, victim empowerment speaks of person-centred, holistic support for victims through a range of integrated multi-disciplinary services that aim to restore victims to "a state as close as possible to that existing prior to the offence and ideally to a state where the person has been able to learn and grow (National DSD, n.d., p. 33)". Victim empowerment transitions from policy to practice through victim empowerment programmes (VEPs), which provide support services to victims. One way in which VEPs are implemented, is through the provision of shelter services for victims of abuse.

2.3.4.2 *Role of the social sector*

Globally, many non-governmental welfare associations exist that support and provide shelter for women away from abuse (Sprague, Hatcher, et al., 2016, p. 1594). WHO (2013, p. 13) recommends that this support is built around "women-centred care" based on the fact that each victim of IPV has had different experiences

and will therefore need different interventions. This resounds with person-centredness and client-centredness that occupational therapists are familiar with. As Creek, Ilott, Cook and Munday (2005, p. 283) explain, “Occupational therapy is ideally client centred, comprising an active partnership between the therapist and the client.”

Further, the WHO (2017, paras. 16–17) found that in high-income countries counselling and advocacy services to survivors of IPV reduce future violence. In low-income countries, this may not be feasible. However, the WHO found that prevention strategies such as, empowering women through skills training, promoting communication skills with couples and communities, as well as challenging harmful gender norms through group training and critical reflections on gender and power, show promising results in reducing violence.

In South Africa, the National Policy Guidelines on Victim Empowerment (National DSD, n.d., p. 33) place the responsibility for responding to IPV in the hands of the DSD. Thereby all shelters are expected to be registered with the DSD. Shelters provide temporary accommodation and food for women and children who have left their abusive partners. All shelters need to comply with the National DSD’s Minimum Standards on Shelters (National DSD, 2001). A well-funded and well-managed shelter includes counselling, support groups and recreational activities. Shelters also assist women with their legal needs, accessing healthcare and finding employment (Lopes, 2016, p. 2).

2.3.4.3 *Role of the Health Sector*

WHO (2013, p. 10) states that “health-care providers are in a unique position to create a safe and confidential environment for facilitating disclosure of violence, while offering appropriate support and referral to other resources and service providers.” The healthcare sector is therefore seen as a potential gateway for victims to be referred to services such as legal aid and social welfare (WHO, 2013, p. 11). However, much controversy exists regarding the role of the health sector and the

role of healthcare professionals in screening for and responding to IPV abuse (Sprague, Hatcher, et al., 2016, p. 1594). Thereby, although it is accepted that IPV is a critical public health issue, many countries have not included it in healthcare policies (WHO, 2013, p. 10).

The controversy regarding the role of healthcare professionals in screening for IPV, is largely centred around the benefit versus the risk to patients when they leave clinical settings to go home (Sprague, Hatcher, et al., 2016, p. 1594). Organisations such as the United States Preventative Service Task Force (USPSTF) have recognised that the benefit of screening for IPV in the United States of America outweighs the risk. In 2013, they were the first organisation ever to recommend that clinicians screen all women of child-bearing age for IPV, even if they do not have any visible signs of abuse. This is done to ensure that women can be provided with or referred to appropriate intervention services (Swailes, Lehman, & McCall-Hosenfeld, 2017, p. 215). In contrast, the WHO does not recommend universal screening for IPV at healthcare settings, especially in low-income countries who do not have the resources to refer and manage people affected by IPV. The WHO recommends that the focus rather be on training clinicians on IPV to respond and refer appropriately if IPV is disclosed to the clinician as part of their clinical inquiry. Despite these recommendations, the role of the healthcare provider in 'asking' or screening for IPV remains a topic of controversy.

In South Africa, there are no guidelines or protocols available for healthcare providers for the screening and management of IPV or any other type of violence which are being implemented in all the provinces (Joyner & Mash, 2012a, p. 4). This is problematic, because due to the adverse health effects of IPV, healthcare practioners do encounter and are forced to repond to IPV. Due to the lack of guidelines, the care for people affected by IPV is at risk of being fragmented, discontinuous, and uncoordinated (Joyner & Mash, 2012a, p. 4). In reponse to these problems Joyner and Mash (2012a) performed action research to develop a model for comprehensive and intersectoral care of people affected by IPV that is to be

piloted in the Western Cape province. Although the model was developed before the release of the WHO guidelines for responding to IPV (2013), it does comply to the recommendations. In short, the model asks of a healthcare practitioner to ask a woman that presents with specific cues “Are you happy in your relationship?” If the answer is yes, the health practitioner performs a clinical examination and then refers the woman to an IPV champion to co-ordinate psychological, social, and legal services within a personal empowerment group. This champion should be specially trained and available at each healthcare facility. The IPV survivor is eventually discharged to a community-based support group. At the time of this writing, the outcome of piloting the model was not yet published.

Gordon (2016) also recognises the need for all healthcare professionals to be equipped to respond to IPV. She developed six practical steps in identifying and managing IPV. They are in summary, the six Rs (Gordon, 2016, p. 1): “Realise that abuse is happening (be aware of cues); Recognise and acknowledge the patient’s concerns; Relevant clinical assessment; Risk assessment; cRisis plan; and Refer as needed for medical, social, psychological, and/or legal assistance.”

Sprague, Hatcher, Woollett and Black (2017) also became aware of the lack of the Department of Health’s guidelines and sought to explore how and why nurses in Johannesburg, Gauteng respond to IPV, despite the lack of guidelines. They found that their responses were uniform despite the nurses lacking training on IPV and clinical guidelines. If they suspected IPV, nurses would probe to ascertain abuse, treat injuries, and refer to social workers. Interestingly, this process is similar to that of Joyner and Mash (2012a) in viewing the social worker as the IPV champion. However, the difficulty arises that this process is informal, and thereby compliance to the process is not required. The implication of this has two aspects. Firstly, the nurses may not have institutional support with implications of funding, training, and job descriptions. Secondly, patients (who are people affected by IPV) may not get the same type of care. Their care would depend on the experience of the nurse

assisting them and whether they have figured out the informal, organic system of managing IPV.

These studies have shown the effect of the lack of guidelines to respond to IPV. Healthcare professionals have seen the need to repond to IPV and have attempted to develop structures that can be used to ensure that people affected by IPV obtain the care that they require. Each approach has its own merit, however, the three studies clearly show that the responses differ and are un-coordinated. Considering the prevalence of IPV in South Africa, the implementation of guidelines to manage IPV at healthcare settings in South Africa is crucial.

2.4 Intimate partner violence in occupational therapy literature

As far as could be established in South African occupational therapy literature, specifically (using the search engines mentioned in Chapter 1 (cf. 1.8), no publications relating to domestic violence or IPV could be found. Therefore, it seems the profession is collectively silent on this prevalent issue. Internationally, literature from an occupational therapy perspective regarding IPV and/or domestic violence is limited.

Helfrich is one of the first authors to publish on the topic of domestic violence in occupational therapy literature (Helfrich, 2001; Helfrich & Aviles, 2001). Hefrich and Aviles (2001) comprehensively describe the role of the occupational therapist in assessing and treating people affected by IPV in the United States of America (USA). Along with other assessment tools they recommend using The Model of Human Occupation Applied to Domestic Violence (Helfrich & Aviles, 2001, p. 58) as an assessment tool for determining the safety of the patient. They then describe five levels of intervention which are respectively, report, referral, direct treatment, indirect services and program consultation.

It is well supported in literature that occupational therapists are highly likely to come into contact with people affected by IPV (Helfrich & Aviles, 2001, p. 54; Javaherian, Krabacher, Andriacco, & German, 2007, p. 39; Javaherian, Underwood, & DeLany,

2007, p. 705). Javaherian, Underwood, et al (2007) support this argument with a series of case studies. The case studies show that occupational therapists came across victims of intimate partner violence in a variety of settings, namely: at a shelter for survivors of domestic violence (Javaherian, Underwood, et al., 2007, p. 707), in a physical rehabilitation setting where the patient was 'falling' a lot and had an increasing number of bruises on their arm (Javaherian, Underwood, et al., 2007, p. 707) ; in school-based setting where a teenager was being physically abused and her behaviours were being controlled by her boyfriend (Javaherian, Underwood, et al., 2007, p. 708); in an early childhood intervention service for infants with developmental delays, a mother had difficulty stimulating her child as the abusive father did not want the child to play (he said the child was being noisy) as well as at a diabetic clinic where a patient was non-compliant with her medication because of her difficulty coping in general after leaving an abusive relationship (Javaherian, Underwood, et al., 2007, p. 708). Although it is clear from literature that occupational therapist are likely to encounter women affected by IPV, there is a gap in literature for quantitative data to determine the frequency and/or likelihood of occupational therapist to encounter people affected by IPV in their practice settings.

Literature also supports that occupational therapists have the skill set to intervene with people affected by IPV. Indeed, Hefrich and Aviles (2001, p. 66) argue that ethically it should be standard practice for occupational therapists to intervene. Javaherian et al. (2007, p. 705) found that survivors of IPV may have difficulty with cognitive functioning and in areas of occupation, especially work performance, education, home management, money management, task initiation, child-rearing, participation in recreation, coping skills, stress management and interpersonal relationships.. In this statement piece to define the role of occupational therapy in domestic violence, they state that occupational therapists are competent to use their training to work with the victim and the abuser to facilitate engagement in daily activities and achieve role competence and healthy lifestyles (Javaherian, Underwood, et al., 2007, p. 706). This supports the work of Gorde, Helfrich and Finlayson (2004) which explored the life skill needs of domestic violence victims.

Humbert et al.(2014, p. 378) also performed a study in the USA and found that women hoped to regain independence following IPV and are concerned about unemployment and homelessness. They support that occupational therapists have the skills needed to intervene in this population group. (Humbert et al., 2014, p. 378). However, at the time of writing this, I did not come across published literature that describes the impact of occupational therapy intervention with people affected by IPV.

In the light of the knowledge that occupational therapists encounter people affected by IPV and are well equipped to intervene, Johnston, Adams and Helfrich (2008) performed a study among occupational therapists from the USA to determine if occupational therapists have the knowledge to identify people affected by IPV. They found that although occupational therapists have an empathetic attitude toward wife abuse, they lacked the knowledge to identify it (Johnston et al., 2008, p. 45). Lack of knowledge on the topic of IPV is prevalent among South African health professionals across all disciplines (Gordon, 2016, p. 1). Despite the high prevalence of IPV in South Africa, and the fact that people affected by IPV approach health settings for help most undergraduate curricula do not equip students to be conversant and competent on the issue of IPV (Gordon, 2016, p. 1).

With the evolving discourse in literature on the topic of violence and occupational therapy there is a need to look at the effects of IPV from an occupational perspective. Smith and Hilton (2008) published the first article that described abuse and violence through a lens of occupational risk factors. Their focus was on women with disabilities experiencing IPV and they argue that they are especially at risk of experiencing occupational injustices. In doing so they provide a different perspective of abuse. They suggest empowerment as appropriate mechanism to address injustice in this population(Smith & Hilton, 2008, p. 70). They, however did not use or refer to qualitative research, where people describe their experiences, to describe the manner in which people affected by IPV experience occupational risk factors and the effect of this on their wellbeing. Twinley and Addidle (2012) also identified this

gap in literature. In an opinion piece they recommend that research need to be done to understand the effect of violence upon an individual and their wellbeing (Twinley & Addidle, 2012, p. 204).

Most recently, Waldman-Levi, Bundy and Katz (2015) performed a study at a shelter to determine the relationship between children's playfulness and their mothers exposure to domestic violence. This study is the first to use research from an occupational therapy perspective to show that domestic violence impacts the occupations of victims as well as their families. However, the study did not provide any information related to occupational justice.

The MOHO (cf. 2.2.3) is an example of how occupational therapists are expected to consider the entire person and their contexts in their assessments. The relational contexts of women clearly play a significant role on their occupational well-being (cf. 2.2.4.1 – 2.2.4.4). Considering that occupational therapy was introduced to South Africa admits major power struggles including apartheid, colonialism and feminist movements (cf. 2.2.1) and people in South Africa are subject to some of the highest rates of violence against women globally, it is likely that occupational therapists are desensitised to violence and blinded to the issue of IPV thereby unknowingly perpetrating occupational injustice. It is crucial to intervene in the culture of violence against women in South Africa by bringing the topic of IPV to light and equipping occupational therapists to respond appropriately in the inevitable case that they are confronted with the issue.

2.5 Occupational therapy for people affected by intimate partner violence

To successfully intervene in IPV we need to consider and address the full complexity of the roots of violence (cf. 2.3.2). In this sub-section, I will use the Ecological Model for understanding violence from (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002, p. 12), to describe the recommended occupational therapy interventions.

At an individual and relationship level, occupational therapists are trained to use activities to enable clients and achieve therapeutic goals that contribute to life skills development (Wilcock, 2006, p. 1; World Federation of Occupational Therapists, 2013). These life skills involve learning to take care and develop one's self and include self-esteem, self-assertiveness, communication, conflict management, decision making, stress management, household management and financial planning (Gorde et al., 2004, pp. 704–705; Helfrich, 2001, p. 2; Khumisi et al., 2015, p. 379).Occupational therapists can thereby comfortably form part of skills training programs at women's shelters or as part of victim empowerment programmes.

At a community level, work is an area of occupation that is of notable importance. Being unable to sustain themselves and their children is one of the reasons why women do not leave an abusive partner (Helfrich & Rivera, 2006, p. 35; Sprague, Woollett, et al., 2016, p. 174). When victims leave their abusive partner, they must become economically independent. Inability to be economically independent results in these women either remaining in such abusive relationships or prolonged reliance on assistance from shelters (Helfrich & Rivera, 2006, p. 35). Occupational therapists can play a crucial role here by equipping victims with pre-vocational skills and work habits. These skills include, setting up a curriculum vitae, finding a job, interview skills, exploring entrepreneurial opportunities (Gorde et al., 2004, p. 703; Helfrich & Rivera, 2006, p. 42).

At a societal level we seek to address the patriarchy and power imbalances prevalent in IPV. This is closely related to occupational risk factors, especially occupational marginalization. There is not literature available explaining from an occupational perspective, how people affected by IPV experience these risk factors. This indicates a gap in knowledge that needs to be addressed for occupational therapist to assume their responsibility toward people affected by IPV.

2.6 Conclusion

It appears that occupational therapy as a profession has been unresponsive in its responsibility toward victims of IPV. The profession of occupational therapy has deep origins in the care and rehabilitation of casualties following the two world wars. In those times, occupational therapy gained recognition as a profession in its unique ability to use occupation in providing solutions to restore individuals and communities. Koch (2001, p. 100) uses this example to illustrate how the occupational therapy profession has neglected the casualties of the war that battered women - victims of GBV and IPV - have been silently fighting for decades. As Townsend and Wilcock (2004, p. 84) explain “occupational therapists can choose to either advocate consciously with others for justice, or comply with occupational injustices through silence and inaction.”

The mortal and morbid effects of IPV, as well as its prevalence, have been well described through research. Resultantly the needs of people affected by IPV are finally being recognised globally and in South Africa. This is reflected in the increased attention that victims of GBV are receiving in national policies (DSD, n.d.; Department of Justice and Constitutional Development, 2012, p. 33). On the contrary however, the same response is not reflected in occupational therapy literature. In South Africa specifically, no literature is available regarding occupational therapy and GBV. This evident gap in the literature sounds the need for exploratory research to be done in this field. Such research can form part of the foundation for occupational therapists to act as agents of change by formulating a relevant response to the needs of those third of women who have been affected by IPV (WHO, 2011, p. 1). As stated by Garcia-Moreno et al. in a publication for WHO (2013, p. 3) “It is time for the world to take action: a life free of violence is a basic human right, one that every woman, man and child deserves.”

Chapter 3: Research Methods

3.1 Introduction

Chapter 1 provided a rationale and purpose for the research. This chapter discusses the methodology, with regards to the research paradigm, methods of enquiry, and ethical considerations, that was utilised in this study to answer the following research aim and objectives:

Research Aim

To identify and describe how victims of IPV, who reside at women's shelters in Gauteng, experience, and adapt to occupational risk factors.

Research Objectives

- To identify and describe how victims of IPV who reside at women's shelters experience and adapt to occupational imbalance.
- To identify and describe how victims of IPV who reside at women's shelters experience and adapt to occupational alienation.
- To identify and describe how victims of IPV who reside at women's shelters experience and adapt to occupational deprivation.
- To identify and describe how victims of IPV who reside at women's shelters experience and adapt to occupational marginalisation.

3.2 Philosophical assumptions (Paradigms)

The aim of this section is to clarify the fundamental ideas and beliefs that guided decision making throughout the research process, thereby providing an interpretive framework. The study is positioned in the constructivist as well as the feminist paradigms. Denzin and Lincoln (2018c) explained, "The open-ended nature of the qualitative research project leads to a perpetual resistance against attempts to impose a single, umbrella-like paradigm over the entire project." Initially, it was

attempted to position this study solely within the constructivist paradigm, however, as the study progressed, it was realised that the constructivist paradigm alone did not do justice to the vulnerable and marginalised population included in the study. It was found that the aim of the research (cf. 3.1) resounds strongly with the feminist paradigm. There is no definitive agreement amongst qualitative researchers on whether philosophical assumptions can change over time and whether multiple assumptions can be used. Creswell and Poth (2018, p. 19) suggest that changing and multiple philosophies are acceptable. It was decided not to impose a single paradigm over this study. Consequently, the ideas espoused by both the constructivist and feminist paradigms will be discussed to demonstrate how a constructivist and feminist stance shaped the research.

3.2.1 Positioning within the constructivist and feminist paradigms

The organisation of research paradigms differs in literary sources. However, in the sources consulted, the organisation is somewhat universal in that paradigms are explained in light of the evolution of scientific enquiry (Creswell & Creswell, 2018, p. 46; Merriam & Tisdell, 2016, p. 9; Taylor & Kielhofner, 2017, pp. 25–33). The constructivist paradigm evolved after the positivist paradigm as researchers started to acknowledge that the goal for a scientific inquiry could also be to understand and explain phenomena rather than to prove it (Creswell & Poth, 2018, p. 66). Paradigms remain ever evolving, and a growing need has developed for research to challenge ways of thinking and to focus on conditions in this world today. This paradigm shift is referred to as postmodernism or a transformative approach (Creswell & Poth, 2018, p. 69). Feminist research is therefore part of a postmodern/transformative approach and focuses on injustices and power imbalances that women face (Creswell & Poth, 2018, p. 74).

The study aim (cf. 1.4.1) lends itself to both the constructivist[13] and feminist paradigms. The constructivist approach is appropriate because to truly understand the experience of the participants I should rely as much as possible on the participants, view and interpretation of a situation (Creswell & Poth, 2018, p. 67). The feminist paradigm is also appropriate because the study aims to address injustices surrounding marginalised and vulnerable women who have been victims of IPV. Further, the purpose of the research is not focused on action and a solution to the problem, as would be the case with pragmatism (Creswell & Poth, 2018, p. 72), however dissemination of the results will lead to increased discourse on the topic of IPV and justice within a profession that has been mostly silent on the matter (cf. 1.5).

3.2.2 Ontology, epistemology and axiology

Constructivism has a relativist ontology (Creswell & Poth, 2018, p. 86; Denzin & Lincoln, 2018a) which acknowledges that multiple realities exist due to subjective experience. Feminism holds that reality is based on power and identity struggles (Creswell & Poth, 2018, p. 87). Through exploring the realities of victims of IPV, the aim of this study is to provide insight into how victims of IPV navigate struggles related to occupational injustice, power, and identity.

The constructivist paradigm has a subjective epistemology (Creswell & Poth, 2018, p. 86; Denzin & Lincoln, 2018a). The researchers will, therefore, want to minimise the 'objective separateness' between themselves and the participants to understand their context. The implications are that study design and methods have to permit a level subjectivity that will allow the researcher to understand the experiences of the participants deeply. Feminism, on the other hand, assumes that knowledge about the situation of women is generated through studying social structures related

[13] The constructivist paradigm and interpretivist paradigm are typically discussed in conjunction and the terms are used interchangeably (Creswell & Poth, 2018, p. 67; Merriam & Tisdell, 2016, p. 9). In this study I will use the term constructivism.

explicitly to freedom and oppression as well as power, and control (Creswell & Poth, 2018, p. 87). The implications are that in this study knowledge will be generated through a subjective interaction with women affected by IPV, regarding their struggles related to issues of occupational injustice.

Constructivism leans toward `balanced axiology'[14] (Kivunja & Kuyini, 2017, p. 34) which means that the researcher will provide a balanced report of the findings and also reflect the values of the researcher. In constructivism, the researchers' values are primarily informed by the ethical codes required of them (Denzin & Lincoln, 2018b, p. 196). The axiology of feminism respects cultural norms (Kivunja & Kuyini, 2017, p. 35). The axiological stance adopted for this study guided ethical decision-making with particular regard for the vulnerable population that was being dealt with (cf. 3.4).

3.2.3 Positionality as a researcher

In the epistemology of the constructivist paradigm (cf. 3.2.2) is subjective in nature. To enhance rigor (cf. 3.3.8) it is necessary to clarify my background and biases. I am a female that has never experienced or been exposed to IPV or other forms of GBV. Living in South Africa, I have unavoidably been exposed to violence and GBV however, the neighborhoods that I live in were not known for violence. Before this research I was admittedly ignorant to the prevalence and severity of GBV and specifically IPV. Further, being white and from a comfortable socio-economic background, I have privileges which I take for granted that people-of-colour or impoverished people may not have. However, I was unaware of the concept of male-privilege and the effect that patriarchal mind-sets have on society.

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[14] Axiology refers to the role of values in research and directly influences the ethical context of the research and moral principles or values that inform the research process in the given paradigm (Creswell & Poth, 2018, p. 63)

Engaging in this research made me cognisant of several biases that I had to confront. Of relevance to the study is that I realised that I was being critical of how some of the participants were managing their recovery. Upon reflection I found that was guilty of victim-blaming (cf. 4.2.1.2). Second, I realised that as a health-care provider I was ignorant of the complexities of IPV and how to respond appropriately. As I reflected in the Preface, engaging in this study has enabled me to confront my ignorance and biases. However, the interpretation of the results remains subjective and may reflect my changing perspectives as well as remaining biases that I am unconscious of. Strategies were employed to limit the subjective effect of my perspectives and biases on the interpretation of the results (cf. 3.3.8.2).

3.3 Method of enquiry

This section discusses the method of enquiry into the research question (cf. 1.3) with regards to the study design, research context, research population, exploratory research, data collection, data management, data analysis, and finally strategies to enhance rigour.

3.3.1 Study design

This study was approached qualitatively using principles of transcendental phemenological design where the researcher describes ‘what’ and ‘how’ particpants experienced a phenomenon. Qualitative methods are predominant in the constructivist paradigm. In other studies related to IPV, (Garnweidner-Holme, Lukasse, Solheim, & Henriksen, 2017; Joyner & Mash, 2014; Ruark, Stern, Dlamini-Simelane, & Kakuze, 2017; Thaggard & Montayre, 2019; Vella, Miller, Lambert, & Morgan, 2017), a qualitative design proved valuable in understanding the context of victims of IPV. In this study the lived experiences of individuals affected by IPV were described in terms of how they experienced occupational injustice while in the abusive relationship and how they experienced those injustices. This allowed the building of a detailed, rich description of the particpants’ experience of IPV and then the interpreting of it (Merriam & Tisdell, 2016, p. 17).

3.3.2 Research context

Describing the context of the research contributes to rigour regarding transferability (cf. 3.3.8). At the time of performing the interviews there were twenty-six shelters registered with Gauteng DSD. The study was executed at women's shelters in one of the districts of Gauteng province in South Africa, which at the time of performing the interviews had seven registered shelters[15]. The district was purposefully selected by convenience sampling (Creswell & Poth, 2018, p. 272) to contribute to the feasibility of the study. A detailed description of the area cannot be shared to protect the women residing at these shelters. This level of confidentiality is recommended by WHO (2001, p. 10) which explains that when people participate in research where they expose the details of the violence they are exposed to, they are put at risk of severe harm and potentially life-threatening danger if the abusers had to find out about their participation.

In South Africa, shelters resort under the Department of Social Development. All women's shelters in Gauteng have high-security levels with private locations and restricted access, because of a variety of vulnerable women at these shelters, including victims of abuse and human trafficking. Such shelters provide temporary accommodation and food for women and their children, who have left their abusive partners. The department requires that victims who reside in shelters form part of victim empowerment programmes (cf. 2.3.4). These programmes are typically run by social workers at the shelters and include counselling, support groups, and recreational activities. Shelters also assist women with their legal needs, accessing health care, and finding employment.

Women are typically brought to the shelter through social workers, although there are cases where a victim contacts the shelter or is dropped off by a community

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[15] Information on the number of shelters in Gauteng is based on a resource list sent to the researcher by a contact person at Gauteng DSD in the year 2017.

member. The latter, however, occurs seldom, as only 9% of South African households know how to access shelters or places of safety for abused women (Stats SA, 2018, p. 14). Upon arrival at the shelter, a woman's situation is assessed by a social worker to ensure that she is suitable for the shelter. Women typically stay at the shelters for three to six months; however, depending on their situations, this can be extended for up to twelve years. The latter is typically the case if there are school-going children involved (Rafferty, 2017). From my observations of the shelters when performing the interviews, the setup varies from shelter to shelter. All of the shelters had shared bathrooms, kitchens and living areas however at some shelters bedrooms were shared while at other shelters residents had

3.3.3 Study population and sampling

The study population was drawn from the research context described above using criterion sampling as a strategy for purposive sampling (Creswell & Poth, 2018, p. 273; Etikan et al., 2016). Purposive sampling is used in qualitative research because participants need to provide information about their experience of IPV (Merriam & Tisdell, 2016, p. 26).

3.3.3.1 Eligibility Criteria

The eligibility criteria were set to ensure that the data gathered from participants will sufficiently inform the study. Considering the axiology of constructivism (cf. 3.2.1), legal and ethical considerations were also incorporated into the criteria. To participate in the study, the participants had to meet the following requirements:

- Participants should have had a history of being a victim of IPV (see Glossary). The time that elapsed since the victim had left the relationship was not considered.
- Participants should be residing in a women's shelter within the selected district of Gauteng.
- Participants should be over the age of eighteen years to have the legal capacity to consent (Health Professions Council of South Africa, 2008, p. 8).

Participants should have the decisional capacity, according to the participants' assigned social worker[16] to provide consent (Health Professions Council of South Africa, 2008, p. 7; Nienaber, 2010, p. 120).

- Participants should be orally competent in either Afrikaans or English to communicate with the interviewer. The researcher included this criterion to minimise the costs involved in hiring an interpreter for conducting the interview, as well as transcribing and translating the interview.

3.3.3.2 Research participants

This research study aimed to include ten to twelve participants, as literature suggests that this number would be sufficient for data saturation. Permission was required to access the participants. Firstly, I approached the Gauteng DSD for permission to access the shelters and then approached the managers of the shelters to access the women residing at those shelters (cf. Appendix A). Of the seven shelters in the selected district, six shelters were successfully contacted, of which four shelters consented that the researcher could recruit participants from those shelters.

Participants were approached in one of two ways. The researched conducted a field visit to explain the research to all the women staying at the shelter according to the participant information sheet (see Appendix C) before asking the women who met the inclusion criteria to participate. Alternatively, the social workers would identify women who meet the eligibility criteria and explain the research according to the participant information sheet before asking them if they will consent to participate in the study. Recruiting of participants continued until twelve participants had agreed. One participant withdrew. Data saturation was reached after about eight interviews

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[16] Each woman making use of shelter services has a social worker assigned to her case. This criterion was made known to the managers of the shelter before participants were recruited (cf. Appendix A).

and it was decided that the remaining eleven participants would be sufficient to obtain the necessary data.

3.3.4 Exploratory study

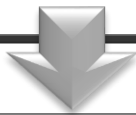
An exploratory study was conducted with the first participant that was recruited (cf. 3.3.3.2). The participant voluntarily gave informed consent to participate, and the exploratory study (typically referred to as 'pilot study' in quantitative studies) was conducted according to the data collection methods described in the next section (cf. 3.3.6). The exploratory study was successful as it confirmed that the eligibility critera for participants and the data collection methods used were suitable to address the research question and also provided information regarding the time needed to complete the different aspects of the data generation. Additionally, it provided the opportunity to gain feedback on and reflect on the researcher's interviewing technique (Merriam & Tisdell, 2016, p. 117). No methodological changes were made, and the data generated during the exploratory study was used to inform the final results.

3.3.5 Data collection

Three methods, namely a demographic questionnaire, a prompted collage technique, and unstructured interviews, were used to collect data about the participants in a two-part process. Figure 3-1 summarises the research procedure and also indicates where data collection fits in the research process. Data was collected over two contact sessions. The first session involved gaining informed consent and demographic information from the participants followed by a prompted collage technique related to their experiences of IPV. The second contact session involved conducting individual interviews with each participant. The following are the details of each contact session:

a) Obtain permission to conduct the study.		
Obtain ethical approval from UFS Faculty of Health Science Ethical committee.	Obtain permission from the Gauteng DSD to execute the study at women's shelters.	Obtain written permission from the managers of all participating shelters.

b) Conduct an exploratory study.		
Recruit a participant for exploratory study.	Contact session 1: • Obtain written informed consent. • The pilot participant completes a demographic questionnaire. • The participant makes a collage.	Contact session 2: • Conduct an unstructured, open-ended interview with the pilot participant. • Obtain feedback from the pilot participant.



c) Data Collection.		
Recruit participants from participating shelters.	Contact session 1: • Obtain written informed consent. • The participant completes the demographic questionnaire • The participant makes a collage	Contact session 2: • Conduct unstructured, open-ended, individual interviews with the participants.

d) Transcribe all interviews.

e) Analyse the data with two co-coders and organise codes into categories and themes.

f) Interpret the data through triangulation with literature, making deductions and drawing conclusions.

Figure 3-1. **Summary of the actions and responsibilities of the researcher in the research process.**

3.3.5.1 *First Contact Session*

a) Location

I arranged with the shelter management to meet with all the interested participants as a group. The meeting took place in the recreation or dining rooms of the various shelters. Non-participating residents were asked to refrain from entering the communal area for the duration of this contact session.

b) Informed consent

I informed the participants of the study purpose verbally and in writing. The written information was available in English and Afrikaans, however all the participants preferred information in English. If participants were willing to participate, I secured written consent before proceeding with data collection (see Appendix C).

c) Demographic Questionnaire

Participants then proceeded to complete a demographic questionnaire (see Appendix D). This allowed me to describe the participants thereby contributing to transferability (cf. 3.3.8.2). The questionnaire was available in English and Afrikaans; however all the participants chose to complete the questionnaire in English.

d) Collage Technique

The Association for Qualitative Research (2013, p. 1) articulates the value of using the collage technique as the "enforced move away from the verbal helps to access intuitive knowledge and may allow access to non-verbal aspects of the topic that would otherwise remain unarticulated and thus open them up to discussion".

The participants had the choice of completing the collage individually or in a group setting with other participants from the same shelter. Although the collage

was not interpreted as a data source[17], it had a dual purpose as a presentation method (Merriam & Tisdell, 2016, p. 65). Firstly, it allowed the participants to prepare themselves mentally and emotionally for an interview in which they will have to recall trauma. Secondly, the collage also provided the participants with a visual aid that they can refer to during the interview. This preparation and use of art-based visual aids are supported by the research paradigm, as it enables participants to better share their reality by giving them the opportunity to use symbols and metaphors (Merriam & Tisdell, 2016, p. 65).

The participants were then briefed on the instructions for the collage technique. I explained the purpose of the collage and instructed them, in lay language, as survivors of IPV, to visually represent their experience of occupational balance, occupational alienation, occupational deprivation, occupational marginalisation, and their hopes for the future (The outline of the participant briefing for the collage is available in Appendix E.). I selected these topics for the collage to align data collected with the research aims (cf. 1.4).

The participants were provided with all the resources required to make their collage. The collage was made in a group set-up with other participants from the same shelter with the researcher present. This setup enhanced universality. Participants were able to selectively choose if they would want to share their experiences with each other and this allowed the participants to be more comfortable with the research set-up.

[17] As part of the master's study programme, the research proposal is submitted to a panel of experts for revision before it is submitted to the research ethics committee which consists of people experienced in academic research. The research committee determined that interpreting the collage as a data source would be outside of the scope of the requirements for a master's degree.

3.3.5.2 *Second contact session: interview*

Following the initial contact session, I scheduled an interview with each of the participants within three to ten days. These individual, unstructured interviews were the primary source of data.

Regarding the location of the interview, the managers of the shelter were asked to provide a private area for the participant and researcher to sit comfortably and be uninterrupted for the duration of the interview. It was also requested that the shelter provide a social worker for debriefing the participants if needed. At all the shelters, the managers affirmed that the social worker assigned to the participant's case would be available for debriefing. Counselling sessions with a social worker were part of the victim empowerment programme at all the shelters and some of the participants reported speaking to their social workers about the research, between the first and second contact sessions.

When conducting the interview, the scheme in Appendix F was used to guide the interview, together with the collage as point of departure. Great care was taken in preparing the participants for the interview, because the researcher was cognisant that she was asking the participants to reflect on a traumatic topic. The researcher engaged the participants in friendly small talk to find commonality, and to decrease potential anxieties. The researcher then re-affirmed consent by reiterating the purpose of the study with the participants, that participation was voluntary, that the interview will be recorded, and that the researcher would de-identify all information before sharing it to maintain confidentially.

Following this the partcipant was asked for permission to start recording the interview. All interviews were voice-recorded as this method provides a reliable verbatim record. I opened with a version of the following open-ended introductory instructions:

I want you to tell me your story, and I want you to tell me about the collage that you made. You can do it in any order that you prefer.

As the participant led the interview, this was followed with probes. The following techniques were applied to achieve quality interviews (Merriam & Tisdell, 2016, p. 122; Nieuwenhuis, 2007, p. 88): using open-ended questions, using detail orientated probes, asking for elaboration, clarification (through paraphrasing), and allowing for silence. Throughout the interview, observations of non-verbal behaviours and notes on when the participants referred to their collages, were made on the template provided in Appendix G. The researcher reflected on the field notes and added observations only after concluding the interview so as not to disturb the participant.

Upon concluding the interview, the participants were asked to share what they would want people to know about IPV. All the participants shared something; most of which related to a strong desire to raise awareness of IPV in communities and to let women know, who are in abusive relationships, that their situations are not acceptable. When the participants indicated that they were finished, they were thanked and reminded that a social worker was available for debriefing, before explaining the research process that will follow.

The interviews were scheduled to be ninety minutes, and most were completed in approximately sixty minutes. The duration of the shortest interview was fifty-three minutes, and the longest interview was 113 minutes.

3.3.6 Data management

Following the interview, the data had to be managed to ensure that it stays safe and to prepare it for interpretation. Within twenty-four hours after each interview, the voice recordings from the voice-recorders were transferred to a computer and the original records deleted from the voice recorders. The researcher also created a backed-up copy of the voice recordings to minimise the risk of losing data. All recordings were saved using only the participant's number, and the researcher alone had access to the voice recordings.

Verbatim transcriptions of the voice recordings were done by the researcher and an independent professional transcriber, within six weeks of completing the interviews. The transcriber received voice-recordings of the interviews on an external storage device, and the verbatim transcriptions were returned to the researcher on the same external storage device. The independent transcriber did not keep a copy of the interviews or the transcriptions as per professional ethos. Upon completion of all the transcriptions, the researcher checked the content on the transcriptions by reading the written transcription, while listening to the voice recordings. The researcher also de-identified the transcriptions by substituting the names of person's and places with a general descriptor for example [BOYFRIEND] or [DAUGTHTER] and [TOWN] or [CITY]. At this point, field notes relevant to data analysis were added to the transcriptions. The eleven de-identified verbatim transcriptions were then given to two co-coders for data analysis.

3.3.7 Data analysis

This section describes the process used in analysing the data to develop the research results. Each interview was considered as a data set. Therefore, the eleven interviews resulted in eleven data sets. The researcher and two co-coders independently, manually analysed the data. Both the co-coders were senior occupational therapists associated with an educational higher institution and with post-graduate experience in qualitative data analysis. To ensure uniformity, the process used in coding was discussed with the co-coders. The five part process was informed by Creswell and Poth (2018, p. 183) and it is summarised in the diagram in Figure 3-2.

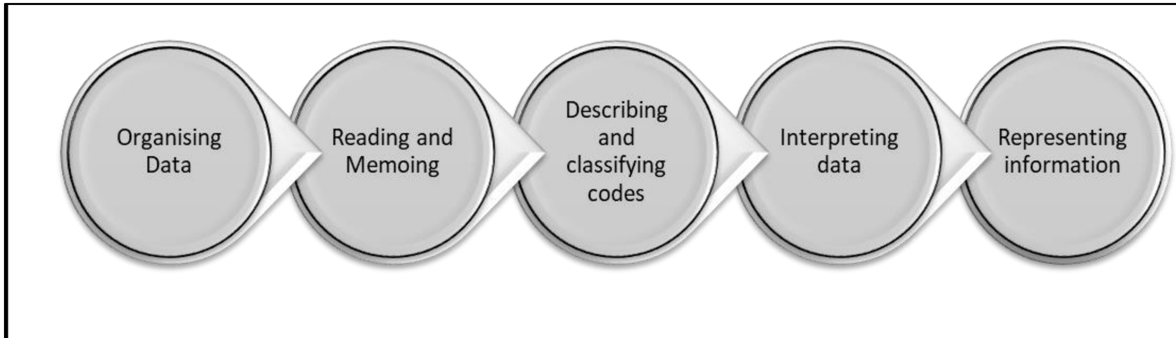


Figure 3-2. **Data management process**
(Creswell and Poth 2018, p. 183).

a) Organising data

The organisation of the data is described in the previous section (cf. 3.3.7). Each transcribed data set was emailed to the co-coders. They printed the transcripts and filed them in order of their choice.

b) Perusal and memoing

In this part, the coders separately and in their own time read through each data set and marked sections which 'pop-out' to them and relate to the research purpose. The coders were asked to take notes of thoughts and ideas that occur to them, while perusing the data sets.

c) Describing and classifying codes

The classification of data was also done by the coders separately and in their own time. To code the data, inductive coding was used, because the researcher was working from a constructivist framework, where meaning is derived from interpreting the participants' reality.

The coders classified the data by assigning codes to segments that stood out to them as relevant. The coders were given the option of making use of descriptive codes where coders assign a descriptor of the meaning of the topic covered in the segment (Saldaña, 2009, p. 70), or in vivo codes, where coders use participants' exact words to convey the meaning of the segment

(Saldaña, 2009, p. 74). As the coders assigned codes, they kept a list of codes and subcodes created to generate a coding scheme. The coders then applied this initial coding scheme to the next data set. While coding the second data set, the coders edited the initial coding scheme. They could expand by adding codes and subcodes and synthesise, by reflecting on overlapping ideas that could be combined into a single code, or identifying parts of the data that are irrelevant to the research aims. The coder would then apply this new coding scheme to the third set of data and edit it accordingly. This process continued with the subsequent data sets until the coder didn't identify any new codes and had worked through all their data sets. Each coder developed a final set of codes and subcodes to arrange into themes, which relate to the research aims. This final set of codes was kept for an audit trail.

d) Interpreting the data

After the final set of codes had been compiled, the coders individually synthesised their final sets of codes into categories followed by themes. Categories and themes are defined by Creswell and Poth (2018, p. 318) as "broad units of information that consist of several codes aggregated to form a common idea." Creswell and Poth (2018, p. 319) use the metaphor of a family tree to demonstrate how related codes (children) can be described under a theme (parents) and how related categories can be described under a theme (grandparents). The coders used a similar structure to organise their codes into themes.

Following independent coding to improve rigour (cf. 3.3.8) the coders met via a three-way telephone call and discussed and compared their codes, categories, and themes. The coders found that the emerged themes were similar. Discrepancies existed in the wording and naming of the codes, categories, and themes, as well as the amount of data synthesised into categories and themes. Following this meeting, the researcher interpreted the

themes in the light of published literature to make deductions and draw conclusions.

e) Representing information

The interpretations deducted are discussed in Chapter 4. Tables are used to visually present the demographic information, as well as the themes, categories, subcategories, and codes. Each code is further presented with at least one verbatim quote alongside triangulated theory and a discussion of the deductions made.

The above process is presented as a linear process. However, as with most qualitative studies, the process was more iterative, where the coders went back and forth between data analysis and interpretation as needed (Creswell & Poth, 2018, p. 183). It is also evident that the researcher self was involved in all aspects of the study resulting in inevitable subjectivity. Because of this, methodological strategies had to be incorporated into the study design to enhance the rigour of the research.

3.3.8 Enhancing Rigour

Validity and reliability involve ensuring that the study was conducted rigorously. Although these terms are traditionally associated with quantitative research, while other terms such as “trustworthiness” is used in qualitative research, modern perspectives on qualitative research encourage the use of these terms (Creswell & Creswell, 2018, p. 323; Creswell & Poth, 2018, p. 404; Merriam & Tisdell, 2016, p. 237). Transformation was included in enhancing rigour as the study formed part of the feminist paradigm.

3.3.8.1 Internal Validity

Validation in qualitative research is an evolving concept. In this study validity is understood as a process that everyone involved in the research process (the researcher, participants and the readers or reviewers) partakes in to enhance its accuracy and value (Creswell & Poth, 2018, p. 410). Regarding accuracy, it is

necessary to assess to what extent the findings express what is being experienced by the participants. Regarding value, to statistically generalise the findings to other populations and settings is not appropriate in constructivist research (Merriam & Tisdell, 2016, p. 254). For readers to find value in the research, they need to have sufficient information to be able to understand and learn from the results and decide for themselves how this understanding and learning could be applicable to the populations and settings they interact with (Merriam & Tisdell, 2016, p. 256).

. The following strategies were used to enhance validity:

- *Triangulation:* Triangulation in research refers to using a variety of referents during data collection and data analysis (Merriam & Tisdell, 2016, p. 244). First, for analyst triangulation (Merriam & Tisdell, 2016, p. 245), the researcher as well as two co-coders were utilised during the data analysis phase (cf. 3.3.8) to prevent researcher bias. Second, for theory triangulation (Creswell & Creswell, 2018, p. 323), multiple data sources across various disciples were consulted when interpreting and discussing the results.
- *Negative case analysis* involves reporting on evidence that does not fit the pattern of a particular code or theme (Creswell & Poth, 2018, p. 413). In the presentation and discussion of the results (see Chapter 4), those that seem to contradict the typical pattern will be included.
- *Clarifying research bias* and reflecting involves being aware of what biases and values the researcher approaches the study with, (Creswell & Poth, 2018, p. 413). These invisible aspects were illuminated by commenting on them when communicating the research study (see Preface & Section 3.3.3).
- *Peer review* (Creswell & Poth, 2018, p. 416) of the data and the research process was performed throughout by the study supervisor who has a doctorate degree in occupational therapy. The study was performed to fulfil the requirements for a Master's degree in occupational therapy research. Consistent peer review and questioning about the data methods and critical

input about the interpretations and the conclusions drawn, were part of the research process.

- *Thick, rich descriptions* were provided, related to the context of the research (cf. 3.3.2), the research process (cf. 3.3.6), the demographic details of the participants (cf.s 3.3.4 and 4.2), and the data gathered through purposefully selected verbatim examples (Cf. 4.3). This best equips readers to decide how the research may be applicable to their situations (Merriam & Tisdell, 2016, p. 256).

Member checking is one of the best ways to enhance validity (Creswell & Creswell, 2018, p. 324; Creswell & Poth, 2018, p. 414; Merriam & Tisdell, 2016, p. 246). However, this could not be performed in this study. The women who participated in this study were at the shelters for a limited period only. By the time all the interviews were completed, the interviews transcribed, and preliminary codes and categories compiled, the participants had left the shelter. The researcher did not acquire permission from the DSD to contact the participants outside of the shelter. Further, it would have been unethical to do so as the researcher had no guarantee that the women were safe from their partners. It is potentially life-threatening for people affected by IPV to have their partners find out they spoke about the details of their relationships (WHO, 2001). The participants who indicated that they would like to have their results communicated with them, will receive a summary of the dissertation by email, through the shelter they were placed at, with no reference to their participation in the research.

3.3.8.2 Reliabilty

Traditionally reliability would refer to the extent that the results can be replicated if the study is performed again. However, in constructivism the people involved (i.e., the study partcipants and the researcher) and the concepts are not static, but ever evolving. Thereby reliability strategies in constructivist research enhance the readers' trust that the "results are consistent with the data collected" and are not skewed by the researcher's biases (Merriam & Tisdell, 2016, p. 251).

The following strategies were used to enhance reliability:

- *Checking transcripts* against recordings to eliminate mistakes (Creswell & Creswell, 2018, p. 325).
- *Analyst triangulation, clarifying researcher bias and peer reviews* are strategies discussed under 'validity' that also contribute to reliability.

3.3.8.3 Transformation

Because of the feminist paradigm basis, the researcher also made use of the concept of transformation, as part of enhancing rigour. This study addressed concerns of occupational justice, a profession-specific form of social justice. Mertens (2010, p. 260) recommends seven criteria for transformation in social justice research. Four of them were utilised in this study. They are as follows:

- *Ontological authenticity.* Mertens (2010, p. 260) describes this as "the degree to which the individual's …conscious experience of the world became more informed or sophisticated". During the making of the collage, participants were asked to reflect on how they see the future. In this process, some participants indicated that participation in the research have made them aware of their responsibility and desire to raise awareness on IPV. This indicates a more sophisticated view and understanding of their experience.

- *Attention to Voice*: Mertens (2010, p. 261) articulates this as, "The researcher must seek out those who are silent and must involve those who are marginalized". In the purpose of this study (cf. 1.4), it is explained that the profession of occupational therapy, especially in South Africa, has been mostly silent regarding a socially unjust phenomenon that influences one-third of women. This study provides a platform for the voices of victims of IPV to be heard by healthcare professionals. This aims to raise awareness and improve service delivery to these people.

- *Critical Reflexivity*. This highlights that knowledge is contextual and qualitative research is inherently subjective (Mertens, 2010, p. 261). Therefore, strategies that enhance validity also contribute to critical reflexivity.

- *Reciprocity*: This refers to how researchers are indebted to their participants (Mertens, 2010, p. 261). The participants, as well as the researcher, should benefit from the research. To highlight the importance of this aspect, during the recruitment stage of this study, a potential participant asked, "You are getting a degree out of this research, what do we get out of it?". As the researcher, I committed to sharing my results and ultimately their stories with the participants, secondly with the shelters, and then on as wide a platform as I can reach in my personal and professional capacity. The participants were given the assurance that the results of their participation in the study will contribute, even if in a small way, to improved awareness of and service delivery towards victims of IPV.

To conclude this section, the study was approached with rigour to improve the quality of the study. This was done by employing a variety of strategies to address validity, reliability, and transformation. The criteria related to transformation, especially considered the impact of the study on the participants. In turn, this contributed to the study being ethically sound. The next section describes the ethical considerations taken in the study.

3.4 Ethical considerations

Ethical permission to conduct this study was obtained from the Health Sciences Research Ethics Committee of the UFS (Ethics number: HSREC 159/2017 (UFS-HSD2017/1434)) (cf. Appendix A). Ethical decision making in this study was guided by the basic ethical principles (Health Professions Council of South Africa, 2016, p. 4) provided by the Health Professions Council of South Africa (HPCSA), as well as the WHO recommendations of ethical aspects that researchers into domestic violence need to consider (WHO, 2001). Additionally, the principles of relational

ethics were also utilised. In more recent literature, Olesen (2018, p. 275) explains that in feminist research specifically, the traditional universal principles of ethics do not recognize the relationship between the researcher and the participant. She suggests that researchers also consider relational ethics, an approach that underscores the need to address power and vulnerability (Olesen, 2018, p. 275). Relational ethics is an action ethic that highlights an ethical approach to a relationship (Upasen, 2017, p. 3). The morals underlying this approach are 1) engagement, 2) mutual respect, 3) embodiment and an interdependent environment (Upasen, 2017, p. 3). The principles of relations ethics were thereby used more during the data collection phase.

Creswell and Poth (2018, p. 114) suggests that ethical issues and principles should be addressed as they relate to various parts of the study. Table 3-1 visually demonstrates how ethics were considered in the five different stages of this study

Table 3-1: Ethical Considerations Applied to Various Stages of the Study

Acknowledgement is given to (Creswell & Poth, 2018, p. 114) and Janse van Rensburg (2015, p. 95) for informing the structure of this table.

SOURCES THAT GUIDED ETHICAL DECISION MAKING		
HPCSA universal ethical guidelines (Health Professions Council of South Africa, 2016).	World Health Organisation (WHO, 2001); "Putting Women First" (WHO, 2001)	Relational ethics (Upasen, 2017)

ADHERENCE STRATEGIES		
Research stage	Ethical principle	Strategy for adherence
Study Planning	Obtain approval from a Research Ethics Committee	In accordance with South Africa's National Health Act (61 of 2003, sec. 69) the study was submitted to and approved by the University of the Free State Research Ethics Committee of the Faculty of Health Sciences (ECUFS no 159/2017) (Appendix H).
	Gain permission from authorities and research sites	Permission to conduct the study was obtained from the Deputy Director General of the Gauteng DSD to contact the shelters. Furthermore, permission was obtained from the four shelters involved in the study. These letters were submitted to the Research Ethics Committee in order to obtain final approval to conduct the study.
Commencing the study	Impartiality	The inclusion criteria state that the participants had to be female. This requirement is not discriminatory, but rather out of the consideration that shelters only catered for females. Further, no participants were excluded or included based on race, culture, age, disability, educational level.
	Informed consent	While recruiting participants, they were provided with both written (see Appendix B) and verbal information regarding the research in a language they understood. This included the consequences, risks, and benefits of the research, the purpose of the research, that there would be no monetary compensation, and also assured participants of confidentiality. The participants had to sign their consent, before starting the research. They were also asked to verbally consent before starting the interviews.

Table 3-1: Ethical Considerations Applied to Various Stages of the Study (Continued)

Research stage	Ethical principle	Strategy for adherence
Commencing the study *(continued)*	Power in consent	Olesen (2018, p. 270) highlights that qualitative research may possibly replicate oppressive power structures. This is especially true if the investigator hopes to get impossible results – i.e., an account of their lived experience in relation to the research question, rather than a series of partial stories of women's lives. To relate this to consent, the researcher was careful not to make hyperbolic promises and create unrealistic expectations of the impact of the research on the participants' immediate circumstances.
	Voluntary participation	The informed consent document mentioned clarified that there was no material benefit or consequence that would result from participating or not participating in the study. It also highlighted that participants could withdraw at any time without consequence (see continued consent)
Collecting Data	Continued/process consent	The researcher continually checked with the participants regarding their willingness to continue participating (Olesen, 2018, p. 280). The participants were also reminded that they could withdraw from the study at any time without consequence. One participant withdrew after making the collage.
	Respect for the research site, and the participants.	For convenience and for safety purposes, the participants were interviewed at the shelters where they were staying. Further, to not cause disruptions to their daily routine, appointments to conduct interviews were made with both the research site and the participants.
	Respect the privacy and confidentiality of the participant	The managers of the shelters were asked to arrange for a private, quiet area to conduct the interview. The collages were not made in a private area, but rather as a group with all the participants from the shelter. This did not breach the privacy of the participants because the information on the collages was symbolic, and the participants could choose the symbolism they wanted to share with the other participants in that setting. If participants indicated that they would prefer to make the posters in their own time and in private, they were given the resources to do so.

Table 3-1: Ethical Considerations Applied to Various Stages of the Study (Continued)

Research stage	Ethical principle	Strategy for adherence
Collecting Data *(continued)*	Pursue the safety of the participant above all.	The WHO (2001, p. 10) recommends that the interviews should be especially confidential to keep victims safe from their perpetrators. Participation in research about violence may subject a victim to further violence from their perpetrators. For this reason, it was decided that the research will be conducted with women who are already in the safety of a shelter and not with participants who are still exposed to the violence of their relationships (cf. 3.3.3).
Analysing Data	Ensure confidentiality in data that is shared	The researcher ensured the confidentiality of the participants according to the methods described in Data Management (cf. 3.3.6.).
	Ensure Accuracy of information	The strategies employed to enhance rigour (cf. 3.3.8), contributed to accurate interpretation of the data.
Writing and dissemination of research	Avoid Plagiarism	For this dissertation, all sources were acknowledged using APA 6th edition as automated by the Mendeley Cite-O-Matic feature for *Microsoft Word*. Page numbers have been included in all in-text references, except when referring to an entire paper. All further dissemination of this study will be referenced according to an acceptable referencing method.
	Ensure confidentially and avoid sharing information that could harm the participants	The interview transcripts and any verbatim quotes were de-identified. The verbatim quotes were carefully selected to ensure that they do not contain information that could be associated with the participant.
	Report findings to stakeholders	This dissertation and further journal articles will also be made available to DSD, the participants (through the shelters contacting them) and the shelters where the research was conducted.

3.5 Conclusion

This chapter provided a description of the methods employed to answer the research question (cf. 1.3). A rationale was provided for the methodological decisions while describing aspects of planning, data collection, data analysis, strategies to enhance rigour, and research ethics. Considering these, the results of this study will be presented and discussed in Chapter 4.

This chapter described the way the researcher undertook this study, explaining all aspects of the planning, data collection, and data analysis. In the next chapter, the researcher will focus on the findings from the study and discuss these findings in their context and support or contrast them with existing literature.

Chapter 4: Findings and Discussion

4.1 Introduction

The qualitative methodology discussed in the previous chapter was applied to address the research aim, namely, to describe how women affected by IPV, experienced IPV and adapted to occupational rights violations in terms of occupational risk factors. In this chapter, a description of the participants is provided, followed by a presentation, interpretation and discussion of the qualitative data gathered from the unstructured interviews. I combined the presentation of the results with the discussion of the findings to better present the literature triangulation (cf. 3.3.9) and to ease the flow of reading

4.2 Description of participants

The study was carried out with eleven participants from four shelters (cf. 3.3.3). The first part of data collection entailed that participants complete a demographic questionnaire (cf. 3.3.5, Appendix D). Table 4-1 represents a summary of the participants. Please note that the names presented are not the participants' actual names, but pseudonyms related to their home language, which I have randomly chosen for them (cf. 3.4).

Table 4-1: Demographic description of participants

Pseudonym	Age in 2018[18]*	Highest level of Education	Home Language	Nationality	Relationship Status	No. of children (Ages in years)	No. of abusive relationships	Years in the previous relationship[19]
Jasmyn	41	Degree	English	South African	Engaged	0	1	7
Lucy	41	Grade 10	English	South African	Single	0	1	6
Mosa	27	Grade 12	Sepedi	South African	Single	1 (4)	1	6
Thandi	n.a[20]	Grade 12	isiZulu	South African	Married	4 (14,10,9,5)	1	10
Ntabiseng	27	Grade 10	seSotho	South African	Married	3 (12,5,3)	2	8
Nonhle	19	Grade 9	Xhosa	South African	Single	pregnant	1	2.5
Joyce	45	Degree	isiZulu	South African	Filing for Divorce	3 (13,11,9)	1	14
Anele	27	Grade 11	isiZulu	South African	In a relationship	2 (9,1)	2	2
Nandi	50	Diploma	IsiZulu	South African	Married	2 (27,23)	1	8
Amahle	24	Grade 11	IsiZulu	South African	Single	0	1	4
Corli	46	Grade 10	English/ Afrikaans	South African	Single	0	2	7

In the constructivist paradigm, it is appropriate to provide the reader with insight into the people whose life experiences informed the research results (cf. 3.2.2). I hereby provide a personalised description of my impressions[21] of each of the participants. I do not mention it for each participant, but participants had limited support available from family and friends, which is likely why they had been brought to a shelter.

[18] Year that the interview was conducted

[19] The marital status provides an indication of how legally binding the relationship of the participants and their abusers were at the time of the interview. When entering the shelter, residents are encouraged to limit interaction with their abuser. For the time that they are in the shelter the women and their abuser are physically and relationally separated. Upon leaving the shelter, the women might enter into a relationship with her abuser again and the abusive cycle might continue.

[20] Participant chose not to disclose this information.

[21] This is an anecdotal account of the impression I had of the participants in my interactions with them.

a) *Jasmyn:* My impression of Jasmyn was that she was a positive, energetic, organised person. She prided herself in her ability to pick herself back up after things went wrong. Jasmyn's abuser was an alcoholic. Jasmyn experienced physical abuse, including attempted murder, financial abuse, emotional abuse, verbal abuse, and isolation. At the time of the interview Jasmyn had not yet broken off her engagement with her abuser although she reported that she intended to do so when she went back to her place of living with a social worker to collect her personal belongings. She said her mantra at the time was, "inspired by life". After leaving the shelter, Jasmyn looked forward to fetching her cat from her abuser's home, reconciling with her family, finding a job, and becoming involved in raising awareness about IPV.

b) *Lucy:* My impression of Lucy was that she was a sensitive person who seemed to value security. At the time of the interview, Lucy was not in a good place emotionally – it was difficult and emotionally taxing for her to share her experiences with me. Lucy had a depressive mood. Her abuse included physical abuse, including attempted murder, financial abuse, emotional abuse, verbal abuse, as well as isolation. At the time I interviewed her, Lucy was unsure about what life would be like after leaving the shelter. She was uncertain about where to live, employment, and her ability to cope independently. She was weighing up her fear of the future with her past experiences and was considering returning to her previous (abusive) relationship. As Lucy said "rather the devil you know."

c) *Mosa:* My impression of Mosa was that she was a determined lady who valued her independence. Despite being forced to quit her job, she found alternative ways to use her resources to find a source of income. Her role of being a mother was very important to her and the well-being of her son appeared to be on the forefront of her mind in whatever decision she made. Her partner often drank alcohol and was more abusive when intoxicated. Mosa experienced physical abuse, financial abuse, emotional abuse, verbal abuse, and isolation. She admitted to having attempted suicide. At the time of the interview, she was excited and determined to start a fresh chapter of her life with her son.

d) *Thandi*: One of the quotes Thandi put on her collage is "Because Mom always laughs with us." This summarised Thandi well. She cherished her four children and carried their best interests at heart. She also loved laughing (albeit she might have used humour as a defence mechanism) and seemed determined that she would not allow her past experiences to shape her future. She experienced isolation, emotional abuse, verbal abuse, sexual abuse, financial abuse, and physical abuse. At the time of the interview, she had positive dreams for the future and hoped that she would have the opportunity to travel the world.

e) *Ntabiseng*: Ntabiseng was a young lady who had a rocky start in life. Growing up, her father was an alcoholic. Her first partner who is the father of her children was abusive. She left him and then met her most recent partner who was also abusive. Her most recent boyfriend abused alcohol and was more abusive when intoxicated. Ntabiseng also started drinking alcohol as a coping mechanism. During the interview Ntabiseng did not always specify which accounts of abuse were from which relationship, she rather shared on her experience of IPV in general. She experienced physical abuse (her youngest child was born prematurely after she was shoved), death threats, sexual abuse (up to five times a day), infidelity, verbal abuse, isolation, financial abuse, and her most recent partner deliberately infected her with HIV. At the time of the interview, she realised that she had healing work to do. She was determined to ensure that her children have a better life than she had and that other women do not experience IPV.

f) *Nonthle*: Nonthle was pregnant at the time of the interview and seemed to prefer the written word to the spoken word. She used the prompts provided for the collage technique to write what she wanted to say. However, she elaborated these verbally during the unstructured interview. She met her partner at a shelter for homeless people. Her partner abused drugs and alcohol, and introduced her to substances which made him act more violently. She experienced emotional abuse, verbal abuse, physical abuse, financial abuse, infidelity, sexual abuse, and her partner deliberately infected her with HIV. She admitted having had suicidal thoughts and using alcohol to cope with the abuse. At the time of the interview, she was uncertain about the future,

as she was pregnant with her first child. She hoped that her story can inspire other women to leave their abusive relationships.

g) *Joyce*: Joyce had a quick, easy laugh and exuded positivity when I met her. Of all the participants she was one of the highest academically qualified, had the most financial independence, and had the best support system in the form of her family. The abuse she experienced was also the most subtle and invisible (although that did not lessen its impact) in that it was not overtly violent. She experienced emotional abuse, verbal abuse, financial abuse, and sexual abuse. At the time of the interview, she was looking forward to living a life filled with laugher, to furthering her studies, and to starting a business.

h) *Anele*: Anele experienced some traumatic events as a young girl including being raped and her mother was murdered at the hands of her mother's intimate partner. She and her partner both abused alcohol and she regretted that this affected her role as a mother to her children. She experienced financial abuse, verbal abuse, emotional abuse, infidelity, isolation, physical abuse including death threats, and stalking (when they were not living together). Anele valued family, comfort, and security and at the time of the interview shared dreams for the future that included all of these.

i) *Nandi*: At the time of being recruited for the research and making the collage, Nandi had only been at the shelter for one day. She described herself as loving, empowered, self-driven, and smart. During the interview it was apparent that she was not yet willing to be completely vulnerable with me about her experience of IPV. As an activist for GBV Nandi focused on her experience on the topic in general and spoke about her personal experience seldomly. Nandi's partner abused alcohol and was more abusive when intoxicated. She experienced financial abuse, verbal abuse, and sexual abuse. Nandi admitted to having considered suicide at some point in the relationship. At the time of the interview, she wanted to focus on letting the process of healing do its work so that she could move forward with her life.

j) *Amahle*: Amahle, in my opinion, experienced the most severe abuse. On the day of the interview her emotions were high. She would be leaving the shelter to live with family, later that day. The interview with Amahle was the most challenging for me, as

the interviewer, because we were the same age (I identified with her) and was deeply appalled by the things she had experienced at the hand of her intimate partner. He had reportedly been convicted for having killed his previous girlfriend. The abuse that Amahle experienced was sadistic and almost torturous. It included physical abuse, sexual abuse, emotional abuse, verbal abuse, isolation, financial abuse, infidelity, death threats, and her partner deliberately infected her with HIV. The participant was stabbed eight times by her partner; was later kidnapped and locked in a room, during which she was forbidden to bath for a week; was not being allowed to sleep on a bed; had a rope tied around her foot, even if she wanted to use the toilet; was woken up with water being dumped on her face; was deprived of food and then being offered food with rat poison to eat; as well as had to feed and wash her abuser at 3am in the morning, before he went out for the day. The participant enjoyed singing and at the time of the interview, wanted to finish grade twelve before moving on with her life.

k) *Corli*: Corli was a loyal, value-driven person who presented a "tough-enough-to-handle-anything" image. Yet through the interview I was fortunate to see a softer, vulnerable side of Corli who loved the outdoors, dogs, and children. She experienced verbal abuse, emotional abuse physical abuse, and infidelity. At the time of the interview Corli dreamed of a future where she had a wide-open space to provide a home for plenty of dogs.

4.3 Presentation and interpretation of data

In this section, the findings from the data analysis process (cf. 3.3.7) are discussed. These findings will reflect the voices of the participants by means of verbatim quotes and paraphrasing, as well as my interpretations and insights grounded in literature, experience, and/or a synthesis of these.

Table 4-2 below provides a summarised overview of the three themes that emerged from the data analysis. I recommend that readers keep referring to this table to orientate themselves throughout this chapter. Three primary themes emerged from the data. They are 1) 'Perpetrators of IPV'; 2) 'Effect of IPV on occupation'; and 3) 'Changes and adaptations within the women affected by IPV'.

Verbatim quotes are presented in their original style including all false starts, interjections, and ungrammatical utterances. If the verbatim quotes were too long, ellipses have been used to indicate sections where phrases have been omitted. Also, where necessary, round brackets have been used to provide context and block brackets have been used to show where information had been omitted to protect the anonymity of the participant. As far as possible thick, rich descriptions of the participants' experiences are provided to contribute to rigour (cf. 3.3.8). Throughout this section, I have included literature related to the findings. The literature is used as an interpretive lens as well as a strategy to triangulate data and enhance rigour (cf. 3.3.8).

The themes are presented according to categories or, where relevant, according to subcategories. For each category I provide the relevant excerpt from Table 4-2, indicating the category, subcategory, and codes. I present the category or subcategory by defining it and indicating how many participants contributed to that particular category or subcategory. I then present one, or occasionally two, verbatim examples for each code. I finally group the discussion of the codes according to category or subcategory as relevant. As far as possible the most recent resources are used to triangulate the results with literature. If older work is referred to, it is either due to limited publications being available on the aspect being discussed or a reference being made to seminal work. At the end of each theme, I present a summary of the theme.

Table 4-2: Themes and Categories

Themes	Category/ Subcategory	Code
Theme 1: Perpetrators of Intimate Partner Violence (4.3.1)	**Coercive control** (4.3.1.1)	i) Physical abuse ii) Financial abuse iii) Emotional abuse iv) Verbal Abuse v) Isolating the victim vi) Silencing the victim vii) Sole decision making
	Family behaviours and attitudes (4.3.1.2)	
	a) The abuser's family	i) Protect abuser ii) Encourage silence
	b) Family of the women affected by IPV	i) Disappointed in the women ii) Blame the women
	Community institutions (4.3.1.3)	
	a) Police	i) Unhelpful ii) Referred to shelter
	b) Healthcare workers	i) Ignorant ii) Referred to shelter
	c) Church	i) Ignorant ii) Referred to shelter
	Cultural attitudes (4.3.1.4)	
	a) Power imbalance	i) Patriarchy ii) Women need to be submissive iii) He is a provider.
	b) Perceived stigma	i) Stigma
	c) IPV is a domestic matter	i) Turn a blind eye
Theme 2: Effect of Intimate Partner Violence on Occupation (4.3.2)	**Diminished occupational participation (4.3.2.1)**	i) Doing nothing ii) Mundane routine iii) Uninterested in activity
	Meaningless activities (4.3.2.2)	i) Forced activities ii) Powerlessness
	De-identification (4.3.2.3)	i) "Nothing about me counted" ii) Estranged to self iii) Believing his insults
	Difficulty in areas of occupation (4.3.2.4)	i) Sleep ii) Unable to work iii) Lack of fun iv) Difficulty with child-rearing
	Feeling dehumanised (4.3.2.5)	i) "I am not a person"

Table 4-2: Themes and categories (continued)

Theme	Category	Sub-category
Theme 3: Changes and adaptations due to Intimate Partner Violence (4.3.3)	**Mental changes (4.3.3.1)**	
	a) Self-destructive reasoning	i) Self-blame ii) Breaking herself down
	b) Compulsive thinking	i) Thinking about future ii) Sense making iii) Suicidal ideation
	c) Acceptance	i) "This is life"
	Emotional changes (4.3.3.2)	
	a) Unpleasant emotions	i) Anger ii) Sadness iii) Fear iv) Stress v) Loneliness vi) Dependence vii) Loss viii) Feeling unloved ix) Shame
	b) Pleasant emotions	i) Hope that he will change ii) Love
	Behavioural adjustments (4.3.3.3)	
	a) Coping strategies	i) Physical excercise ii) Singing iii) Going away iv) Overindulge v) Repress emotions vi) Change appearance and behaviours
	b) Hide abuse from people	i) Pretense
	Spiritual adjustments (4.3.3.4)	
	a) Feeling estranged to self/environment	i) Existential questions about life ii) Stranger
	b) Driving force	i) "Kept me going"
	c) Religion	i) God/prayer
	The final adaptation - leaving (4.3.3.5)	
	a) Help-seeking	i) Crisis ii) Source of courage
	b) Source of help	i) Information about shelters ii) Someone stepped in
	c) Uncertainty about life outside the shelter	i) Work ii) Place to stay iii) Ability to raise children

4.3.1 Theme 1: Perpetrators of Intimate Partner Violence

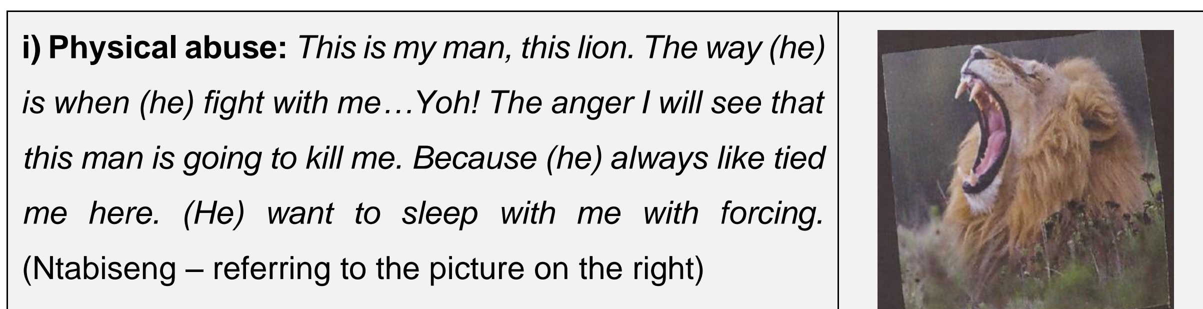
The first theme describes factors that contributed to the participant's experience of IPV. The four categories in this theme are: 'Coercive control'; 'Family behaviours and attitudes'; 'Community institutions'; and 'Cultural attitudes'.

4.3.1.1 Coercive Control

The first category under the theme 'Perpetrators of IPV' is 'Coercive control' (cf. 2.3.1). This category was marked by abusive methods that the partners used to assert control over the participants and included codes that indicated various forms of abuse. Johnson (1995, 2006) equates the term 'Coercive control' to the term 'intimate terrorism' and differentiates this term as a unique type of IPV based on the intention of the perpetrators to control 'their' women (cf. 2.3.1). Therefore, violence that the participants experienced was not situational, but rather tactics employed by the abusers to control the women. All eleven participants gave accounts of various forms of abuse.

Category	Subcategory	Code
Coercive control	n/a	i) Physical abuse ii) Financial abuse iii) Emotional abuse iv) Verbal abuse v) Isolating the victim vi) Silencing the victim vii) Sole decision making

The following verbatim quotes for each of the codes illustrate examples of abusive behaviours experienced by the participants:



i) Physical abuse: *This is my man, this lion. The way (he) is when (he) fight with me…Yoh! The anger I will see that this man is going to kill me. Because (he) always like tied me here. (He) want to sleep with me with forcing.* (Ntabiseng – referring to the picture on the right)

ii) Financial abuse: *I was not free, controlled. I was limited; everything was…He had broken my car to keep me back with him, to make me lose my job, so I couldn't work, so I couldn't have a car. All independence was gone* (Jasmyn)
iii) Emotional abuse: *Imagine talking to my father about sex. That was like, "yoh!", the worst thing. So he phoned my father and said, "your daughter is refusing to have sex with me.* (Joyce)
iv) Verbal abuse: *All his negative energy was sucking the life out of me. And ja, there is really nothing I could do. You know, when your broken down so badly, I was told I am an idiot, I'm stupid, I'm worthless, I'm, you know, I'm not good for anything, ja…I think that after a while you believe it. You know in the back of your head it's not true…but you just get tired of fighting* (Lucy)
v) Isolating the victim: *For an example, you are visiting my house…when you go, the trouble will start…" I don't like her … so she mustn't come to my house anymore." EVERYONE was bad, EVERYONE was not okay* (Thandi)
vi) Silencing the victim: *"I was living a "yes sir" life, a "yes sir" life. I was not supposed to say anything; I was not allowed to do things.* (Joyce)
vii) Sole decision making: *And you know in a way he was like this shark. He was in control of everything. You know, it's like the beast in the ocean kind of thing, and he was in control of finances, when we went out, where we went out, you know. When I bought my clothes when he felt hiring a car, when he felt like throwing me out* (Lucy)

Physically abusive behaviours included the use of or threats with weapons, attempted murder, rape, biting, hitting, and beating as well as in the case of three of the participants, being intentionally infected with HIV. Financial abuse occurred by the abuser either providing excessively or limiting access to money. The comments provided show how abusers limited access to money by withholding money, preventing the participant from working, or taking all her money from her if she did work. Emotional abuse was displayed

by means of intentional humiliation, possessive behaviours, and excessive anger. Verbal abuse that participants had to endure included a combination of constant complaining that what they did was not good enough, false accusations of cheating on their partner or prostitution, insults such as being called useless, fat, ugly, dirty, or stupid as well as death threats.

The above forms of abuse are typical in IPV cases (Mkhonto, Sengane, & Havenga, 2014, pp. 339–343). A study performed by Joyner and Mash (2011, p. 2) in Western Cape, South Africa with 168 women with a history of IPV, measured the prevalence of different types of abuse they had endured over the preceding two years. They found that 81% of the women had experienced name-calling and 56% had experienced threats. Regarding physical abuse, 68.5% had been hit and 33% had experienced being sexually coerced. Regarding financial abuse, 72% had been withheld money. Of all these forms of abuse, participants expressed that the verbal abuse was the most hurtful type of abuse.

This man tortured me most with insulting me (Ntabiseng)
You know, he throws a word at you, it's like a bomb. And then you will feel like screaming. (Thandi)

Jasmyn commented on how the abuse was directly linked to control.

> *It was pathetic. Because the only way this man could be a little higher than me was through me having absolutely nothing. And the only way he could control me was through violence, the threat for violence.* (Jasmyn)

From an occupational therapy perspective, this relationship context jeopardises all five aspects of the participants' health as identified by Ramugondo (2017, p. 34) (cf.s 2.2.2; 2.3.3.1). Firstly, their *physical well-being* was jeopardised by physical abuse; secondly, their *intellectual well-being* could have been jeopardised by head trauma as well as the physiological impact of stress; thirdly, their *social well-being* was jeopardised by being isolated and through the unhealthy relationship dynamic; fourthly, their *emotional well-being* was jeopardised through the impact of all the types of abuse of the victims' psyche;

and lastly, spiritual health was also impacted (The impact of the abuse on the participants' spiritual health will be discussed under the next theme).

The jeopardy that the abusers place on their victims' health, supports that occupational therapists are highly likely, in their clinical practices, to come across people affected by IPV for a variety of physical or mental health reasons (Helfrich & Aviles, 2001, p. 54; Javaherian, Underwood, et al., 2007, p. 705). In this study, Amahle had to seek help from a clinic following stab wounds and Lucy was admitted into a mental health hospital for stress. When assessing their clients' context, occupational therapists need to be aware of the likelihood, if their client is female, that there is a 33% chance that she has been affected by IPV according to global trends (WHO, 2017, p. 1). In their assessments of people affected by IPV, occupational therapists need to consider all aspects of their health.

4.3.1.2 Family behaviours and attitudes

The second category under the theme 'Perpetrators of IPV' describes how the participant's family responded to IPV. The two subcategories relate to a) 'The abuser's family' and b) the 'Family of the women affected by IPV'.

<table>
<tr><th>Category</th><th>Subcategory</th><th>Codes</th></tr>
<tr><td rowspan="2">4.3.1.2 Family behaviours and attitudes</td><td>a) The abuser's family</td><td>i) Protect abuser
ii) Encourage silence</td></tr>
<tr><td>b) Family of the women affected by intimate partner violence</td><td>i) Disappointed in women
ii) Blame the women</td></tr>
</table>

a) The abuser's family

The first subcategory describes ways in which the woman's experience of IPV is influenced by how the abuser's family responds to IPV. Four of the eleven participants gave accounts of how the abusers' families responded. The following verbatim excerpts illustrate how, in this study, the family either protected the abuser or encouraged silence:

i) Protect abuser: *His family begged me to drop charge*s (Lucy)
ii) Encourage silence: *His mother*[22] *would say: "No, you just need to just work with him. Don't let the people know. You mustn't let the people outside the house know about this*". (Jasmyn)

The reactions of the abusers' family were never in support of the women. Lucy's experience was also seen among victims of sexual assault, where in one case the family of the abuser tried to bribe the family of the victim to drop the charges (Steinbrenner et al., 2017, p. 8). Jasmyn's experience of the family trying to conceal violence was also seen in studies by Mannell Jackson and Umutoni (2016, p. 6) as well as Thaggard and Montayre (2019, p. 219) where the families believed it is the duty of a woman to keep her family secrets safe.

Further, the attitudes of the abusers' families also shed light on the environment that the abuser grew up in. In the case of Jasmyn, her mother-in-law was also a victim of IPV. This means that Jasmyn's abuser was exposed to IPV as a child. This supports that children who are exposed to IPV are more likely to be in violent relationships themselves (Callaghan et al., 2018, p. 33; Hines, Brown, & Dunning, 2007, p. 68).

b) Family of the women affected by intimate partner violence

The second subcategory under 'Family behaviours and attitudes', is related to how the woman's experience of IPV is influenced by the response of her own family to IPV. Six of the eleven women gave accounts of their families' responses. The women's own families' attitudes, resonate with those of the abusers' families who either mitigated or negated the abuse. The following verbatim excerpts illustrate how, in this study, the women's families were either disappointed in them or blamed them for the abuse.

[22] In this case, the mother of the abuser was also in an abusive marriage

i) Disappointed in the women:

Jasmyn: It [the participant's abusive relationship] was an absolute slap to my father's face: "Did I raise you to become this?" It is a lot of shame, a lot of shame.

Interviewer: So you felt your father was ashamed of you?

Jasmyn: Yes, for being in an abusive relationship. Because I kept going back. Why would you do this to yourself? What did I [referring to her father] do wrong that made you so weak, so useless.

ii) Blame the women: *We hide things because we are scared that gossip, the family members will start gossiping about my marriage (if they find out)…maybe they'll blame me for it. They'll think I am the cause of the problem – you know those things?* (Joyce)

The verbatim examples show how the lack of support could stem from victim-blaming. It has been shown that in cases of IPV, that people not relationally tied to the victim or the perpetrator would typically blame the perpetrator more than the victim (Menaker & Franklin, 2015, p. 3; Yamawaki, Ochoa-Shipp, Pulsipher, Harlos, & Swindler, 2012, p. 3206). However, the blame towards the victim increases when observers, in this case, family, believe that the victim contributed to her abuse through certain provoking behaviours (as in Joyce's case where her family might think that she caused the problem) or returning to the abuser (as in Jasmyn's case where her father was ashamed that his daughter repeatedly returned to an abusive relationship) (Menaker & Franklin, 2015, p. 3; Yamawaki et al., 2012, p. 3206). With regards to provoking the abuser, it has been found that more than 50% of men and 33% of women in South Africa believe that it is acceptable for a husband to beat his wife if she committed one of the following wrongs: neglects children; argues with him; goes out without telling him; refuses to have sex; and/or burns food (Stats SA, 2018, p. 10). In this study the participants would expect verbal or physical abuse most especially when they argued with their partners, as indicated by the following verbatims.

My days were very silent. I was not allowed to speak…Speaking was very dangerous if you said the wrong things (Jasmyn).

Whenever we were fighting, whenever I raise my voice he will say, "you don't have respect." He will start slapping me (Mosa).

Such beliefs seem to be deeply seated in patriarchal ideas which in turn perpetuate IPV (cf. 2.3.3).

With regards women being blamed for returning to their abuser (as in Jasmyn and Kim's cases), this notion seems to be based in the belief of the women affected by IPV, not meeting the criteria for an 'ideal victim' as described by Christie (1986, p. 18). She speculated that the 'ideal victim' is someone who is: weak, involved in respectable tasks when being victimised, cannot be blamed for the incident, physically harmed, and does not know the offender personally. Building on this Meyer (2016, p. 77) argues that the only criteria of an ideal victim that people affected by IPV do not meet are that they know the abuser and return to him. The process of leaving an IPV relationship is complex (as illustrated in the third theme). Family members do not always understand this process or the complicated dynamics thereof. They expect a woman to simply pack her things and leave for good – if she does not, she is perceived to be 'asking' for the abuse (Meyer, (2016, p. 83). Ntabiseng expressed the lack of empathy that she experienced:

People, they give up easily to the woman who are abused. They don't ask questions. They want you, when they say, "Leave that husband", to leave him. They don't know he's sick inside of you, like you are infected. Like he will abuse you - you stay - he abuse you - you stay. (Ntabiseng)

Family members are some of the first people that people affected by IPV approach for help (Meyer, 2016, p. 78). However, if the family members blame the victim, the family will not be effective in providing the victim with the help she required. Good social support structures aid recovery from IPV (Meyer, 2016, p. 83; Woodward et al., 2015, p. 64; Yamawaki et al., 2012, p. 3209), hence lack of family support is concerning. However, the lack of support from family is not always the case with women affected by IPV. In a study by Anderson, Renner and Danis (2012, p. 1292) some women expressed how their families were instrumental in their leaving their relationships. This difference could be

attributed to the participants in this study being drawn from shelters. In this study, with each participant, it was never the family that intervened and brought the victim to the shelter – it was always a friend, neighbour, or a government service provider. The support from an external structure may indicate a lack of, or limited support from the family. The participants' being at a shelter could be because they had no one else to go to. Whereas if the women have supportive families, they could have gone to live with their families instead of a shelter. Thereby, in order to strengthen the social support system of people affected by IPV (Yamawaki et al., 2012, p. 3209), the family members of people affected by IPV need to develop insight into the process of IPV by being educated and having their assumptions and views challenged.

4.3.1.3 Community Institutions

The third category under the theme 'Perpetrators of IPV' describes how institutions responded to IPV. The three subcategories relate to a) 'Police', b) 'Healthcare workers', and c) the 'Church'. Unlike the previous category which highlighted informal support, all these institutions have been identified as sources of formal support (Liang, Goodman, Tummala-Narra, & Weintraub, 2005, p. 72). The participants expressed contrasting experiences with all institutions.

Category	Subcategory	Code(s)
Community Institutions	a) Police	i) Unhelpful ii) Referred to shelter
	b) Healthcare workers	i) Ignorant ii) Referred to shelter
	c) Churches	i) Ignorant ii) Referred to shelter

a) Police

This first subcategory under the category 'Community institutions' illustrates how the participants experienced police services when they sought help from them. Three of the eleven participants found the police unhelpful and two of the eleven participants were appropriately referred by the police for help.

i) Unhelpful: *The police says to me, "We've got nothing to do with family issues"* (Mosa)
ii) Referred to shelter: *I've asked (the police) for a place of safety. I know there was a place of safety but I didn't know much about it. So, I've asked for a place of safety. Then they (the police) organised it for me (Anele).*

Women with a similar experience to Mosa, displayed a distrust in the justice system and did not expect their case to be taken seriously with the police. However, women who had experiences similar to that of Anele, found the police were helpful in protecting them from their abusers. Participants in a study in Australia had similar positive experiences with police (Meyer, 2016).

As indicated in the second verbatim quote, in South Africa police are expected to refer victims of GBV, including women affected by IPV to units within the police stations equipped for managing cases of abuse (CSVR, 2016b, p. 4). However, qualitative studies show that police have generally been unhelpful toward women affected by IPV in South Africa (CSVR, 2016b, p. 4). The lack of responsiveness from police is concerning seeing that it is not rooted in ignorance, but rather in ignoring the guidelines stipulated in the Domestic Violence Act 116 of 1998 and the National Policy Guidelines on Victim Empowerment (National DSD, n.d.). In investigating South African police's responses to women in need of shelter, Stone and Lopes (2018, p. 21) found that police: was either unwilling to assist women in finding shelter services, or they did not have correct information on the scope of shelter services; did not understand the domestic violence act; would react to complaints of IPV inappropriately; as well as, was found to be insensitive or apathetic towards women reporting IPV. Concerningly, in September 2020 it was alleged that at least 139 policemen across 113 police stations in South Africa, have been charged with offences related to GBV (Njilo, 2020, para. 1). It appears that some members of the police system: have internalised patriarchal ideas (cf. 2.3.3); have been desensitised to violence; or are ignorant of the severity of IPV and their responsibility to people affected by IPV. However, as Anele experienced, if the police do respond appropriately, they can be an invaluable source of help for people affected by IPV. Stone

and Lopes (2018, p. 22) found that in some stations in South Africa, police services that fully comply with the Domestic Violence Act, do exist.

b) Healthcare workers

The second subcategory under the category ‘Community institutions’ illustrates participants’ interactions with medical staff, while they were still with their abusive partners. Three of the eleven participants reported interactions with medical staff. Two of the three interactions show medical staff to be ignorant, whilst one of the three interactions provides an example of or knowledge of how to respond appropriately.

i) Ignorant: *He, uh, stabbed me … last year, and then … I tried to, uh, go to clinic and then he came to fetch me* (Amahle).
ii) Referred to shelter: *I went to the clinic for flu. But when I got there, as I sat in the chair, something just said to me, “it’s a clinic, they must know something about social workers. Go and ask them if there a social worker here.” I went and asked the nurse, “is there a social worker here?” She said yes, she took me to the social worker and then he sat me down. He also then asked me, it wasn’t long, it was a very informal chat. I sat for about 10min, 15min with him. But I think the gist of what I was telling him, he didn’t like. Especially with the fact that I had nowhere to go. I did tell him that. And um, then he gave me the numbers, then he called the next day to say he got this place, I must pack and he will come and help me get out of there* (Jasmyn).

In this study, three of the participants had to seek health care at the hand of their abuser. Two of the participants were tested for HIV infection at a clinic after their partner deliberately infected them and Amahle was stabbed by her partner and she had to go to a clinic (with her partner) for stitches. Although Amahle struggled to explain the story to the researcher in broken English, seemingly, there was no inquiry into the cause of her stab wounds, or the enquiry was made in front of her abuser. For whichever reason Amahle didn’t disclose her home-situation to the clinic staff and Amahle ended up going home with her abuser. Amahle, having been stabbed by her abuser and having to seek

medical attention, was in an ideal position to be screened for IPV and referred to a social worker for help. The apparent lack of screening may indicate an ignorance from the clinic staff of the prevalence of IPV or their role in addressing IPV. Atkinson et al. (2012, p. 19) found that antenatal nurses in Johannesburg, South Africa, are aware that IPV is prevalent. However, they were uncertain how to inquire and respond to it. They had a tendency to miss subtle signs and when they did respond it was only in the case of severe physical injuries (Atkinson et al., 2012, p. 19). The National Policy Guidelines on Victim Empowerment (National Department of Social Development, n.d.) recommend that healthcare workers receive training in how to counsel victims of IPV. Seemingly this recommendation is not being adhered to, which highlights the need for increased awareness of and training in responding to IPV for healthcare workers.

Contrary, Jasmyn's case illustrates good implementation of the National Policy Guidelines on Victim Empowerment (National Department of Social Development, n.d.). Jasmyn was referred to the appropriate service provider (i.e. a social worker) who was able to assess the situation and determine that placement in a shelter would be best for Jasmyn. He also ensured her safety by following up with her and offering a home visit.

Joyner, Reese and Honikman (2015, p. 2) identified one of the roles of healthcare providers in IPV, is to liaise and actively follow up with people affected by IPV. Referring a person affected by IPV and who is seeking help, to social work or to police services is not enough. Occupational therapists need to follow up on their referrals to ensure the way the case is being managed is compliant with the Domestic Violence Act 116 of 1998. Occupational therapists thereby need to familiarise themselves with the Domestic Violence Act[23] to such an extent that they can confidently educate people affected by IPV of their rights under the act. Also, occupational therapists need to be able to advocate for

[23] *A Simplified Guide to the Domestic Violence Act* (2014) by the Woman's Legal Center is a helpful resource in this regard.

their clients if they see that the way their cases are being managed is not compliant with this Act.

c) <u>Churches</u>

The third subcategory under the category 'Community institutions' illustrates how people of the church acted towards the participants when they sought help. Three of the eleven participants report mentioning their abuse to church leadership. Similar to the previous sub-category, two of the three interactions showed that people from the church were either ignorant of appropriate ways to support women of IPV or, as in one of the three cases, the church had knowledge of the appropriate response.

i) Ignorant: '*Cause I've been telling them (i.e. elders in the church), they said, "No, it will be okay. No, it will be okay. We are praying, we are praying." For 14 years. "We are praying, things will be fine.* (Joyce) *The pastor's wife was always quoting the Bible verses for me, um, telling me most reasons why I should stay in the relationship. Because God does not want divorce* (Thandi)
ii) Referred to shelter: *I spoke to my church and that and I said please... I can't [go back to him] because I'm gonna get beaten again and they found this place for me* (Lucy)

Similar to Thandi's experience, qualitative studies on IPV (Anderson et al., 2012, p. 1921; Liang et al., 2005, p. 81) have found that women seeking help from churches are advised to remain in the relationship because their doctrine is not supportive of divorce. Wood (2019, p. 7) uses a striking image of a tree to explain the effects of patriarchy in the church on women. She compares Christian churches in South Africa to the trunk of a tree that has tangled roots in patriarchy. There are many branches on this type of tree, all related to social justice, including unemployment violence and abuse. The leaves are the people

going to church, whose worldview is invariably affected by patriarchy. Advising women exposed to IPV to remain in relationships, exposes a patriarchal interpretation of Christian doctrine where men have a right to assert dominance. It also reflects a dangerous level of ignorance to the possible severity of IPV.

However, as in Lucy's case, the church could also be a major source of support. This has also been found in another study on IPV (Anderson et al., 2012, p. 1291) where women affected by IPV expressed how the church played a crucial role in their receiving help. In Lucy's case specifically, the church that she went to was involved at the shelter where she was staying. The people in the church were therefore more aware of IPV; the best way to help women affected by IPV. The contrast in these two examples of women's experience with churches, indicates that if churches are aware of IPV and informed on the best way to respond to IPV, they can be utilised as a source of support in the community.

4.3.1.4 Cultural attitudes

Category	Subcategory	Code(s)
Cultural attitudes	a) Power imbalance	i) Patriarchy ii) Women need to be submissive iii) He is a provider
	b) Perceived stigma	i) Stigma
	c) IPV is a domestic matter	i) Turn a blind eye

The fourth category under the theme 'Perpetrators of IPV' describes how the women experienced cultural attitudes toward IPV. The three subcategories relate to a) 'Power imbalance and patriarchy', b) 'Perceived stigma' and c) that 'IPV is private'.

a) Power imbalance and patriarchy

The first subcategory under 'Cultural attitudes' illustrates the pervasive effect of patriarchal ideas on IPV. In this study, the participants overtly attributed IPV to patriarchy (cf. 2.3.3). This supports a feminist view of IPV and intimate terrorism (cf. 2.3.1). All eleven participants reported on the implied patriarchy they experienced. Patriarchal ideas that

participants expressed, included that women need to ‘submit’ to men and that men need to provide for women.

i) Patriarchy: *He’s a man. His word, his voice. It’s a matter of it must be heard. While I am a woman, I am not working; I don’t have money. You see like my voice is not heard at all* (Mosa).
ii) Women need to be submissive: *We are living in a patriarchal society. And we’ve got the norms and standards that we have. Those norms and standard, they, they condition us as well, and that makes me powerless, ‘cause now you’ll go into the community, or into the village, when they believe that a woman will always be submissive*. (Bontle)
iii) He is a provider: *Wives don’t talk because they’re getting a roof over their head, food in their mouth that kind of thing (crying). So I think they (the police) had that attitude towards me like this man is providing for you, you know, you don’t lay charges against him or if he beats you, just shut up about it, and you go sleep or whatever. You don’t have any rights because he is providing for you (sniff) and that is what I experienced* (Lucy)

In a South African qualitative study by Mkhonto et al. (2014, pp. 345–346), participants also attributed IPV to patriarchy. The verbatim quotes above show how patriarchal structures in society made the participants feel powerless and violated their human rights. The participants felt that society saw women as lower than men and had an expectation that women should be dependent on men. The previous categories illustrate how patriarchal ideas filtered through to the community level in some of the participants’ interactions with police and church members. It also filtered through to an interpersonal level and influenced the participants’ families’ attitudes and most prominently, their intimate relationships. Patriarchal structures influence occupational participation in that women are restricted from accessing some activities that men can access freely (De Jongh, Hess-April, & Vermeulen, 2018, p. 65). Occupational therapists need to be involved in community initiatives to address these social structures.

The effect of patriarchy on the way males and females interact with each other is far-reaching. For example, when exploring the history of occupational therapy in South Africa, Joubert (2010) found that patriarchal ideas are prevalent in the epistemology of occupational therapy. She even uses a metaphor of a coercive marriage (one that has characteristics of IPV) to explain how the medical model of viewing people and the positivist outlook were enforced upon the functioning of the profession. Joubert (2010, p. 25) also looks at South Africa's political history and points out how "it is hardly likely that occupational therapists practising in the apartheid era deliberately marginalised and oppressed those individuals of other race groups that they served." Similarly, it is hardly likely that occupational therapists are deliberately oppressing, stigmatising, or marginalising people affected by IPV. Yet, if occupational therapists are holding on to patriarchal mind sets, then we contribute to the experience of powerlessness and human right violations, of people affected by IPV.

b) Perceived stigma

The second subcategory under 'Cultural attitudes' illustrates the damaging effects of stigmatisation. Stigma is implicitly present in codes for all participants, with three of the eleven participants overtly reporting on stigmatisation.

i) Stigma: [The participant ascribed her inability to secure employment to stigma]
Interviewer: *What do you think the stigma is?*
Jasmyn: *That we were weak, and we were stupid and we were foolish, and we were... weak.*

Meyer (2016, p. 80) supports that a stigma associated to women affected by IPV is one of weakness. A weak will can be seen as a character blemish that attracts discrimination (Link & Phelan, 2001, p. 369). However, women affected by IPV are not at all weak (see for example, Bruno, 2019). People affected by the stigma related to IPV should thereby become active challengers of the stigma as opposed to passive victims (Link & Phelan, 2001, p. 378).

Stigmatisation has serious consequences for people affected by IPV. Stigmatisation results in decreased help-seeking as well as difficulty with finding employment (as in Jasmyn's case), social interactions, and psychological well-being (Link & Phelan, 2001, p. 380; Menaker & Franklin, 2015; Meyer, 2016, p. 80; Thaggard & Montayre, 2019, p. 220). Occupational therapy literature describing the effect of stigma in people with mental illness (Crouch, 2014, p. 61) and HIV (Van der Reyden, Joubert, & Christopher, 2014, p. 90) describes similar challenges related to stigma. Stigmatisation is also associated with occupational injustice (Hocking, 2017; Zietsman & Casteleijn, 2014, pp. 36–37) especially occupational marginalisation (cf. 2.4.4) and exclusion. Further, Thibeault (2011, p. 156) compares the needs of an old woman with leprosy to a young landmine survivor as an example to observe that "To a large degree, level of stigma seemed to determine the breadth of occupational needs, the most stigmatized requiring the most support."

Public ignorance is a contributing factor to stigma. Crouch (2014, p. 61) observed that stigma surrounding mental illness is greatly influenced by familiarity and education surrounding the nature of the illnesses. It is well supported in occupational therapy literature as well as literature from other disciplines that awareness is an essential part in addressing stigma (Menaker & Franklin, 2015, p. 4; Van der Reyden et al., 2014, p. 90).Through increasing public knowledge and conversation about IPV occupational therapists can address the stigmatisation surrounding IPV. As an example of how this can be applied, Joyner and Mash (2011, p. 2) suggest that, routine enquiry about IPV at healthcare settings contributes to addressing stigma due to increased conversation on the topic[24].

c) IPV is a domestic matter

The third subcategory under the category 'Cultural attitudes' illustrates how the general public responded to IPV. All eleven of the participants implicitly referred to how they felt

[24] Enquiry about IPV should be done with care. A useful resource is provided by Gordon (2016) "*Intimate partner violence is everyone's problem, but how should we approach it in a clinical setting?"*

that people reacted passively to their abuse. Six of the eleven participants explicitly reported they experienced that people in their communities were unresponsive towards IPV. This excludes the unresponsiveness of the people working in institutions already discussed (cf. 4.3.1.3).

i) Turn a blind eye: People *[e.g. colleagues and neighbours]* knew exactly what was going on, and nobody did anything (Jasmyn).

Participants expressed that people they knew in settings such as neighbourhoods and workplaces were aware of the abuse. Yet, these people never intervened. This is likely due to the societal view that IPV is a domestic matter and therefore not an area to be interfered in (Joyner & Mash, 2012b, p. 3; Mannell et al., 2016, p. 6; Stark, 2007; Thaggard & Montayre, 2019, p. 219). However, contrary to this belief, participants expressed a desire that people enquire into their situation although the participants did not specify what type of intervention would be most helpful.

No one should keep quiet for abuse. No one. I know some people tend to think that, "Ah it's not my business", but... *if they allow it to happen to another person* [*emphasis added*] then that means it will continue until it's unstoppable. That's why there are women who are dying every day. Killed by their intimate partners. And there are kids are being raped and stuff. Because people are not talking. People need to talk. People need to say something. Because there is help. Ja. (Thandi)

Thandi showed the importance of talking about IPV by highlighting the danger of intimate terrorism being intimate femicide (cf. 2.3). Thandi felt especially strongly about this topic because her mother was killed as a result of IPV. Thandi also pointed out how through silence, people are permitting the abuse to happen. The openness of women, affected by IPV, to talk about their experiences is reflected in the positive response that women have displayed to routine screening for IPV (Joyner & Mash, 2014, p. 661, 2011, p. 2) and toward participation in qualitative research (Mkhonto et al., 2014, p. 343). This highlights

that women affected by IPV do not see it as a domestic matter and the assumption of society that IPV is a private domestic could be life-threatening.

4.3.1.5 *Summary Theme 1: Perpetrators of IPV*

The theme 'Perpetrators of IPV' sketched the context of women affected by IPV who participated in this study. This is an important starting point as the Ecology of Human Performance model emphasises that all human performance should be viewed through context (Turpin & Iwama, 2011, p. 108). In summary, I present the context with the metaphor of mould growing on food. Mould growing is like IPV, both are undesirable, and in the right environments, both can be prevented. Mould tends to grow in dark, moist, environments, whereas it is unlikely to grow in environments that are light and well ventilated. Similarly, when looking at the context of the participants, one can identify factors that are favourable to the perpetration of IPV, as well as conditions that prevent IPV from being perpetrated.

The categories in this theme can be compared to the Ecological Model for Understanding Violence (Krug et al., 2002, p. 12) (cf. 2.3.2). Working from a micro to a macro level, the first two categories 'Coercive control' and 'Family behaviours and attitudes' take place on an interpersonal level. The third category 'Community institutions', illustrates the community level while the fourth category, 'Cultural attitudes' relates to the societal level.

On an interpersonal level, the first category addresses the intimate relationship context of the participants. The need for the abusers to have control of the women was a dynamic present in all the relationships. This factor indicates that IPV, specifically intimate terrorism, was present. As a strategy to establish control of the participants, their partners employed a variety of abusive tactics. The experience of these abusive behaviours jeopardised all aspects of the participants' health. This highlights that occupational therapists are likely to encounter people affected by IPV in a clinical setting. In case they do encounter these people, occupational therapists need to holistically consider all aspects of a person's health during their assessment and treatment.

Continuing the interpersonal level, the second category describes the family support available to the participants in the study. Regarding the abuser's family, some participants experienced that the family was protective of the abuser, not wanting to involve the police, and they encouraged the women affected by IPV to keep family matters private. On the other side, the participants also did not receive much support from their families. The family attitudes showed elements of victim-blaming. This is related to the expectation of a woman affected by IPV to act as an ideal victim. If they act differently to those expectations, the women are blamed as being deserving of abuse. An environment with poor support favours the presence of IPV as it reduces help-seeking from people who have experienced IPV.

On a community level, the third category illustrates aspects of the participants' institutional environment. These include 'Police', 'Healthcare workers', and 'Churches'. Participants had contrasting experiences with each. Generally when people working at the institutions were aware of IPV and followed guidelines stipulated in the Domestic Violence Act 116 of 1998 and the National Policy Guidelines on Victim Empowerment (National Department of Social Development, n.d.), the participants' help-seeking was successful. The participants were referred to shelters and they were able to leave their relationships. On the other hand, if the people working at the institutions were ignorant of the dynamics of IPV, or did not comply to the Domestic Violence Act 116 of 1998 and the National Policy Guidelines on Victim Empowerment (National Department of Social Development, n.d.), then the participants returned home to their abusive relationships. These contrasting experiences show that people at community institutions, such as occupational therapists, have the power to create either a favourable or unfavourable environment for IPV. They can either keep the matter hidden in darkness or they can shed light on it. It is their ethical responsibility to be aware of IPV and the appropriate way to respond.

On a society level, the final theme considers the cultural context of the participants. The theme illustrates how a patriarchy and the belief that women are lower than men and should be dependent on men, filtered down to all levels of the participants' context. Further a stigma that people affected by IPV are weak shows that society at large is

ignorant of the experiences of people affected by IPV, and the perception that IPV is a domestic matter prevents people in general from getting involved, when they suspect IPV. Stigmatising beliefs that are present in society contribute to an environment that allows for IPV to continuously be perpetuated. While it is true that intervening in matters if IPV carelessly may have harmful consequences for women being affected by IPV, contacting a shelter for advice or encouraging a woman affected by IPV to call helplines is a reasonable, safe action that any member of society can take to support women affected by IPV.

When considering a person affected by IPV, it is imperative to consider her within the environments she is functioning. Humbert (Humbert et al., 2013, p. 29) compares using the MOHO and Kawa model to approach IPV. She argues that the MOHO views the person as an individual, distinct to her environment, who has agency to overcome challenges. Such a view may support a victim-blaming attitude. On the contrary, Humbert argues that the Kawa model sees an individual as inseparable from her context, which supports that occupational therapists should also address external factors when working with IPV.

4.3.2 Theme 2: Effect of Intimate Partner Violence on Occupation

In the second theme, I describe the impact of IPV on the participant's occupations with special emphasis on the participants as occupational beings. The five categories in this theme are: 'Diminished occupational participation'; 'Meaningless activities'; 'De-identification; 'Difficulty in areas of occupation'; and 'Feeling dehumanised'.

4.3.2.1 Diminished occupational participation

The first category under the theme 'Effect of IPV on Occupation' relates to how the participants had diminished participation in activities that would contribute to their well-being. Eight of the eleven participants informed this category. The category had no subcategories and constituted three codes: i) 'Doing nothing'; ii) 'Mundane routine' and iii) 'Uninterested in activity'. The first two codes illustrate that one of the effects of the controlling dynamic in the relationship is that abusers used access to occupations as a

means of oppressing the participants. The third code differs from the first two in that something *internal,* was also preventing the participants from participating in occupation

Category	Subcategory	Code(s)
Diminished occupational participation	n/a	i) Doing nothing ii) Mundane routine iii) Uninterested in activity

A verbatim example is provided for each code below:

i) Doing nothing: *But, I'm like an object. I'm not allowed to cook. I love cooking! I'm not allowed to do ANYTHING!. I must just sit and watch him do whatever he likes…But he is not a great cook. And then he'll force me to eat that food. Sometimes, yoh!, it was bad…I wasn't allowed to do what I like. I must just sit at home. Why can't he just allow me to be a wife or a women?* (Joyce) *My days were pretty boring, my entire event was limited…I couldn't work, I couldn't have a car, all independence was gone… I would send the child off to school and things and then go back to bed because there was nothing else to do, he wouldn't let me look for a job.* (Jasmyn)
ii) Mundane routine: … *Then I stopped working. So, that was my routine. House and church, house and church, house and church* (Thandi) *I sleep, I eat, I sleep, I eat, I sleep. Every day when I wake up I know, I'm eating and sleeping* (Ntabiseng).
iii) Uninterested in activity: *Yeah, so I'll feel that I'm like I'm different from girls my age, really different…I'll lock myself in the room, I wouldn't wanna go out* (Nonhle) [Participant explained that her abusor is away during the week]… *so on my own you know, Monday to Friday. I could have gone and done what ever I wanted to do, but I didn't have the, I didn't feel like it...* (Lucy)

Regarding the codes 'Doing nothing' and 'Mundane routine', the abuser chose what activities the participant could and could not participate in. In this study, for all of the participants, the partners removed the choice of whether the participants should work,

who they should socialise with and/or whether they wanted to have sex. In Joyce's case, she was even prevented from doing housework, such as cooking and ironing. The boredom that the participants experienced in their everyday routine, highlights how limited participants' options for activities were. These are examples of occupational deprivation where something *external* is preventing a person from participating in activities (Whiteford, 2010, p. 330). Occupational deprivation is present in several oppressive relationships with power imbalances. These include victims of human trafficking (George & Stanley, 2018, p. 10), live-in domestic workers with their employers (Galvaan et al., 2015, p. 45), and inmates in prison (Whiteford, 2010). The parallel of inmates and women affected by IPV is a striking reminder that although perceived as free in society, the participants were prisoners in their own homes. Referring to imprisonment, Whiteford (2010, p. 312) explains,

> *Such a sanction represents a powerful reminder that the right to do what one chooses, when, and where (within the confines of the law) is considered to be so central to our cultural understandings of what it is to be human, that to* remove that freedom of choice and participation in occupations is considered the most severe punishment *(emphasis added).*

Restrictions on activity participation for people affected by IPV are evident in many qualitative studies (Crossman et al., 2016, p. 467; Flasch et al., 2015, p. 11; Humbert et al., 2013, p. 256) and typically are classified as a form of emotional abuse (Crossman et al., 2016, p. 457; Taherkhani et al., 2014, p. 235). However, from an occupational justice perspective, considering that being able to participate in occupation is "central to the human experience" (Wilcock, 2006, p. 10), I propose that purposefully depriving another person of their choice in occupation, could be seen as a separate form of abuse.

In this study and in anther qualitative studies (Humbert et al., 2013, p. 256), this internal desire was always related to avoiding social interactions. From a physiological and psychological perspective, this avolition is typically attributed to the effect of a depressed mood (American Psychiatric Association, 2013, p. 133). However, from an occupational perspective this can be attributed to occupational dysfunction. Whiteford (2000) explained

that the prolonged effect of occupational deprivation is occupational dysfunction which is "atrophy of some of the innate human capacities for occupation" (Whiteford, 2000, p. 201). Participating in occupations is part of what it means to be human (Wilcock, 2006, p. 56). In this way occupational dysfunction resulting from occupational deprivation touches on the very core of what it means to be human. The effect of oppression in IPV is that victims who have atrophied occupational capacities, have reduced drive to express themselves through participating in occupations.

4.3.2.2 Meaningless activities

The second category under the theme 'Effect of IPV on occupation' relates to participants expressing that they were not achieving fulfillment from what they were doing. Nine of the eleven participants informed this category. The category had no subcategories and constituted of two codes: i) 'Forced activities' and ii) 'Powerlessness'.

Category	Subcategory	Code(s)
Meaningless activities	n/a	i) Forced activities ii) Powerlessness

A verbatim example is provided for each code below:

i) Forced activities: *I HATE cleaning, I am an educated woman. You see so every day would be pushing this mop and I'd feel like 'urggghhhhhhh!'* (Jasmyn). *I know I have to cook, I have to do the laundry, I have to iron, I have to clean the house. But always when I do those things I am not happy...I was feeling used* (Mosa)
ii) Powerlessness: *What can I say, what can I do?* (Corli) *I feel tied up, I want to get out, but it's hard*. (Nonhle)

The first code is defined by the participants forcing themselves to do activities that they did want to do and feeling frustrated as a result. The reasons why they forced themselves to do these tasks were either to avoid aggravating their partners or because they felt it's their role as a female partner to perform these tasks. In this study the 'forced' activities

included housework such as cleaning, cooking, or child-care. These type of activities are fundamental in supporting the functioning of a home (American Occupational Therapy Association, 2014, p. S13). Occupational therapists are not only concerned with the fact that an activity is performed but also a person's motivation for performing it and their experience while performing the activity (Hayward & Taylor, 2011, p. 134). Whenever a person feels forced to participate in activities, that do not add meaning to their life, the person is experiencing occupational alienation (cf. 2.2.4.1). Groups of people who experienced occupational alienation due to feeling forced to participate in some activities include, those who make use of mental health care services (Bryant, Craik, & Mckay, 2004, p. 287), victims of human trafficking (George & Stanley, 2018, p. 10) and inmates (J. P. Munoz et al., 2011, p. 236). Jasmyn and the other participants did not experience cleaning the house as contributing to improving their quality of life. By continuing to participate in these activities, that from a patriarchal perspective is considered a women's role (cf. 2.3.3), the oppression the participants experienced as occupational beings was continually being reinforced (Stadnyk et al., 2010, p. 339).

The second code highlights the participants' deep sense of powerlessness and being unable to change their circumstances. In their research on IPV, Munoz Brandy and Brown (2017) and Flasch et. al (2015) attribute the powerlessness their participants experienced to the aspect of control present in IPV. The more the abusers asserted control over the participants, the less the participants felt they had power to control the outcome of their lives. From an occupational perspective this can be attributed to self-efficacy which is people's "sense of what kinds of outcomes they are able to control" (Turpin & Iwama, 2011, p. 140). Self-efficacy is thereby strongly related to control and power. It has been established that the abusers used a variety of methods to assert control by oppressing the participants (cf. 4.3.1.1). This code therefore indicates that the participants had a low self-efficacy. People avoid tasks in which they experience low self-efficacy (Turpin & Iwama, 2011, p. 140). Thereby by feeling powerless the participants were unable to seek out and participate in activities that would add meaning to their lives, which makes help-seeking difficult and further contributes to their experience of occupational alienation.

4.3.2.3 <u>De-identification</u>

The third category under the theme 'Effect of IPV on occupation' is marked by the participants that expressed that their sense of identity was either lost or changed in some way. Occupational identities are expressed and changed according to the occupations a person participate in (Turpin & Iwama, 2011, p. 138). All eleven participants informed this category. This category has no subcategories, and the three codes that constituted this category were: i) "Nothing about me counted"; ii) 'Estranged to self'; and iii) 'Believing his insults'. Occupational therapists view identity in the light of occupational identities (i.e., how a person views themselves as an occupational being).

Category	Subcategory	Code(s)
De-identification	n/a	i) "Nothing about me counted" ii) Estranged to self iii) Believing his insults

A verbatim example is provided for each code below:

i) "Nothing about me counted": *I was helping him live his life – I had to forget about my life* (Joyce)

Picture of a snake swallowing a small animal

I was just this grey entity, like a shadow or something [referring to picture] I am inside this person, you never saw me. (Jasmyn)

ii) Estranged to self: *I was quiet an independent women… I used to be a positive person… I am not this person* (Jasmyn) *I was living a 'yes-sir' life. 'Yes sir' life. I was not supposed to say anything. I was not allowed to be myself.* (Joyce)
iii) Believing his insults: *You look at yourself in the mirror, "Ai, he is telling the truth*." (Thandi) *All his negative energy was sucking the life out of me. And ja, there is really nothing I could do. You know, when your broken down so badly, I was told I am an idiot, I'm stupid, I'm worthless, I'm, you know, I'm not good for anything, ja…I think that after a while you believe it. You know in the back of your head it's not true…but you just get tired of fighting* (Lucy)

Jasmyn referred to the picture of a snake swallowing a small animal to highlight how she felt consumed by her abuser. Wilcock (2006, p. 9) explains, "It is only by doing that people can demonstrate what they are and what they hope to be". Occupational identities (see Table 2-2) are thereby formed and expressed through what people do. However, considering the occupational deprivation that the participants experienced, I propose that occupational identity is also formed by the occupations one does *not* participate in as one does not have the platform to express one's unique identity. The participants felt consumed by their abuser because he was dictating their occupational participation.

Second, the participants expressed a dissonance in their present occupational identity and the occupational identity of who they wanted to be. In the second verbatim quote, Jasmyn expressed an estrangement to her state of being when she considered how she used to participate in activities (i.e., independently) before she was in the abusive relationship. This may be attributed to occupational alienation. The activities that the participants were engaged in and the satisfaction that the participants gained from these activities were not in-line with their occupational identity (see Table 2-2) of what they would like to be doing. Jasmyn expressed that she wanted to be an independent strong

woman, however, her activity participation while she was in the relationship did not align with that identity.

Third, the participants expressed that they started believing the insults of the abuser. In other qualitative studies on IPV, it was found that being controlled and verbally abused had a negative effect on the participants' self-esteem (Flasch et al., 2015, p. 10; Mannell et al., 2016, p. 15) However from an occupational perspective, we can attribute this to internalised roles. Internalising a role refers to incorporating a socially defined status, along with its attitudes and actions into one's sense of self (Turpin & Iwama, 2011, p. 142). The "Ai," in Thandi's verbatim shows that she was disappointed in what she believed to be true. This affirms the dissonance in occupational identity. How she was experiencing her current occupational role was not in line with the identity that she wanted to have.

4.3.2.4 Difficulty in areas of occupation

The fourth category under the theme 'Effect of IPV on Occupation' describes specific areas of occupation that the participants experienced difficulty in. The Occupational Therapy Practice Framework Fourth Edition (American Occupational Therapy Association, 2020) identifies nine broad categories or areas of occupation namely, "activities of daily living, instrumental activities of daily living, health management, rest and sleep, education, work, play, leisure, and social participation" (p. 7). Each of these broad areas of occupation consist of many specific occupations.

All eleven participant informed this category. The category had no subcategories and constituted of four codes: i) 'Sleep', ii) 'Unable to work', iii) 'Lack of fun', and iv) 'Difficulty with child-rearing[25]'. The participants' lack of social participation was categorised under the category 'Coercive control' (cf. 4.3.1.1) and the effect of diminished social participation is explained in the category 'Diminished occupational participation' (cf. 4.3.2.1).

[25] In occupational therapy, 'child-rearing' is an 'instrumental activity of daily living' that is unique to people with children in their care (American Occupational Therapy Association, 2020, p. 31).

Category	Subcategory	Codes
Difficulty in areas of occupation	n/a	i) Sleep ii) Unable to work iii) Lack of fun iv) Difficulty with child-rearing

A verbatim example for each code is provided below.

i) Sleep: *I think there is a fine line of 8 hours of good sleep and then 16 hours of... you just sleep... you are dead you know.... and I was tired! I was doing nothing but I was tired…because I was so bored. And ja, at the moment, every time I would find a pillow I would sleep* (Jasmyn) *For I was thinking, "What if this guy just wakes up and strangles me. Because he is angry, now I don't know what is he angry about." I never used to sleep peacefully. I never used to sleep ja, peacefully, 'cause I didn't know what was he thinking* (Thandi)
ii) Unable to work: *I was going to work with blue marks on my face…he even locked me up for days. How would I have explained that?" I would have never lasted in a job*." (Lucy) *When I go look for a job, he, he take my ID. He didn't want me [to work] my CV, he start [gesturing tearing] because he didn't want me to go* (Ntabiseng)
iii) Lack of fun: *I had no fun at all* (Mosa)
iv) Difficulty with child rearing: *I cannot handle that situation of my child*[26]*, I'm busy having my situation* (Ntabiseng)

The first three codes related to sleep, work and fun are examples of occupational imbalance. The definition of occupational imbalance (see 2.2.4.4) shows that there are three aspects of imbalance to consider, namely: balance between strenuous and restful occupations; between chosen and obligatory occupations; and between productivity,

[26] The child was having issues at school regarding bullying.

pleasure, and restoration. When considered together, these verbatim quotes show that the participants did not have balance between productive, pleasurable, and restorative occupations meaning that the participants did not reap the benefits of healthy engagement with each of the categories of occupation (Wilcock, 2006, p. 170).

First, the participants had contrasting experiences with sleep. Most participants expressed that they had difficulty sleeping due to stress for fear of their safety. Some participants, like Jasmyn, expressed how they slept too much during the day due to boredom. However, both reported that their quality of sleep was poor for the same reasons of stress and for fear of their safety. Sleep problems are common in people affected by IPV (Gallegos, Trabold, Cerulli, & Pigeon, 2019, p. 1). Good quality sleep contributes to occupational well-being through meeting the occupational need of renewal (Ramugondo, 2017, p. 40). Further, sleep quality affects immune function, mood, cognitive capacity, physical abilities, and healing (Pierce, 2001, p. 253). Thereby lack of sleep and poor quality sleep have negative effects on physical health by increasing the risk for, obesity, diabetes, cardiovascular disease, hypertension, inflammation, as well as mental health by increasing the risk for anxiety and depression (Gallegos et al., 2019, p. 2).

The second code, ‘Unable to work’, highlights forced deprivation of employment. Most of the participants were not allowed to work. In the first category under this theme (cf. 4.3.2.1), I discussed how the participants experienced reduced participation in occupation largely due to occupational deprivation. Deprivation from employment is especially potent in contributing to the experience of occupational injustice because of the high value that society places on paid employment (Wilcock, 2006, p. 165). Paid employment also has the potential to contribute to occupational well-being through meeting the occupational needs of accomplishment and affirmation (Ramugondo, 2017, p. 40). Further, by not allowing their partners to work, abusers prevented the participants from the benefits of employment which include financial independence, developing skills, earning status in society, building self-esteem, and feeling accomplished (Whiteford, 2010, p. 362).

The example of being deprived from work, along with being deprived of social opportunities (cf. 4.3.1.1) and other activities discussed earlier under 'Diminished occupational participation' (cf. 4.3.2.1), show how the participants lacked balance between chosen and obligatory occupations. In the following statement by Backman (2010, p. 232) we see that choice is crucial in maintaining occupational balance: "Responding to changing circumstances by making choices about which occupations to do, as well as when, how, and for how long, reflect adjustments made to maintain occupational balance." Without the freedom to choose occupations it is impossible to achieve occupational balance. Thereby, occupational imbalance is common in coercive situations where one party has limited power, such as human trafficking (George & Stanley, 2018, p. 7), imprisonment (Prioletti et al., 2011, p. 354) and live-in domestic workers (Galvaan, 2011, p. 354).

The third code, 'Lack of fun', highlights how the participants expressed that they never had fun. Lack of fun and leisure activities were noted in other qualitative studies with women impacted by IPV (Javaherian, Krabacher, et al., 2007, p. 46). 'Fun' or 'pleasure' are considered an occupational need. Pleasure is linked to hope (Wilcock, 2006, p. 126), eudemonic well-being and thereby occupational well-being (Ramugondo, 2017, p. 40). Pleasure also affects mood and health by contributing to sensory and limbic processing and arousal through endorphins (Pierce, 2001, p. 253). Thereby through experiencing an imbalance in pleasurable occupations, participants were unable to glean the benefits of pleasure which would contribute to their occupational well-being.

Fourth, in the verbatim quote provided for the code 'Difficulty with child rearing', Ntabiseng expressed how she was unable to fulfil tasks that would be required of her in her role of mother because she was just barely coping with her role of wife[27]. A similar result was found in a study in Australia (O'Doherty et al., 2016, p. 232). It has been found that when mothers are involved in family discord or is experiencing depression they have decreased

[27] Exploring the impact of IPV on children from an occupational perspective is beyond the scope of the study, however it is a topic that should be explored.

time, energy, attention, and patience to engage in healthy parenting practices (Austin, Shanahan, Barrios, & Macy, 2019, p. 499; Letourneau, Fedick, & Willms, 2007, p. 656).

Backman (2010, p. 241) used the term ‘role-overload’ with regards to work-life balance to explain how people are unable to achieve balance, because they have too many demands in one area of their lives and not enough time to meet those demands. They then spend too much time trying to meet those demands resulting in less time available to fulfil their roles in other areas of their lives. In the same way, the emotional demands of the abusive relationship exhausted Ntabiseng’s emotional capacity, leaving no reserve for her to cope with the emotional demands of her child. This in turn made her feel like an inadequate parent which negatively influences her self-esteem. The participants’ feeling unable to cope with the demands of all their roles, is thereby a direct result of occupational imbalance.

4.3.2.5 Feeling dehumanised

The fifth category in the theme “Effect of IPV on occupation” is marked by the participants expressing that they felt dehumanised. This category has no subcategory and one code, ‘I am not a person’.

Category	Subcategory	Codes
Feeling dehumanised	n/a	i) ‘I am not a person’

The two verbatim examples provided, highlight the deep effect of occupational injustices on the participants’ sense of being human.

i) I am not a person: *I felt like I had no rights as a human being* (Lucy)

	I could not talk to anyone and if I did they would always find something to like to, to turn it back to me, blame me. I'll cry and just shut down from everything, I'll be angry, because I knew I should be saying something but it does not happen. ***It was like, I'm not a person, I'm just a toy*** *[referring to the picture]* ***that does not feel a pain. Like everyone would just say whatever they feel like saying even if its a wrong choice of a word or what, but as long as they say it to me. You know it feels like they doing the right thing****. I needed that one person who would listen to me just someone who would listen and support, but they put me in the box,* ***...what I said would not matter to them****. Yeah. So this is like I wouldn't have to say anything, I would just have to listen, and if I need someone to listen to me I would not be listen to like, I would always be shut and um, I would have to take what they say and um, yeah,* ***I just have to be somebody else*** *[emphasis added].* (Nonhle)

The previous four categories highlighted how the participants have experienced occupational injustices at the hand of their intimate partners. From an occupational perspective, these injustices are severe and should be addressed in earnest because it has been shown that participation in occupation is a fundamental human right (Hammell, 2017a, p. 51). This code highlights how the participants experienced no longer feeling human. Nonhle felt that she no longer had a voice and that she was not allowed to feel and express emotions. She used a picture of a toy sitting one side, alone on a bed, to illustrate how she felt she was being treated differently compared to other members in society. Interestingly, this 'different' treatment was not from her abuser, but rather from the community around her. By not listening to her and saying unwanted things to her, Nonhle's community made her believe that she does not belong. One can safely conclude that Nonhle was not fully participating in her community. The first theme (cf. 4.3.1) highlights the context in which IPV takes place. Abusive partners are not the only perpetrators of IPV. Rather, society also perpetuates IPV in the way that it treats people affected by IPV.

From an occupational perspective, the feeling of not being able to do things, such as speaking out or expressing emotions, that other people in mainstream society are allowed to do, is described as occupational marginalisation (cf. 2.2.4.3). Occupational marginalisation has been described in many populations, including single migrant mothers (Kielsgaard, Kristensen, & Nielsen, 2018, p. 32), domestic workers (Galvaan, 2011), victims of human trafficking (George & Stanley, 2018, p. 10), women involved in sex work (Rule & Twinley, 2020), and transgendered people (Beagan et al., 2012). These examples indicate that occupational marginalisation occurs among minority populations. Occupational therapy has its origins working among marginalised groups (cf. 2.2.1), however many occupational therapists themselves likely fall into majority groups. Thereby occupational therapists themselves, may unknowingly be contributing to people in minority groups, such as women affected by IPV, experiencing occupational marginalisation. Occupational marginalisation is closely related to discrimination and stigmatisation. It calls for occupational therapists to be critically reflective in their practice to ensure that they are not perpetuating IPV through their own deeply imbedded prejudices and the way they respond to people affected by IPV.

4.3.2.6 Summary Theme 2: Effect of IPV on occupation

The theme 'Effect of IPV on Occupation" highlighted occupational injustices that the participants experienced as well as the effect of these injustices on their lives. Through analysing each of the codes and categories in this theme, I found that examples of occupational injustice cannot be ascribed to one risk factor. Rather, the risk factors overlap and co-exist, highlighting the occupational injustice that the participants experience.

Most prevalently, the participants experienced occupational deprivation due to the control that the abuser was exerting over the activities that the participants were or were not allowed to participate in. Thereby, they were unable to access activities that would contribute to their well-being. The prolonged experience of occupational deprivation resulted in occupational atrophy. This was expressed in the participants not *wanting* to participate in activities. Further, because occupational identities are influenced by the

occupations one does and does not participate in, prolonged occupational deprivation also resulted in a change of occupational identities. Controlling another person's occupations has severe negative impacts on the person being controlled and I propose that 'occupational abuse' can be seen as a separate type of abuse.

Occupational alienation was experienced in that participants were forced to participate in activities that had no meaning to them. Most often this was related to domestic chores. Occupational alienation is closely related to loss of personal capacity. This in turn resulted in decreased self-efficacy which was expressed in a deep sense of helplessness to change their circumstances. The prolonged experience of occupational alienation made the participants feel that they were no longer able to control the outcomes of their lives, as well as experience a dissonance in their occupational identities between what they are currently doing with their lives and what they would like to be doing with their lives.

Occupational imbalance was experienced either as a result of the stress associated with or as a secondary effect to occupational deprivation. The participants reported either sleeping too little or having poor quality of sleep. This is attributed to increased levels of anxiety and sleep. In a vicious cycle, poor quality of sleep in turn makes people less effective at managing stress and places a person at an increased risk for physical and mental health conditions. Further, due to occupational deprivation, participants were unable to work or participate in activities that they found leisurely and fun. The resulting occupational imbalance means that the participants did not reap the benefits of those occupations which include financial independence, skill development and increased self-esteem or improved mental health, life satisfaction, and hedonic well-being. In this study the effect of prolonged occupational imbalance was role-overload. The participants felt that they were unable to meet the demands in different areas of their lives, especially related to the roles of wife, mother and practicing self-care. This contributed to feelings of incompetence. Occupational imbalance thereby had a negative effect on the participants' physical and mental health.

Occupational marginalisation was perpetuated at the hands of society at large. Participants felt they were stigmatised and thereby could not fully participate in their

communities. Participants experienced their stories not being taken seriously, they were being objectified, and dehumanised. Resultantly, participants felt that they did not have access to help and support. This supports the ecological view of IPV and highlights that occupational injustice is not only perpetrated by the abuser, but also on multiple levels in society.

The participant's health and well-being were affected through experiencing each of the occupational risk factors. In this summary, I presented each of the risk factors with the outcome of the prolonged experience of that risk factor. The prolonged experience of occupational deprivation resulted in occupational atrophy and a change in occupational identity. The prolonged experience of occupational alienation was a deep sense of helplessness and a type of occupational dissonance. The prolonged experience of occupational imbalance was role overload and increased risk for physical and mental health conditions. The prolonged experience of marginalisation is the participants feeling dehumanised and hesitant to seek out help and support. The negative outcomes of the occupational risk factors, affected the participants' ability to thrive as occupational beings, thereby contributing to the experience of occupational injustice. It is important to note that although presented systematically, the risk factors cannot be separated and occur concurrently. In the same way, the negative outcomes of experiencing the risk factors cannot be ascribed to one particular risk factor, but should rather be seen as a collective set of outcomes as the result of experiencing occupational injustice.

4.3.3 Theme 3: Changes and Adaptations Due to Intimate Partner Violence

The third theme describes the changes to the participants' wellbeing due to IPV as well as the adaptations they made to cope with the IPV. 'Adaptation' and 'change' are often used synonymously however in this theme I differentiate between the terms. Adapting refers to change over time that is usually intentional and typically has a positive effect while change refers to more involuntary differences that appear and typical have an adverse effect on well-being. The theme constitutes five categories namely: 'Mental changes'; 'Emotional changes'; 'Behavioural adjustments'; 'Spiritual adjustments' and 'The final adaptation – leaving'.

4.3.3.1 Mental changes

The first category under the theme 'Changes and Adaptations due to IPV' describes the changes in the thought patterns of the participants. The psychodynamic frame of reference is a theoretical frame of reference that occupational therapists can draw upon to interpret occupational phenomena. In this theoretical frame of reference, mental well-being involves having a balanced view of ourselves. Furthermore, we need to be aware of how the way we view ourselves impacts our emotions, actions and other people (Daniel & Blair, 2011, p. 175). This category highlights how the participants' mental changes impacted their behaviours. The three subcategories relate to a) self-destructive reasoning, b) compulsive thinking and c) acceptance.

Category	Subcategory	Code(s)
Mental changes	a) Self-destructive reasoning	i) Self-blame ii) Breaking herself down
	b) Compulsive thinking	i) Thinking about future ii) Sense making iii) Suicidal ideation
	c) Acceptance	i) "This is life"

a) Self-destructive reasoning

The first subcategory under the category 'mental changes' illustrates how the participants thought of themselves. All of the participants informed this code. In this study many of the participants expressed that at some point in the relationship they believed that they somehow deserved the abuse. The participants also expressed that they often felt angry, disappointed or frustrated at themselves either for not thinking wisely thereby getting themselves in the relationship and/or for staying in the relationship. The following verbatim quotes illustrate how the participants experienced self-blame and breaking themselves down mentally.

Self-blame: What have I done to deserve this? (Corli)

Breaking herself down: Cause really, why didn't I think? Like, um, and there is this curse that I used to curse myself with. And I would say "I take my brains and I put them on a chair and I sat on them with my butt [laugh]." So this is how I used to really think about myself. (Thandi)

In other qualitative studies self-blame and breaking yourself down appear to go hand in hand among people affected by IPV (Baholo, Christofides, Wright, Sikweyiya, & Shai, 2015, p. 643; Menaker & Franklin, 2015, p. 11; Neal & Edwards, 2017). Self-blame especially has been found to be present in other forms of gender based violence such as sexual assault (Christensen, 2019, p. 7; Mullu, 2015, p. 70; Schoeffel, Boodoosingh, & Percival, 2018, p. 10).

From an occupational perspective this can be described to the participants' volition especially as being influenced by their personal causation (cf.Table 2-2). The MOHO describes a volitional cycle where "volition affects how people anticipate action, make choices about what action they will engage in, experience action and interpret or give meaning to their actions (Turpin & Iwama, 2011, p. 139)". In this study, the self-blame expressed by the participants indicate that they interpreted their actions in the relationship as somehow deserving of abuse. Further by breaking themselves down, the participants indicated that they had an unhealthy sense of personal causation, which is their sense of capacity and effectiveness (Turpin & Iwama, 2011, p. 140). This explains why self-blame is viewed as major obstacle to help-seeking (Liang et al., 2005, p. 79).

b) <u>Compulsive Thinking</u>

The second subcategory under the category 'mental changes' illustrates how the participants experienced that they were constantly thinking. Eight of the eleven participants informed this sub-category. In this study these thoughts were mostly related to thinking about the future, making sense of the abuse and suicidal thoughts as illustrated in the following verbatim quotes:

Thinking about the future: I'm always thinking, "What am I going to do with this life? I will be able to live again happy, or am I going to die? I don't know, I will see if I get out. (Ntabiseng)
Sense Making: What changed? What happened? (Joyce)
Suicidal thoughts: I should maybe kill myself (Nonhle)

Thinking about the future and finding sense or meaning was also seen in other qualitative studies on IPV (Humbert et al., 2014, p. 372). The transtheroetical model (Prochaska, DiClemente and Norcross 1992 in Brown, 2011, p. 334) describes five stages of change namely, precontemplation, contemplation, planning, action and maintenance. The participants appear to have spent a lot of time in the contemplation phase, which is marked by thinking about the problem and weighing up the benefits of change (Catana Brown, 2011, p. 334). Additionally, thinking about the future is related to an individual's personal convictions, their view on what matters in life (Turpin & Iwama, 2011, p. 140). To highlight the importance of intervention in cases of IPV, like Nonhle, a few of the participants had considered killing themselves. The life that they were living was not aligned with their personal conviction. As part of the contemplation phase, participants were likely concerned about pragmatic implications of leaving the relationship, especially pertaining to as housing and finances (cf. 4.3.3.5.c). Being unaware of alternative options, such as shelters, suicide may have appeared to be a desperate option of a way to leave the relationship. Intervention in IPV, and referring women affected by IPV to shelter services is a matter of life or death.

c) <u>Acceptance</u>

The third subcategory under the category 'mental changes' illustrate how one participant accepted that abuse was part of her life as illustrated in the following verbatim quotes:

Acceptance: It just became life, you know, this is what it is… you don't want to fight anymore so you just fall into a place of acceptance (Lucy).

Initially the acceptance of the abuse was surprising to me considering that the interviews had taken place at shelters, meaning that the participants had physically separated from their abusers. In the case of this participant, when she was questioned about her plans for when she left the shelter[28] she stated that she was unsure and said that she was considering returning to her partner. This is important to look at as it may shed some light on why women do not leave their partners.

From an occupational perspective, the acceptance of the abuse can be ascribed to the cognitive process of habituation which is an internal readiness to behave in way defined by your environment. It reduces the degree of conscious thought that goes into making decisions about action (Turpin & Iwama, 2011, p. 141) (cf. Table 2-1). Habituation is largely influenced by internalised roles which has already been discussed in the previous theme under the category of de-indentification (cf. 4.3.2.3). Lucy was relying on habituation in making decisions about the future which indicates that at the time of the interview she didn't have the cognitive capacity to make decisions that would lead to living a life different to the one she had grown used to. She was thereby defaulting to making decisions in line with the occupational identity of a victim. It should, also be noted that Lucy only been educated up to Grade 10, was unemployed and was thereby reliant on her abuser (cf. 4.3.3.5.c). Overcoming these challenges would require initiative and careful planning from Lucy, which at the time of the interview she was not displaying.

Lucy's seeming acceptance of her abusive situation, has strong parallels with the phenomenon of institutionalisation which is often seen in long-term mental health care users (Zietsman & Casteleijn, 2014). Institutionalisation is marked by apathy, lack of initiative, submissiveness, an apparent inability to make plans for the future and "a resigned acceptance that things will go on as they are – unchanging, inevitably and indefinitely" (Zietsman & Casteleijn, 2014, p. 150). From an occupational perspective, institutionalisation has been ascribed to the experience of occupational alienation,

[28] Her time at the shelter was finished and she was likely leaving within the next two weeks.

occupational deprivation and occupational alienation (Zietsman & Casteleijn, 2014, p. 150).

The reasons why Lucy was still relying on habituation and was showing signs of being institutionalised, even when nearing the point of discharge from the shelter is beyond the scope of the study. However it is evident that changes occur in the thought patterns of people affected by IPV which contribute to the complexities involved in successfully leaving a relationship.

Considering the category from a feminist perspective, three codes in this category, 'self-blame', 'sense-making' and 'acceptance' demonstrate how the participants tried to rationalise the abuse. The participants were trying to normalise their experience while trying to establish how their behaviours could justify their partner having to establish dominance over them while they need to submit. Consider this statement by Nonhle

> I submit…like I am a slave or something (Nonhle).

Such thinking in is line with patriarchal thinking which highlights the impact of patriarchy in society on the participants' perception of 'normal' (2.3.2).

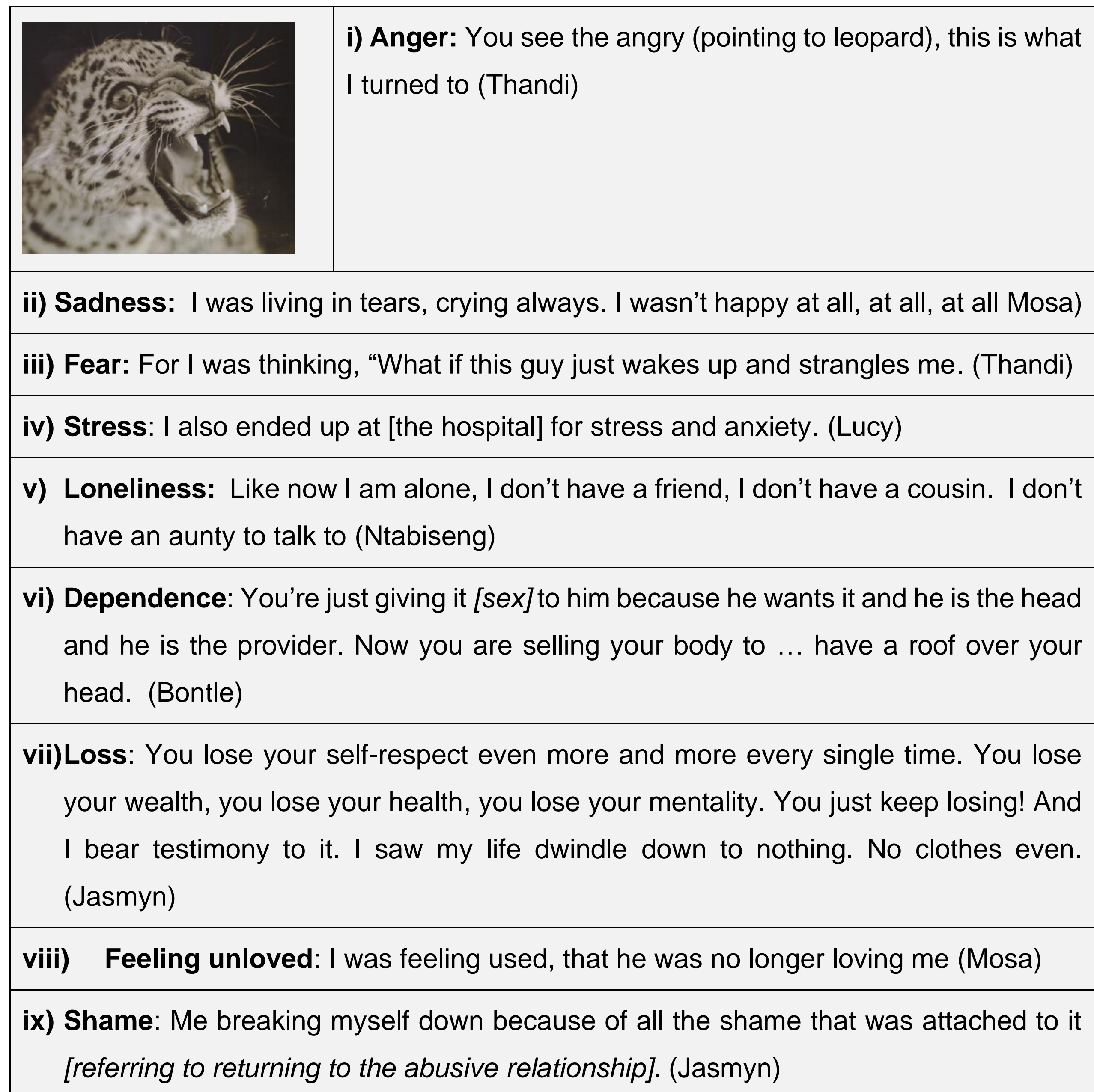
4.3.3.2 Emotional changes

The second category under the theme 'Changes and adaptations due to IPV' describes emotional changes in participants. The two subcategories relate to a) unpleasant emotions and b) pleasant emotions.

Category	Subcategory	Code(s)
Emotional changes	a) Unpleasant emotions	i) Anger ii) Sadness iii) Fear iv) Loneliness v) Dependence vi) Loss vii) Feeling unloved
	b) Pleasant emotions	i) Hope that he will change ii) Love

a) Unpleasant emotions

The first subcategory under the category ‘emotional changes’ describe the variety of unpleasant emotions the participants experienced while in the relationship. All of the participants informed this subcategory. The subcategory has nine codes as indicated by the following verbatim quotes:

<table>
<tr><td></td><td>i) Anger: You see the angry (pointing to leopard), this is what I turned to (Thandi)</td></tr>
<tr><td colspan="2">ii) Sadness: I was living in tears, crying always. I wasn’t happy at all, at all, at all Mosa)</td></tr>
<tr><td colspan="2">iii) Fear: For I was thinking, “What if this guy just wakes up and strangles me. (Thandi)</td></tr>
<tr><td colspan="2">iv) Stress: I also ended up at [the hospital] for stress and anxiety. (Lucy)</td></tr>
<tr><td colspan="2">v) Loneliness: Like now I am alone, I don’t have a friend, I don’t have a cousin. I don’t have an aunty to talk to (Ntabiseng)</td></tr>
<tr><td colspan="2">vi) Dependence: You’re just giving it [sex] to him because he wants it and he is the head and he is the provider. Now you are selling your body to … have a roof over your head. (Bontle)</td></tr>
<tr><td colspan="2">vii) Loss: You lose your self-respect even more and more every single time. You lose your wealth, you lose your health, you lose your mentality. You just keep losing! And I bear testimony to it. I saw my life dwindle down to nothing. No clothes even. (Jasmyn)</td></tr>
<tr><td colspan="2">viii) Feeling unloved: I was feeling used, that he was no longer loving me (Mosa)</td></tr>
<tr><td colspan="2">ix) Shame: Me breaking myself down because of all the shame that was attached to it [referring to returning to the abusive relationship]. (Jasmyn)</td></tr>
</table>

All the codes in this subcategory will not be discussed individually but rather as a cluster. Anger, sadness, fear, stress and loneliness indicate that the participants were experiencing complex trauma (Alers, 2014, p. 339). Complex trauma differs from acute trauma in that the traumatic event is prolonged, repeated and difficult to escape from (Alers, 2014, p. 339). The code related to dependence highlights how dependence of the perpetrator for basic need fulfilment made it difficult for the participants to leave the relationship. Two of the participants even compared this dependence to prostitution which serves to highlight the importance of shelters for women affected by IPV.

The feeling of loss and of being unloved indicate a deep level of grief that the participants experienced. Loss was experienced in multiple aspects of life including that of independence, relationships, material possessions, health and wellbeing as well as dignity. Occupational therapists are often exposed to grief and have to consider it when working with a variety of clients including those recently diagnosed with and those who have recently lost significant function HIV (Van der Reyden et al., 2014, p. 90). This indicates how holistic the rehabilitative process has to be for people affected by IPV.

It is important to note that the participants did not experience the emotions as fleeting but rather as a chronic state of being. Experiencing an array of negative emotions has been seen among other people impacted by IPV and is attributed as an effect of emotional and verbal abuse (Mkhonto et al., 2014, p. 435). The limbic system generates emotions and is the driver behind survival instincts (Alers, 2014, p. 339). Similarly to how physical pain plays a role in protecting our bodies by indicating that something is not right, unpleasant emotions play a crucial role protecting our well-being by signalling that something is not as it ought to be. Thereby, when considering the unpleasant emotions from a psychodynamic frame of reference, increased self-awareness of the function of emotions could be helpful for people affected by IPV (Daniel & Blair, 2011, p. 172). In each of the verbatim quotes provided as an example, the participants indicated what the emotion was signalling. Thandi was acting out of character and felt her life was at risk; Mosa was no longer experienced happiness and saw that her abuser was unloving toward her; Lucy went to hospital for her mental health; Ntabiseng was isolated; Bontle saw sex as an

exchange for a roof over her head; Jasmyn found that she no longer had anything she considered important and that shame was ruining the relationship she had with herself. When people affected by IPV work through these unpleasant emotions instead of repressing them (Daniel & Blair, 2011, p. 172), emotions can fulfil their protective role and motivate a person to make decisions and take action to ameliorate their circumstance.

b) Pleasant emotions

The second subcategory under the category 'emotional changes' illustrates pleasant emotions that the participants experienced. Although only four participants informed this subcategory, the nuances of what they expressed are important to consider. The participants expressed that they had hope their partners would change and that they loved their partners as expressed by the following verbatim quotes:

i) Hope he will change: And if he could just change a few of his behaviours, you know it felt like the relationship would work, could and would work (Lucy)
ii) Love: People they keep telling me that [Amahle], this man of yours he is an abusor and what what what. I, I was like, there was no such a thing to believe you know, cause I was in love with him (Amahle)

The first code related to hope, shows how participants expressed that they stayed in the relationship because they had hope that things would get better. Other studies on IPV have also found 'hope' to be a reason for not leaving the relationship (Baird, 2012, p. 189). Hope has been identified as essential to coping with adversity (R. T. Munoz et al., 2017, p. 2). However the verbatim by Lucy shows that for the participants, while in the relationship the hope that they felt could be a form of denial as a defence mechanism (Daniel & Blair, 2011) this hope was based on an external locus of control namely his behaviour. Lucy hoped that her partner changing his behaviours would bring about her desired outcome of a happy life. She didn't base her hope on something that she had control over, such as how her own behaviours can contribute to her leading a happy life. R.T. Munoz et al. (2017, p. 2) attribute an external locus of control to the deep sense of powerlessness that people affected by IPV experience. An external locus of control is

associated with decreased resilience in people affected by IPV (Shannon, 2009, p. 298) sand generally a lower likelihood to transition

In the previous theme I linked powerlessness as contributing to participants' experience of occupational alienation (cf. 4.3.2.2). When the participants were in the shelter and had the opportunity to seek out and participate in activities they would find meaningful. They no longer experienced occupational alienation. Compare the following verbatim where Ntabiseng reflected on her current state when she was in the shelter.

> Powerful. I want to be a powerful woman … to stand on my own, not to live under the support. Now I'm tired to live under the man's support because I was always thinking like, In my head, *the man is the solution when you are not going to school and that is not the solution. So I want to be powerful***.** Not to say "I don't have a qualification". I don't have life. I want to dream big. I want to dream that one day I'm going to get house for myself and my kids. And I'm going to love myself. … So I want that confidence to myself. I don't have it now, but I'm going to learn more to, to be able to get myself back to have my confidence [*emphasis added*]. (Ntabiseng)

In this verbatim Ntabiseng explicitly explains how she shifted from thinking her partner is the solution to her problems to asserting power over the outcomes of her own life. Once Ntabiseng was in the shelter she started to adopt an internal locus of control by having hopes for the future that were centred on what she was able to do. Thereby I propose the experience of occupational alienation contributes to an external locus of control for hope which in turn prevented the participants from transitioning away from their partner for the duration that they were in the relationship.

The second code is related to love. The concept of love is important to consider as love was reason why all the participants entered into the relationships. In this study, participants explained that feelings of romantic love caused them to ignore the early signs of IPV in the relationship. Many of the participants expressed that they felt romantic love toward their partners for a long time during the relationship – even after it became abusive. Similar results were found in a study among Rawandan and Swazi women who

use phrases similar to that of 'love is blind' when explaining why they ignored the risks to their well-being that the relationship. Lelaurain, Fonte, Giger, Guignard, & Lo Monaco (2018) critique society's idealisation of and adherence to romantic love in relationships as contributing to patriarchy and the justification of IPV. They explain "the romance narrative portrays women as needing to be rescued by man and as needing to be complete and fulfilled, while men are portrayed as naturally strong, full of power, and sure of themselves" (pg. 4). The study by Ruark et al. (2017, p. 277) supports this by observing that if the expectation of love is patriarchal, with the man being the provider and the women submitting to his needs, the relationship has an increased risk of IPV. However as the IPV continued in the relationship, participants expressed that they re-evaluated the love.

I held on to that person. But the years have changed that person. And umm, I have only now realised that, that is what was going on. That I was in love with someone that has died a long time ago and he was never coming back. Now after twenty years and he is just this completely different person (Jasmyn)

This was seen in other cases of IPV in Africa (Ruark et al., 2017, p. 278). It took many years and many cycles of violence and forgiveness for the participants in this study and those in Ruark's study to realise that the relationship is no longer loving. Only at that point were the women able to seek help.

From an occupational justice perspective, it is important for health care professionals to be cognisant on where a women affected by IPV is on her journey and to respect that. Removing her choice of whether she wants to be in the relationship or being judgemental regarding her views of love or hope for the relationship will only perpetuate the occupational marginalisation that she is experiencing from society. The dynamics in a relationship with IPV are complex. Our duty is to take note of the violence and advise the person affected by IPV on what support is available to them (Gordon, 2016, p. 4). This stance aligns with the principle of client-centeredness as it respects an individual's

autonomy and choice (Gretschel & Galvaan, 2017, p. 241). If the person refuses help for reasons such as love or hope, as a mentally competent adult, that is their prerogative.[29]

4.3.3.3 Behavioural adjustments

The third category under the theme 'Changes and adaptations due to IPV' describes adjustments that the participants made in their behaviours. The two subcategories relate to a) coping strategies and b) pretence.

Category	Subcategory	Code(s)
Behavioural adjustments	a) Coping Strategies	i) Physical exercise ii) Singing iii) Going away iv) Overindulge v) Repress emotions vi) Change appearance and behaviours
	b) Hide abuse from people	i) Pretence

a) Coping Strategies

The first subcategory under the category 'behavioural adjustments" illustrate strategies the participants employed to cope with the trauma in the relationship. The terms adaptation and coping can be used interchangeably. Adapting is a more general term to refer to change over time while coping refers more specific behavioural strategies people use in response to difficult situations (Haertl & Christiansen, 2011, p. 313). All eleven participants informed this subcategory and six strategies were identified as indicated by the following codes:

i) Physical exercise: I started gyming as a coping mechanism (Joyce)
ii) Singing: If someone makes me angry I will just sing (Amahle)

[29] The exception being in cases where children are involved. Any suspicion of child abuse need to be reported to the Department of Social Development

iii) Going away: I go to the graveyard… It brings peace, quiet. Cause I can be with them [*referring to her deceased children*]. Not feel lonely... *[long pause, emotional]* And when I go home I got a smile on my face (Corli)
iv) Overindulge: Alcohol kind of like eased things for me because sometimes I'll just, you know, drink to not feel that what is he going to do that I didn't want him to *do [referring to him raping her]*. You know so it will make it easier for me. **(**Nonhle)
iv) Repress emotions: You learn... you have to keep all your emotion inside (Lucy)
v) Change appearance and behaviours: I even cut my hair! It was beautiful. I even cut my hair to say maybe if I could do this. (Bontle) I could not be myself. I have to be someone that I'm not (Nonhle)

Considering the coping strategies of people affected by IPV has been shown valuable in planning treatment for survivors (D. M. Johnson, Zlotnick, & Perez, 2011, p. 2). The above codes show a distinct differences in coping with occupational injustice. Considering coping from a psychodynamic and cognitive-behavioural framework, participants who engaged in physical exercise, singing or going away utilised behavioural coping mechanisms to manage adversary in a healthy manner (Haertl & Christiansen, 2011, p. 321,323). Such coping strategies also serve to meet the participants' occupational needs and contribute to occupational well-being (Lopez & Block, 2011, p. 288). In contrast, participants who engaged in overindulging, repressing emotions and changing behaviours displayed maladaptive coping skills. Similar maladaptive coping strategies were found in other studies with women affected by IPV (Baird, 2012, pp. 246–251) and contribute to vulnerability (Lopez & Block, 2011, p. 288).

When considering maladaptive coping skills one might question, "Why would people knowingly engage in activities that are self-destructive?" Eudaimonic well-being occurs when what a person does is congruent with their values (Hayward & Taylor, 2011, p. 136). Thereby eudaimonic occupations allow for centring of self in that they release nervous energy, foster presence, contemplation, connectedness and creativity (Ramugondo, 2017, p. 41). Eudaimonic occupations are the opposite of occupational alienation. For

Joyce, exercise allowed for centring of herself and fostered presence; for Amahle singing allowed for centering of self and creativity; for Corli visiting her children's graves allowed for contemplation and connectedness. These coping behaviours were effective in increasing reliance against occupational injustice as they decreased the experience of occupational alienation.

Hedonic well-being refers to feeling pleasure and avoiding pain (Hayward & Taylor, 2011, p. 136). Similarly hedonic occupations allow for the experience of happiness. Activities that are in line with one's values and cause happiness contribute to both eudaimonic and hedonic well-being. If an activity aligns with one's values but does not cause happiness it only contributes to eudaimonic well-being whilst if an activity causes only happiness but does not align with one's values it contributes only to hedonic well-being (Hayward & Taylor, 2011, p. 136). The latter is related to occupational alienation. Overindulging, suppressing emotions and changing to please the abuser are all examples of activities that contribute to hedonic well-being only. The participants participated in these activities because they caused temporary escape and happiness. However, the activities were not effective in coping with occupational injustice but rather contributed to the experience of occupational alienation. This corroborates the observation by Lopez and Block (2011, p. 288) that "Counterproductive means of coping with occupational injustice do not eliminate individual or community-level problems. They offer only temporary escape and are likely, in the long run, to increase difficulties."

b) Hide abuse from people

The second subcategory under the category 'behavioural adjustments" illustrates how the participants hid the abuse from the public eye. Six of the eleven participant informed the category and it has one code as indicated by the verbatim examples below:

Pretence: I was living a double life…So I'll lie and pretend I'm fine (Joyce)

I just have to put on a happy face… (Lucy)

Many of the participants would pretend that everything was well in their relationships when in public or in front of their family and/or friends. Baird (2012, p. 227) had similar

results in her studies with women affected by IPV. The need to protect oneself from stigmatisation had already been discussed (cf. 4.3.1.4). It can also been seen as a maladaptive, avoidance coping strategy as explained in the preceding sub-category.

From an occupational justice perspective, changing ones behaviour to meet society's expectation of being in a happy relationship indicates that the participants were avoiding experiencing occupational marginalisation. It is important of creating spaces in society where women are able to be honest about their experiences of IPV and other forms of GBV (cf. 4.3.2.5).

4.3.3.4 Spiritual adjustments

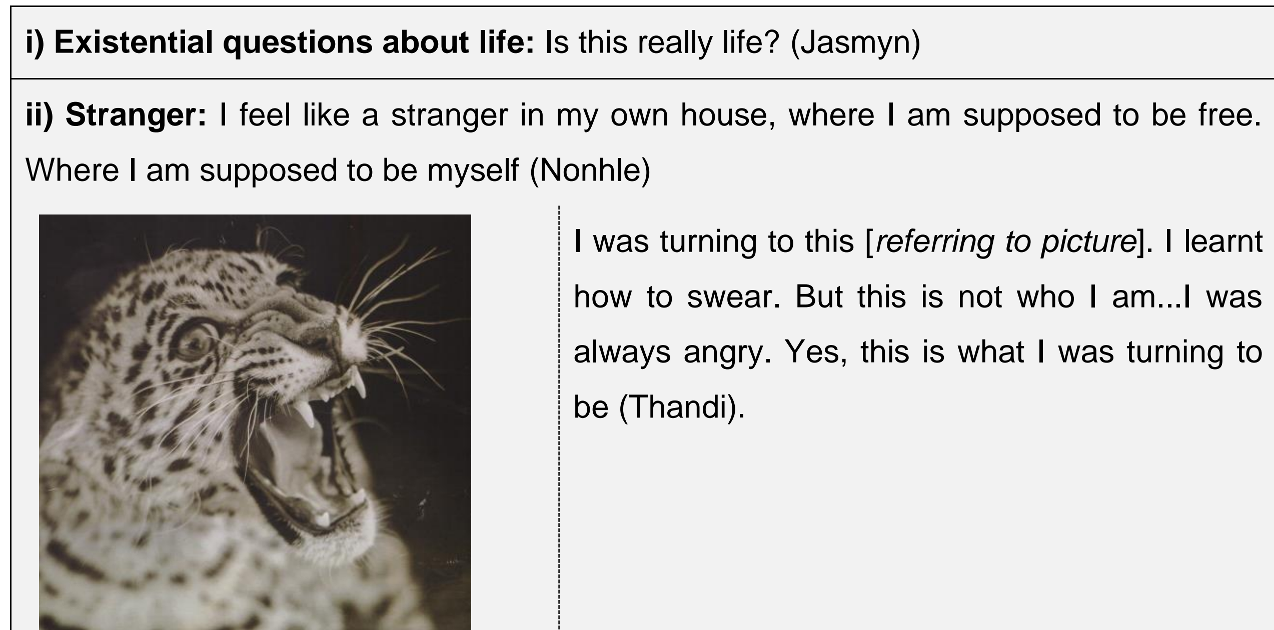
The fourth category under the theme 'Changes and adaptations due to IPV' describes changes in the participants spiritual well-being. In this study spirituality is understood as described by Burgman (2011, p. 94) who says that spirituality "encompasses many qualities including; faith, courage, love, trust, hope, belonging, compassion, purpose, joy, awe, wonder, creativity, awareness and transcendence". Spirituality is strongly related to resilience which "encompasses coping and optimism, which are built on a foundation of hope and faith in life (Burgman, 2011, p. 94)". The four domains of spirituality as it pertains to health is personal, communal, environmental, and transcendental (Ramugondo, 2017, p. 34).

The three subcategories relate to a) 'Feeling estranged to self/environment', b) a 'Driving force' and c) 'Religion'.

Category	Subcategory	Code(s)
Spiritual adjustments	a) Feeling estranged to self / environment	i) Existential questions about life ii) Stranger
	b) Driving force	i) "Kept me going"
	c) Religion	i) God/ Prayer

a) Feeling estranged to self/environment

The first subcategory under the category ‘spiritual adjustments’ is related to how the qualities of purpose and belonging were absent. Ten of the eleven participants informed this subcategory. The subcategory has two codes as indicated in the following verbatim quotes:



i) Existential questions about life: Is this really life? (Jasmyn)

ii) Stranger: I feel like a stranger in my own house, where I am supposed to be free. Where I am supposed to be myself (Nonhle)

I was turning to this [*referring to picture*]. I learnt how to swear. But this is not who I am...I was always angry. Yes, this is what I was turning to be (Thandi).

In this study the participants expressed an estrangement to life as they know it, to their environments as well as themselves. Questioning life and a lost relationship to oneself especially was also observed in other studies on IPV (Flasch et al., 2015, pp. 11–12; Humbert et al., 2014, pp. 368–372). This subcategory is very similar to the category ‘De-identification’ (cf. 4.3.2.3) that has already been discussed in the second theme.

In the preceding theme I discussed how feeling estranged to oneself can be attributed to a type of occupational dissonance, where what you do is not in line with your occupational identity, or your current occupational identity is not in line with your ideal occupational identity. In this subcategory I will continue this discussion by highlighting identity as it relates to spiritual adaptations. The verbatim quotes provided indicate that the participants’ personal and environmental domains of spirituality changed over time from a place of familiarity and connectedness (i.e. “my own house” and “who I am”) to in an unhealthy state of disconnectedness. Furthermore the participants expressed a lack of connectedness to their life course indicating a lack of coherence as an occupational need

(2.2.2).Thereby the spiritual changes that occurred in the participants resulted in lack of connectedness and lack of healthy.

In recovery, the abovementioned changes should be reversed to achieve occupational well-being. To address the code 'stranger', in their research on recovery from IPV, Flasch et al. (2015, p. 5) suggest that people affected by IPV "reconnect the fragments of the self" and reclaim their old identity before building a new identity. From an psychodynamic perspective (cf. Concept Clarification) this can help a person determine how their current actions are influenced by their experience of IPV (Daniel & Blair, 2011, p. 172). With regards to the code 'existential questions', Flasch et al. (2015, p. 11) suggest that people not only recognise their freedom to direct their lives but also act on that freedom by taking steps to improve their life course. From a cognitive behavioural perspective (cf. Concept Clarification), this can help a person realise that the decisions they make can influence their thoughts, emotions and their environment (Duncan, 2011b, p. 155). Occupational therapists can thereby play a valuable role in facilitating the recovery of spiritual well-being in people affected by IPV.

b) Driving force

The second subcategory under the category 'Spiritual adjustments' is related to the aspects of spirituality pertaining to courage and purpose. The subcategory was informed by four participants and has one code as indicated in the following verbatim quotes:

"Kept me going": The only thing that kept me going was my children**.** (Anele)

In this study, some of the participants expressed having responsibility other than themselves that kept them going. Usually, this driving force was their children, however for one participant who did not have children, this was her pet. The need to 'keep going' for their children was seen in other studies on IPV and is seen as contributing to resilience (Mkhonto et al., 2014, p. 323). Children are often given as a reason that people affected by IPV seek help (Humbert et al., 2014, p. 373; Rasool, 2015).

The 'driving forces' provided by the participants speak to the communal domain of spirituality. Being responsible for a child or a pet is a contributive and connected type of eudemonic occupation (Ramugondo, 2017, p. 42). In this case, having a 'driving force' contributes to resilience.

In the MOHO (cf. 2.2.3) the 'driving force' of people is termed 'volition'. Specifically, personal causation is an aspect of volition that refers to people having a sense of being able to cause change and act with purpose in the world. Having a child or a pet to take care of gave the participants a sense of purpose, which counteracts the occupational alienation and the associated powerlessness that the participants experienced (cf. 4.3.2.2). Thereby being responsible for something outside of oneself is a healthy adaptive mechanism for people affected by IPV.

c) Religion

The third subcategory under the category 'Spiritual adjustments' is related to the aspect of spirituality pertaining transcendence. Seven of the eleven participants informed this subcategory which has one code as indicated in the following verbatim quotes:

> **Prayer:** The only thing this marriage did was bring me close to God. Because every time I get frustrated I take my Bible and pray (Joyce).
>
> You go to bed in fear, you pray to God so much. "God, if you save me from tonight, if you just save me, if you just save me tonight, I promise I will pack up and leave tomorrow" (Jasmyn)

Not all of the participants in this study expressed an affiliation with a particular religion, but all of those who did, identified as Christian. The verbatim examples illustrate how the participants resorted to prayer when they felt what they were experiencing was beyond their control. In that way, having a relationship with God, not necessarily taking part in organised religion, such as attending church, helped participants cope with IPV. Similar findings were seen in other studies (Barnes Bey, 2020, p. 83; Mkhonto et al., 2014, p. 8).

Connectedness with a higher being is known as 'transcendence' (Ramugondo, 2017, p. 34). Transcendence contributes to spiritual well-being, one of the five aspects of health, whilst prayer is considered to be an eudemonic occupation (Ramugondo, 2017, p. 42). Considering the four domains of spirituality (cf. 4.4.3.4), it has been established that the participants' personal domain, environmental domain (see subcategory 'Estranged to self/environment'), and communal domain in terms of friendships (cf. 4.3.1.1) was negatively affected by IPV. Transcendence was one of the primary methods that participants could attend to their spiritual well-being. Transcendence thereby ameliorates resilience and occupational well-being and is a healthy adaptive mechanism for people affected by IPV.

4.3.3.5 The final adaptation – leaving

The fifth and final category under the theme 'Changes and adaptations due to IPV' describes how the participants experienced leaving the relationship. The three subcategories and their related codes are presented below

Category	Subcategory	Code(s)
The final adaptation - leaving	a) Help-seeking	i) The crises ii) Source of courage
	b) Source of help	i) Information about shelters ii) Someone stepped in
	c) Uncertainty about life outside the shelter	i) Work ii) Place to stay iii) Ability to raise children

a) Help seeking

The first subcategory under the category 'The final adaptation – leaving' describes aspects that lead to seeking help. This subcategory was informed by six of the eleven participants and has two codes as indicated in the following verbatim quotes:

> **i) The crises:** I love my kids and the reason I went out of the relationship was to protect them. (Thandi)

ii) Source of Courage: He [*a father figure to the participant*] said, "You have my blessing." And that is what really gave me the courage to take the final step. (Joyce)

For a few of the participants, the crises that contributed to them taking action was the well-being of their children or, especially if they did not have children, realising that the abuse in their relationship had escalated to such a point that their lives were at risk, was a major contributing factor in deciding to leave the relationship. Similar results were found in other studies' research on IPV (Humbert et al., 2014, p. 365; Rasool, 2015, p. 1663) which confirmed that children greatly influence the decision of mothers affected by IPV to seek help. From an occupational perspective, the MOHO (cf. 2.2.3) demonstrates how people's roles, in this case the role of mother, influence people's occupational participation to act in accordance with their occupational identities. For the participants in this study, the responsibility of protecting their children served as a drive to seek help. The decision of whether to take action is a complex decision for the mother, as due to the nature of IPV, either staying or leaving could result in the mother and/or child being killed.

Regarding a source of courage, two of the participants found that permission from someone they held in esteem gave them the courage they needed to end the relationship with their abuser. The permission reassured the participants that they would have support following their decision. The support is significant as the abusers had methodologically and systemically isolated the participants from support systems as much as they were able to. Such support is crucial in successfully leaving a relationship with IPV. A report on five shelters in Gauteng found that shelters only had the human resources to follow up with 26% of their participants after they left the shelter (Bhana, Vetten, Makhunga, & Massawe, 2012, p. 62)

b) Source of help

The second subcategory under the category 'The final adjustment – leaving' describes sources that the participants used for help. Six of the eleven participants informed this category which has two codes as indicated in the following verbatim quotes:

i) **Information about shelters:** Talking to almost anyone, what can I do? … Someone told me there is help. Someone brought me here. (Thandi)
ii) **Someone stepped in:** She [*a neighbour]* says we are going for a ride and she brought me here. “You’re not going back home” (Corli)

Most of the participants obtained information about shelters from someone they knew. One participant used the internet to find information on shelters and one participant sought information from a government institution. Some of the participants were only able to leave the relationship when a third party saw the danger of the relationship and stepped in by physically bringing the participant to the shelter.

It is noteworthy that most of the participants did not seek help from a formal government institution, but rather obtained it from civic institutions or informal sources. A report on Gauteng shelters found that of the 147 women in five shelters, none of the inhabitants in the shelters were referred by a healthcare professional and only 34% were referred by police (Bhana et al., 2012, p. 26). This may be attributed to women’s predominantly bad treatment at police or healthcare facilities in South Africa, following cases of GBV such as sexual assault (Steinbrenner et al., 2017, p. 3) (cf. 4.3.1.3).

c) Uncertainty about life outside the shelter

The third subcategory under the category ‘The final adjustment – leaving’ describes uncertainties that the participants had about coping with life once they were discharged from the shelter: Nine of the eleven participants informed this subcategory which has three codes as indicated in the following verbatim quotes:

i) Work: We don’t know how to put ourselves forward into employment (Jasmyn)
ii) Place to stay: I’m scared of when I walk out the gate, where I’m going to. (Corli)
iii) Ability to raise children: [*referring to some of her though processes when considering leavin the relationship]* Can I be one *[i.e. single}* parent to child (Nonhle)

Many of the participants experienced uncertainty about coping with life after leaving the shelter. The areas of concern were related to earning an income, having shelter and being able to raise children in the newly acquired role of 'single-mother'. The participants who did not express uncertainty about life after the shelter, had a secure source of income, supportive family, and independent, adult children. In her research on help-seeking after domestic violence, Rasool (2015, p. 1673) found that motherhood, family preservation, and financial dependence are reasons why women don't seek help for IPV. Lopes (2016, p. 1) corroborates this by attributing to women staying in the relationship, the belief that it is in the best interest of the child, fear of destitution, and lack of support. This suggests that the areas of uncertainty the participants expressed were likely present before they entered the shelter and prevented the women from seeking help in the first place. However, at the time of being interviewed, these were concerns that had not yet been resolved while at the shelter.

The concerns expressed by the participants regarding employment and a place to stay will likely not be resolved at the shelter. A report on shelters in Gauteng found that only 5% of women who were unemployed were able to secure employment while at the shelter. This was attributed to only a few women having qualifications higher than grade 12 in South Africa's context of high unemployment rates (Bhana et al., 2012, p. 18). Further, in the same report, four women required state-subsidised housing and none was successful in obtaining this. It is necessary to advocate for improved services for women residing at shelters so that the help provided aligns with their holistic needs.

With regards to the third code of raising children, some of the participants were concerned about whether it is in the best interest of their child to separate from this father. This concern was related to financial support and finding it important for children to have a father figure in their lives. The report on shelters in Gauteng found that 90% of women did not receive any financial support from the father of the children and only 22% of the children were receiving child support grants (Bhana et al., 2012, p. 63). Concerning having a father figure for the children, in South Africa, it is believed that the best situation for a child to live in is in a stable home with their married, biological parents married to

each other. This two-parent family model is still seen as the ideal family type although it is not the most prevalent (Rasool, 2015, p. 1666). This is another example of societal pressure that expects women to raise their children in a particular way, It will be beneficial for mothers affected by IPV if society celebrates different family models and highlights how each model can still benefit the child.

4.3.3.6 Summary Theme 3

The theme 'Changes and adaptations due to IPV' described the ways in which experiencing IPV affected and changed the participants as occupational beings. Two types of adapting were identified. The changes that occurred in the participants which prevented them from taking action and seeking help, are considered maladaptive. The theme also described some of the adaptations the participants made in the spirit of resilience which contributed to their occupational well-being. This study took place at a shelter and thereby the apex of these adaptions was taking action and leaving the relationship.

First, IPV changed the participants in their mental, emotional, behavioural, and spiritual capacities. The changes in their mental capacities included an unhealthy sense of personal causation resulting in self-blame and their personal convictions being challenged resulting in suicidal thoughts, but also placing the participants in a state of contemplation which is crucial for help-seeking. The most concerning change in mental capacity was signs of institutionalisation and relying on habituation when making decisions about life. Together these had one of the participants in a state of acceptance where she did not want to take action or seek further help.

The changes in the participants' emotional capacities included experiencing both unpleasant and pleasant emotions. Ironically the unpleasant emotions of trauma, grief, and shame, served as signals which could potentially result in the participants taking action while the pleasant emotions of love and hope resulted in the participants viewing the relationship through 'rose-coloured lenses' and prevented them from taking action. It was only when the 'rose-coloured lenses' were removed and the participants realised that

they have power over their own lives and the person they loved had changed that they were able to take action. Emotional awareness is thereby an important tool that occupational therapists can use in supporting victims of IPV to take action against occupational injustice (Daniel & Blair, 2011, p. 175).

The changes in the participants' behavioural capacities indicated activities that the participants engaged with to cope with the experience of occupational injustice. Eudemonic occupations stand in contrast to occupational alienation. Thereby it was observed that if the activities that the participants engaged in were eudemonic, such as singing or physical exercise, the coping mechanism could be considered healthy and contributed to resilience. Alternatively, if the activity was only hedonic in nature, such as overindulging or supressing emotions, the activity perpetuated experience of occupational alienation and decreased resilience against occupational injustice. Another important behaviour change was that the participants hid the abuse by pretending everything was fine. Drawing back to the analogy used in the summary of the first theme as well as the ecological model, this behaviour shows the effect of occupational marginalisation in keeping abuse in the dark where it continues to grow. In response to occupational injustice occupational therapists can harness eudemonic occupations to increase the resilience of people affected by IPV. Occupational therapists can also advocate for healthcare settings where people affected by IPV are not marginalised and feel safe enough to stop pretending.

The changes to the participants' spiritual capacities included both losses and gains. The spirit of occupation involves doing, being, becoming, and belonging. The participants expressed that they had lost connection with themselves which can be attributed to a lack of 'being' and struggled to find a place that they belong. However, it was also observed that by participating in eudemonic occupations, such as caring for others and building a relationship with God, contributed to the participants' spiritual well-being and increased their resilience. This supports the value of eudemonic occupations in building resilience and recovering from IPV.

Lastly, the participants explained some of the facilitators and barriers to taking action and leaving the relationship. Facilitators included crises that influenced the well-being of their children or their own lives, a source of courage and support, as well as external help in the form of information or a third party stepping in. Pointing back to the findings in the first theme (4.3.1.5), on a community level healthcare workers and police are expected to be at the forefront of places where people affected by IPV can seek help. In contrast it was found that civic organisations and members of the public are more active in finding help and providing information for people affected by IPV. It is also concerning that the concerns the participants had leaving the relationship with regards to income, a place to stay and caring for their children, which are also cited as reasons for staying in the relationship, had not resolved while in the shelter. Further it was found that these are all areas that shelters are experiencing difficulties in helping women with. This highlights aspects of the services that shelters can be supported in, to better help women affected by IPV.

4.4 Conclusion

In this chapter, I presented and discussed the findings of this research study. I provided a description of the participants and then presented the results in three themes namely: ‘Perpetrators of intimate partner violence’; ‘The effect of intimate partner violence on occupation’; as well as ‘Changes and adaptations due to intimate partner violence.’ In the following chapter I will discuss how these themes addressed the purpose of the study.

Chapter 5

5.1 Introduction

In the preceding chapter, I presented the results of my study in three themes, along with the interpretations and discussions of all the categories and subcategories. In this chapter, I will provide conclusions according to the objectives of the research; present recommendations for practice; education; and further research; and conclude this dissertation with final reflections on the study.

5.2 Conclusions – answering the research question

The study aimed to describe how victims of IPV, who are residing at women's shelters, experience and adapt to occupational injustice. The four objectives were aimed at describing how victims of IPV experience and adapt to each of the occupational risk factors, namely: occupational imbalance, occupational alienation, occupational deprivation, and occupational marginalisation. However, at the close of the study, it was found that the objectives are narrow. The experience and adaptation to each of the occupational risk factors cannot be described individually, as they are intertwined and many occupational risk factors are experienced at once. The participants' answers to the questions revealed a myriad of complexity of how they experience and adapt in occupational patterns related to occupational (in)justice. Therefore, in this section I will not discuss each of the objectives individually, but rather address the research question (cf.. 1.4.1) in two parts. First, I will address the experience of occupational injustice and second, I will address the changes and adaptation to occupational injustice.

Table 5-1 indicates how the themes generated through this study (cf. 4.3) address the two parts of the research question.

Table 5-1: *Summary of how research themes relate to the research question*

Theme	Category	Subcategory	Aspect of Research question addressed
Theme 1: Perpetrators of intimate partner violence	Coercive control	n/a	'How do victims of IPV experience occupational injustice?' - contextual perspective.
	Family behaviours and attitudes	The abuser's family	
		Family of the women affected by IPV	
	Community institutions	Police	
		Healthcare workers	
		Churches	
	Cultural attitudes	Power imbalance and patriarchy	
		Perceived stigma	
		IPV is Private	
Theme 2: Effect of intimate partner violence on occupation	Diminished occupational participation	n/a	'How do victims of IPV experience occupational injustice?'
	Meaningless activities	n/a	
	De-Identification	n/a	
	Difficulty in areas of occupation	n/a	
	Feeling dehumanised	n/a	
Theme 3: Changes and adaptations due to intimate partner violence	Mental changes	Self-destructive reasoning	'How do victims of IPV adapt to occupational injustice?'
		Compulsive thinking	
		Acceptance	
	Emotional changes	Unpleasant emotions	
		Pleasant emotions	
	Behavioural adjustments	Coping strategies	
		Hide abuse from people	
	Spiritual adjustments	Feeling estranged to self/ environment	
		Driving force	
		Religion	

5.2.1 Experience of occupational injustice

The first theme highlighted the importance of viewing occupational injustices in the context that they take place in. Townsend and Wilcock (2004) emphasised that injustices are socially constructed. The Ecological Model for Understanding Violence (Krug et al., 2002, p. 12) illustrates that occupational injustices are constructed on an individual, relational, community, and a societal level. The participants in this study experienced occupational injustices on all these levels.

On a relational level, within their intimate relationships, the results showed how the participants experienced coercive control at the hands of their intimate partners. The controlling behaviours included being unable to freely socialise, earn an income, make decisions about their own lives, or express opinions. Limiting activities is often classified as emotional abuse. In this study, the consequence of the participants not complying with the restrictions placed on them was likely physical or verbal abuse. This type of relationship is comparative to incarceration, human trafficking, or kidnapping. From an occupational justice perspective, the participants experienced occupational deprivation, occupational alienation, and occupational imbalance at the hands of their intimate partners. The adverse effects of the occupational injustices on the participants as occupational beings included occupational dysfunction, a deep sense of powerlessness and decreased self-efficacy, internalising the role of victim, occupational dissonance, role-overload, as well us being unable to fully reap the benefits of engaging in a variety of occupations including productive, restorative, and pleasurable occupations (cf. 4.2.2). These adverse effects negatively influence a person's violation and thereby the participants were impaired in their ability to initiate change. Thereby, in the Ecological Model for Understanding Violence (Krug et al., 2002, p. 12) the participants experienced an impairment of violation on an individual level which in turn created a negative cycle by keeping them in the coercively controlling relationships.

Applying the importance of having free access to a variety of occupations for human well-being (Doble & Santha, 2008, p. 186) contributes to the current understanding of IPV. Limiting a person's activities has such a severe impact on a person that I propose it can

be separately referred to as occupational abuse. In addressing the effects of IPV on a person, occupational therapists need to be cognisant of the coercive control element of abusive relationships. Occupational therapists can work to remediate occupational dysfunction through creating opportunity for people affected by IPV to participate in a variety of meaningful occupations of their choice. This has the potential to result in increased self-efficacy, decreased role overload, and ultimately recalibration toward occupational well-being when a person realises their occupational identity.

However, considering the dynamics of the intimate relationship alone, is not sufficient. The results of the study indicated that IPV is not only a domestic issue, but also a societal issue. The perpetrators of occupational injustices are thereby not only abusive partners, but also people within institutions on a community level. In this study, participants approached people working in police, healthcare institutions, and churches for help. The participants had different experiences at the community institutions. When these experiences were negative, the participants found the service providers to be unresponsive or ignorant of the appropriate way to respond to IPV. In some cases, supposed service providers perpetuated the cycle of abuse. When the experiences were positive, the participants found the service providers to be responsive with knowledge of how to utilise shelter services.

The participants in this study needed help to leave the relationship. They needed physical safety, shelter, food, and emotional support for themselves and their children. Considering that the participants in this study displayed an impairment in their ability to initiate change, due to the occupational injustices they experienced, the action of seeking help took courage and was a major step for them, one that they had spent months or even years contemplating. The participants who had positive experiences with help-seeking were all referred to shelter services in accordance with the Domestic Violence Act of South Africa, indicating that it is possible for effective, responsive services to be operationalised. The fact that some of the participants were confronted by unresponsive and ignorant service providers in the community, is unacceptable, especially in a country that has some of the highest rates of IPV globally. There is an urgent need to advocate

for improved service delivery for people affected by IPV and conscientisation on the topic if IPV for people working in institutions, such as the police force, healthcare, and churches. This study indicated that ignorance perpetuates injustices.

At the societal level, The Ecological Model for Understanding Violence (Krug et al., 2002, p. 12) demonstrates that the community institutions, the family of the abuser, the family of the person affected by IPV, the abuser, as well as the participant are all influenced by the ideas propagated by their social environments. People working in community institutions remain blissfully unaware of how to respond to IPV, which is considered an epidemic in South Africa. The families of the abuser normalised IPV and the families of the women practiced victim-blaming. The abuser rationalised his abusive behaviour and the participants rationalised the abuse they received. This study viewed IPV from a feminist perspective (cf. 3.2) and therefore all the above were largely attributed to patriarchy. The culture of patriarchy and the normalisation of violence in South Africa make male violence and female submission acceptable (cf. 2.3.2). This contributed to the participants in this study feeling stigmatised and experiencing occupational marginalisation.

For the participants in this study, the marginalisation reached a threshold. Each of the participants either had a moment of insight on an individual level or encountered a responsive person on community level that led them to act against the injustice they experienced by leaving the relationship. However, not all women in abusive relationships have reached that point and continue to experience occupational injustices. It is crucial for occupational therapists to undergo critical reflection to determine the influence that their social environments have on their responsiveness. Whiteford and Hocking (2012, p. 102) explain that:

> *The transformational intent of critical work involves opening up possibilities for dialogue and action regarding how practices, systems and social structures can be constructed and enacted in alternative ways that minimize human suffering and support human flourishing*

Occupational therapists have a responsibility to deliberately seek out ways to influence social structures to reduce the occupationally unjust suffering that people affected by IPV experience, as well as seek out ways to support flourishing despite having experienced IPV.

5.2.2 Adaptations to occupational injustice

The finding in this study affirmed that humans have incredible abilities to adapt to the harshest circumstances. In this study two types of adaptation and strategies were observed, occupationally 'non-nutritive' activities and occupationally 'nourishing' activities. The strategies are metaphorically compared to the nutritional value of food according to the extent that they would meet the participants' occupational needs (see Table 2-1).

First, adaptions and coping strategies that were occupationally 'non-nutritive' include: mental changes such as self-destructive reasoning, compulsive thinking, and acceptance; emotional changes of clinging to the positive emotions of hope and love, as well as internalising unpleasant feelings of shame and dependence; behavioural adjustments including overindulging, suppressing their emotions, changing their appearances, and hiding abuse from people. These adaptive techniques are not 'nourishing' occupations in that they do not address any of the occupational needs of accomplishment, affirmation, agency, coherence, companionship, and renewal (see Table 2-1). At best the adaptations of overindulging and clinging to positive emotions contribute to pleasure, but only at a hedonic level.

Second adaptations and coping strategies that were occupationally 'nutritious' include: emotional changes including feelings of anger, sadness, loss, fear, and loneliness; behavioral adjustments including physical activity, singing, and going away; as well as spiritual adjustments including having a driving force and turning to God. In various ways these adaptations and strategies 'nourished' the participants as occupational beings and in various ways addressed all of the participants' occupational needs. They could obtain some occupational nourishment which allowed them to remain resilient, however, due to

the occupational abuse the participants still experienced occupational deprivation, alienation, imbalance, and marginalisation. Thereby, despite these coping strategies, the participants were unable to experience occupational well-being.

In calling activities ‘non-nutritive’ and ‘nutritious’ I do not propose that one is bad whilst the other is good. To continue with the analogy of nutrition, all people eat nutritious and non-nutritious meals daily. Similarly, we engage in activities daily that either contribute to our occupational well-being or not. If a person is starving and severely malnourished, it is expected they should eat whatever food they have access to for survival, regardless of the nutritional value. Similarly, if a person is severely occupationally deprived, occupationally alienated, occupationally imbalanced, and occupationally marginalized, it can only be expected that they will do whatever they can to feel human again. For occupational therapists the idea of ‘nutritious’ occupations can be a powerful way of helping people affected by IPV. When people are recovering from an abusive relationship, occupational therapists can work to ensure that they have access to meaningful occupations that do meet their occupational needs. Even if the person affected by IPV is not ready to leave the relationship or cannot yet leave the relationship, occupational therapists can still work with them to identify ways that they can engage in ‘nutritious’ occupations rather than ‘non-nutritive’ occupations, thereby contributing to their occupational well-being, improving resilience, and reducing the effects of occupational injustices.

5.2.3 Summary

In answering the research question, participants in this study, who experienced IPV, and were residing at women’s shelters, experienced occupational justices on all levels of the Ecological Model for Understanding Violence. Occupational deprivation, occupational alienation and occupational imbalance on a relational level, at the hand of their intimate partner through occupational abuse. On a relational level with their families, and on a community level, the participants experienced either responsiveness which allowed them to leave the abusive relationships. or the participants experienced indifference and ignorance which perpetuated the injustices that were taking place on an intimate relational

level. On a societal level, the participants and people in their communities were subject to deep-rooted stigmatisation and patriarchal ideas which perpetuated the injustices and resulted in the participants also being occupationally marginalised.

The participants responded to the experience of occupational injustice and being occupationally un-well through adaptations and coping strategies which were either mental, emotional, behavioural, or spiritual in nature. The adaptations and coping strategies could metaphorically be considered ‘nutritious’ or ‘non-nutritive’ depending on the extent to which they met the participants’ occupational needs. The ultimate adaptation was seen to be leaving the relationship. For the participants in this study, help from an external source was crucial to them making the adaptations to leave the relationships.

5.3 Limitations of the study

Several limitations influenced the finding in this study:

- The study was qualitative in nature and was thereby performed on a small, cohort of women. The results of the study should not be generalised to all people affected by IPV. Strategies, such as using rich descriptions (cf. 3.3.9), were utilised to allow the reader to determine the extent to which the findings of this study might apply to their context.

- The demographic questionnaire did not consider how long the participants had been in the shelter or if they had made use of shelter services before. Such information would provide an interesting context for researchers to consider when interpreting the results.

- Due to financial implications of outsourcing interviews and translating interviews, the participants were limited to using either Afrikaans or English in communicating with the researcher. All the participants completed the interview in English. It was observed that some of the participants had difficulty finding the right words to express themselves as English is not their home language. The language-barrier may have influenced the extent to which the participants could share their

experiences. Further, although English is widely spoken in Gauteng province, the restriction in language did exclude a demographic of women who do not speak English. It will add great value to literature on IPV to include their voices.

- Although the participants were diverse in ethnicity, backgrounds, age, and duration that they had experienced IPV, the participants in this study were similar in that they were females from heterosexual relationships and residing at shelters, which implies that they had all recently left their partners and were all at the beginning stages of their recovery stages. Future research on IPV from an occupational perspective should accommodate more diversity by including people of different genders and sexual orientation, people who left their partners without seeking help, and people who are at different stages of their recovery process. I would caution researchers who would want to involve potential participants who are still in abusive relationships to carefully consider the safety of the participants as IPV is potentially life-threatening.

5.4 Implications and Recommendations

Considering that the occupational therapy profession in South Africa consists mostly of females, the topic of IPV is not only relevant to occupational therapy clients. There is a high probability that the topic of IPV may, literally, hit close to home for therapists. The recommendations are thereby made with a great deal of compassion and a heightened sense of urgency. In making these recommendations, I refer to a person affected by IPV as a ‘client’, although this might apply to friends, acquaintances, family members, and colleagues. IPV is not only a domestic problem, nor a professional problem, but is ultimately a societal problem that occupational therapists may encounter in every aspect of their professional ambit. In this section, I will discuss the implications of this research and the subsequent recommendations as they relate to practice, education, and further research.

5.4.1 Implication and Recommendations for Practice

The recommendations for practice will be discussed first in terms of the therapist and then in terms of the client. First, in considering the ecological model for understanding violence (Krug et al., 2002, p. 12) (cf. 2.3.2), practicing occupational therapists will form part of the community level for their clients. Further, occupational therapists as well as their clients are influenced by the society level of the model. For occupational therapists to become aware of the way they are being influenced by society, I recommend that:

- Occupational therapists need to take categorical cognisance of and critically reflect on colonial and patriarchal ideas that are propagated by society and then become aware of the extent to which they have internalised these ideas.
- In South Africa especially, occupational therapists, as part of society, need to critically reflect on the extent to which they may have become desensitised to and normalised high levels of violence against women.
- Occupational therapists need to reflect on their expectations of people affected by IPV. Therapists need to determine if they are sub-consciously holding people affected by IPV, to an unfair standard of behaving as an 'ideal victim'.

Journal clubs or continuous professional programmes in institutions are ideal platforms to carry out the above recommendations. Regarding the community level, the first theme (cf. 4.3.1) illustrated the danger of people in community institutions being ignorant of the prevalence and severity of IPV, as well as being ignorant of the appropriate response. However, the theme also highlighted that if community institutions are well-equipped with knowledge, they can be a valuable source of help and support to people affected by IPV. I thereby recommend that:

- Occupational therapists should educate themselves on the signs of IPV, the appropriate way to respond to suspected IPV[30], the appropriate institutions to refer to[31], as well as familiarise themselves with the contents of the Domestic Violence act 118 of 1998[32].

- Occupational therapists should conscientise their colleagues within their settings of practice on the above-mentioned aspects of IPV. Continuous Professional Development programmes that are part of many healthcare practices, provide a useful platform for such education.

- Occupational therapists should be thorough in their assessments of the relational context of *all* their clients, especially looking out for signs of IPV.

- Occupational therapists should follow up with people affected by IPV, in a safe and confidential manner, even after referral to another stakeholder, until the therapist is confident that their client is safe from abuse.

- Occupational therapists should liaise with community stakeholders, especially police departments, departments of social development, and shelter services, to develop a standard operating procedure of how to respond to IPV in a manner which is appropriate for their practice setting within their specific community.

- Occupational therapists should clinically treat people affected by IPV holistically by considering the occupational injustices they are/were subject to, by providing and finding opportunities for them to (safely) participate in activities that address their occupational needs

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[30] See Gordon (2016), *"Intimate partner violence is everyone's problem, but how should we approach it in a clinical setting?"*

[31] See Lopes (2016), "*Intimate partner violence: A helpful guide to legal and psychosocial support services"*

[32] See Women's Legal Centre (2016), *"A Simplified Guide to the Domestic Violence Act"*

- Occupational therapists can contribute to improved service delivery for people affected by IPV by advocating for their role in the recovery process on a systematic and policy level.

5.4.2 Implications and Recommendations for Education

Occupational therapy training institutions and occupational therapy educators have the power and the responsibility to influence the attitudes of future occupational therapists. I hereby recommend that occupational therapists involved in student training consider the following. These recommendations can, for example, be presented at the 2021 Occupational therapy Association of South Africa (OTASA) National Congress and to the Education Committee of OTASA

- Despite high rates of GBV in South Africa, educating students on how to approach this in a clinical setup is not overtly part of student curricula. Those involved in curriculum development should critically consider the social contexts that their students and their potential clients will be a part of and ensure that the graduate will be equipped and informed to respond to issues of social and occupational justices around them. This research study specifically highlights that students need to be trained on managing IPV in their clients.
- This study indicated that the colonial and patriarchal roots of occupational therapy in South Africa could be a contributing factor to the profession's lack of responsiveness to IPV and other issues of GBV. I support the recommendation by Simaan (2020, p. 440) that educators need to utilise pedagogical processes that will lead students to critically reflect on conscientising the links between social issues in their environment and occupational justice[33].

[33] In Simaan (2020), *"Decolonising occupational science education through learning activities based on a study from the Global South"* the author provides an example of a pedagogical process that she did with her students.

5.4.3 Implication and Recommendations for Further Research

There is very limited information available in occupational therapy literature on topics related to IPV or GBV. This study provides a starting point to discuss the occupational injustices that people affected by IPV may be experiencing. It thereby highlights the ethical responsibility that occupational therapists have to respond to people affected by IPV. Increased research on the topic of IPV will increase the theoretical base that occupational therapists can use to powerfully advocate for their role in responding to IPV, treat people affected by IPV from a solid evidence base and increase awareness among therapists on the topic of IPV. I recommend the following regarding further research:

- This research study described occupational injustice and the effects thereof shortly after women have left their abusive relationships. Further research could be done, either in a longitudinal fashion or with a cohort of women who have been separated from their partners for some time, to describe the long-term influence of occupational injustice and recovery from occupational injustice.
- The study was performed at shelters where women were being intentioannly seperated from their abusive partners. However after the women are discharged from the shelter they may return to their abusive partners. Longitudinal studies should be performed to explore how occupational therapists can best support women who seek help from shelters to successfully leave the abusive relationship after they have discharged from the shelter.
- This research study was performed at shelters. Currently in South Africa, occupational therapists seldom work in women's shelters. Further research can be done to determine settings that occupational therapists do encounter IPV in. Research can also be done to explore the potential role of occupational therapists to support the recovery from IPV of women at shelters.
- In the results of the study, it was found that as healthcare professionals on an environmental level, occupational therapists may be contributing to perpetuating IPV by responding in an inappropriate manner. Research can be done exploring occupational therapists' perceptions on IPV and how they respond to IPV when

they are confronted with it. This is especially appropriate for occupational therapists in South Africa as GBV is highly prevalent in the country and possibly unconsciously normalised.

- During the search for literature, it was found that South African occupational therapy literature on the topic of IPV and other GBV is scarce. Currently in South Africa GBV is a topic that is generating a lot of conversation through news reports, activist movements, and social media trends. A critical investigation is required to determine reasons for the profession's silence on topics surrounding GBV.
- This research study was performed with a feminist paradigm and shed some light on occupational injustice that arises from a system of patriarchy on women in heterosexual relationships in particular. Further research on IPV can be approached from a different paradigm to examine the experiences of people affected by IPV from different groups, for example, men and people of other sexual orientations.
- This research study has demonstrated that an occupational justice perspective on topics can provide unique insights into current affairs. Occupational therapists thereby have potentially valuable contributions to make on other issues related to justice.

5.5 Value of the Study

In their early writings on occupational injustice Townsend and Wilcock said (2004, p. 83):

> "Occupational therapists can choose to either advocate consciously with others for justice, or comply with occupational injustices through silence and inaction. Given occupational therapists' populations of concern, professional values, beliefs, and client-centred intentions, and focus on social inclusion, occupational justice is an implicit issue, whether or not we choose to make it explicit."

In this research study I made explicit the occupational injustices that women affected by IPV face. This study contributes to occupational therapy literature by investigating the important and relevant topics of GBV and IPV. Disseminating the results of this study, for

example, through published articles or presentation at conferences, could further serve to increase awareness among occupational therapists about the prevalence of IPV and their responsibility and role in responding to people affected by IPV. Therefore, this study can contribute to improved responsiveness and service delivery for people affected by IPV.

5.6 Final reflections and closure

IPV is not a light topic and the constructivist paradigm (cf. 3.2) allowed me to inevitably become subjectively involved in all aspects of the research process. I read academic articles, news articles, and books describing the shocking stories, filled with brutality, of women affected by IPV. I listened while eleven women generously shared their stories with me, transcribed the majority of those interviews myself, co-coded the data and then read some more literature on the topic before turning the 'stories' into academic interpretations. I realised during the course of this journey, at some point, perhaps too as a sort of coping mechanism, that I was becoming desensitised to the fact that these experiences I was describing in the research, are indeed the reality of countless women across South Africa and in the world. On the one hand, at that point I realised how easy it is to intellectualise this phenomenon and how potentially dangerous it is. On the other hand, perhaps it would be untenable to indeed attempt to integrate such a reality in full.

I am a human being before I am an occupational therapist. The clients that I interact with are human beings, before whatever the reason that made our paths cross. Before anything else, we have to meet each other first on a basic human to human level, free from power imbalances, before stepping into a therapy relationship. I realised that if I forget this simple fact, I could easily be part of the community who occupationally marginalised some participants by making them feel like an object instead of a person. I am also then part of the institutional and cultural environments that perpetuate the occupational justice the people affected by IPV experiences. Once I am aware of our shared humanness, I can fully commit to doing what is in my power to contribute to a more occupationally just world.

This study makes a theoretical contribution to the field of occupational therapy by looking at eleven women's experience of IPV through the lens of occupational justice. I do not claim that the descriptions I provide are generalisable for all people affected by IPV. Thereby the study will only have a true impact if occupational therapy practitioners will allow the stories of the participants to affect them personally and reflectively find ways that they can contribute to justice for people affected by IPV within *their sphere of influence* on an individual and a community level.

Personal responsibility aligns with South African president Cyril Ramaphosa's (2020) sentiment as he addressed the nation regarding GBV after the country had been in lockdown for 100 days due to the COVID-19 pandemic:

> *Ultimately, the success of our fight to end gender-based violence will require the involvement and support of our entire society. If we are serious about ending these crimes, we cannot remain silent any longer. These perpetrators are known to us and our communities. By looking away, by discouraging victims from laying charges, by shaming women for their lifestyle choices or their style of dress, we become complicit in these crimes.*
>
> *I once again call on every single South African listening this evening to consider the consequence of their silence. As a country, we find ourselves in the midst of not one, but two, devastating epidemics. Although very different in their nature and cause, they can both be overcome – if we work together, if we each take personal responsibility for our actions and if we each take care of each other. The road ahead will be long and difficult. The task of recovery will be considerable. But if there is anything that we have learnt in the last 100 days, it is that we are a resilient, resourceful and determined people.*

Consider the consequence of silence. It is inhuman and possibly fatal. Occupational therapists often bear witness to the result of people being resilient, resourceful, and determined as they face challenges. With individual and collaborative work, *change is possible* as we work toward the vision of an occupationally just society.

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Appendix A: Ethics Approval Letters

In this section you will find the following letters:

- Approval letter to conduct the research by the University of the Free State's Health Science Research Ethics Committee.
- Approval letter to conduct the research by the Gauteng Department of Social development.
- A template of the letter sent to the women's shelters. The letter was altered for each shelter and all identifying information was removed (such as the district) to protect confidentiality.
- Please note that the permission letters to conduct the research from the shelters have not been included to protect confidentiality. However, these letters have been submitted to the University of the Free State's Health Science Research Ethics Committee. To confirm this one can contact them using the ethics clearance number (UFS-HSD2017/1434).

Health Sciences Research Ethics Committee

16 March 2018

Dear Miss Tanya La Cock

Ethics Clearance: **Victims of Intimate Partner Violence: An Occupational Justice Perspective**
Principal Investigator: **Miss Tanya La Cock**
Department: **Occupational Therapy Department (Bloemfontein Campus)**
Submission Page

APPLICATION APPROVED

Please ensure that you read the whole document

With reference to your application for ethical clearance with the Faculty of Health Sciences, I am pleased to inform you on behalf of the Health Sciences Research Ethics Committee that you have been granted ethical clearance for your project.

Your ethical clearance number, to be used in all correspondence is: **UFS-HSD2017/1434**

The ethical clearance number is valid for research conducted for one year from issuance. Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the HSREC for approval to ensure we are kept up to date with your progress and any ethical implications that may arise. This includes any serious adverse events and/or termination of the study.

A progress report should be submitted within one year of approval, and annually for long term studies. A final report should be submitted at the completion of the study.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; The International Conference on Harmonization and Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH Tripartite), Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely

Prof. A. Sherriff
Chairperson: Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee
Office of the Dean: Health Sciences
T: +27 (0)51 401 7795/7794 | E: ethicsfhs@ufs.ac.za
IRB 00011992; REC 230408-011; IORG 0010096; FWA 00027947
Block D, Dean's Division, Room D104 | P.O. Box/Posbus 339 (Internal Post Box G40) | Bloemfontein 9300 | South Africa

GAUTENG PROVINCE
SOCIAL DEVELOPMENT
REPUBLIC OF SOUTH AFRICA

Enquiries: Dr. Sello Mokoena
Tel: (011) 3557949
File no.: 2/9/79

MS TANYA LA COCK

Dear Ms Tanya La Cock

RE: APPLICATION TO CONDUCT RESEARCH IN THE GAUTENG DEPARTMENT OF SOCIAL DEVELOPMENT

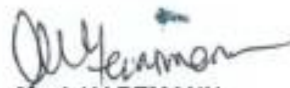
Thank you for your application to conduct research within the Gauteng Department of Social Development.

Your application on the research on **"Victims of Female Intimate Partner Violence: An Occupational Justice Perspective"** has been considered and approved for support by the Department as it was found to be beneficial to the Department's vision and mission. The approval is subject to the Department's terms and conditions as endorsed on the 28th of November 2017. In order for the department to learn and draw from the findings and recommendations of your study, please note that you are requested to provide the department with a copy of your dissertation/thesis once your study has been completed.

May I take this opportunity to wish you well on the journey you are about to embark on.

We look forward to a value adding research and a fruitful co-operation.

With thanks



Ms A HARTMANN
Deputy Director General: Support Services
Date: 4/12/2017

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[date]

To the manager and/or board members of [your women's shelter]

REQUEST TO CONDUCT RESEARCH

I am an occupational therapist employed in Gauteng Department of Health and seeking to do research with victims of intimate partner violence as part of a Master's degree in Occupational Therapy Research through the University of the Free State.The aim of the proposed research study is to identify and describe how (previous) victims of intimate partner violence, that are residing at women's shelters, experience and adapt to occupational injustice. (The terms are discussed in the attached proposal).

The study is considered relevant in the light of the reality that very eight hours a women dies at the hands of her intimate partner, making South Africa the country with the highest rate of intimate partner homicide. Further the accumulation of the effects of gender based violence cost South Africa at least between R28.4 billion and R42.4 billion in the year 2012/2013. Legislation such as the National Policy Guidelines on Victim Empowerment acknowledges the impact of gender based violence and aims to seek redress through the implementation of victim empowerment programs at government funded women's shelters. Victim empowerment resounds with occupational therapy in that it aims to restore the well-being victims following traumatic incidents. Occupational therapists are well equipped to provide interventions for victims of intimate partner violence, as it has been proven that well-being and meaningful activity (occupation) are intrinsically linked. However, if one seeks to comply with evidence based practice one will find that there is a lack of recent, South African literature on the topic of occupational therapy and intimate partner violence. This calls for exploratory research in this emerging field.

Participants

I will then need an estimated 10-15 participants from various shelters in [this district] to participate in the data collection process. The number of participants will be finalized at the point of data saturation.

The eligibility criteria for participants are:

- Should have been a victim of intimate partner violence. (cf. Glossary).
- Residing at a women's shelter in Gauteng
- Have the legal capacity to consent - i.e. be over the age of 18
- Have the decisional capacity to provide consent (Health Professions Council of South Africa 2008:7; Nienaber 2010:120). In this study, adults may be unable to consent as a result of mental illness. In this case it must be assessed whether the mental disorder prevents the person from: (i) understanding the information provided in the participant information sheet (cf. Appendix B); (ii) choosing decisively regarding participation in research; (iii) communicating her choice (Nienaber 2010:120).
- Orally competent in either Afrikaans or English in order to communicate with the interviewer. This was decided in order to minimise the costs that would be involved in hiring an interpreter for conducting the interview, as well as those that would be involved in transcribing and translating the interview. This is recognized as a limitation to the study which will be communicated in the interpretation of the results

Data Collection

In order to execute this research, I will collect data in two parts. The first part will consist of the participants making collages on their experience of 'occupational risk factors' (The terms are discussed in the attached proposal). For this I will require a well-lit room with tables and chairs from the shelter where the women can be undisturbed for 90min. The women will be allowed to complete the collages in their own time when the three hours is

complete. For the second part, I will require from the shelter a private room where I can conduct 90 min uninterrupted in-depth interviews with each participant. The interviews may evoke emotion in the participants and I therefore request that someone from the shelter is available to counsel the participants if need be. I am hoping to collect the data in May and June (although it may extend into July).

For more information regarding the proposed research and the proposed methodology, I have attached the research protocol. Also please find attached the conditional ethical approval from the University of the Free State Health Science Research Ethics Committee as well as from the Department of Social Development.

In order to obtain full ethical clearance I will require a letter from you giving me permission to conduct the research at your shelter.

Your assistance in this matter is greatly appreciated.

Kind Regards,

Tanya La Cock (researcher)
tanya.lacock@gmail.com
078 559 9646

Tania Rauch-van der Merwe (study leader)
vdmraucht@ufs.ac.za
051 401 2829

Appendix B: Participant Information Sheet

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PARTICIPANT INFORMATION SHEET

Dear prospective participant,

About one third of women in South Africa have been abused by an intimate partner, making it a major issue in our country. Such abuse impacts a victim's well-being. It has been identified that occupational therapists have the potential to play a role in the recovery and restoration of women who have been victims of intimate partner violence. However, in South Africa, there is very little literature that describes how occupational therapists could fulfil their responsibility towards victims of intimate partner violence

I am an occupational therapist who is employed in the public health sector and I am doing this research as part of the requirement to obtain my masters degree in occupational therapy research. This research project is titled: "Intimate Partner Violence, an Occupational Therapy Perspective." The study aims to, from an occupational therapy perspective, explore factors that influence well-being in women who have been victims of intimate partner violence. In doing this the research has the potential to contribute to improved services for women of intimate partner violence.

You have been identified as a potential participant based on criterion set up based on the need described above. The following will be required of you if you choose to participate in the research:

- In the first contact session of about three hours, you will be asked to fill in a form to give some background information about yourself. You will also make a poster showing how the abuse and violence has impacted you as a person and your life. This will be done privately, however, in the same room as other participants from the shelter

where you are staying. When you are finished with the poster, I will take a picture of it. You may keep this poster.

- The next contact sessions will be a private interview at your shelter lasting no more than 90 minutes each. In these interviews you will tell me about your poster. If needed we may have to schedule a third interview. These interviews will be recorded and typed out. Some of what you say may be quoted in the presentation and publication of this research.

In order to protect you I will ensure the following:

- All your information will be treated as highly confidential. This means that I will mark all your documents with a code instead of your name. I will use this code when referring to you. I will also make sure that all documents are kept safe and in private.
- Someone will be available for counselling at all times during the study.
- You may withdraw from the research at any time with no penalty.

Please also take note that you will not receive any remuneration (payment) for participating in the study.

If you want to participate in the research please fill in and sign the informed consent form on the next page. You are also welcome to contact me or my supervisor if you have any questions about the research.

Kind Regards,

_________________________ _________________________

Tanya La Cock (researcher)
tanya.lacock@gmail.com
078 559 9646

Tania Rauch-van der Merwe (study supervisor)
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DEELNEMER INLIGTINGSBLAD

Geagte voornemende deelnemer,

Ongeveer een derde van vroue in Suid-Afrika was al binne ‘n intieme verhouding mishandel, en veroorsaak 'n groot probleem in ons land. Sulke mishandeling beïnvloed 'n slagoffer se welsyn. Daar is geïdentifiseer dat arbeidsterapeute die potensiaal het om 'n rol te speel in die herstel van vroue wat slagoffers van ‘intieme verhouding geweld’ (intimate partner violence) was. In Suid-Afrika is daar egter baie min literatuur wat beskryf hoe arbeidsterapeute hul verantwoordelikheid kan nakom teenoor slagoffers van intieme verhouding geweld

Ek is 'n arbeidsterapeut wat in die openbare gesondheidsorg werksaam is en ek doen hierdie navorsing as deel van die vereiste om my meestersgraad in arbeidsterapie-navorsing te verwerf. Hierdie navorsingsprojek is getiteld: " Intimate Partner Violence, an Occupational Therapy Perspective” (of intieme verhouding geweld, 'n arbeidsterapie perspektief). Die studie beoog om van n arbeidsterapie perspektief, fakore wat welsyn beïnvloed in vroue wat slagoffers van intieme verhoudings geweld was, te ondersoek. . Hierdeur het die navorsing die potensiaal om by te dra tot verbeterde dienste vir vroue van intieme vennootgeweld.

U is geïdentifiseer as 'n potensiële deelnemer wat gebaseer is op kriterium-opstelling gebaseer op die behoefte hierbo beskryf. Die volgende sal van jou verwag word as jy kies om aan die navorsing deel te neem:

- In die eerste kontaksessie van ongeveer drie uur sal u gevra word om 'n vorm in te vul om agtergrond inligting oor jouself te gee. Jy sal ook 'n plakkaat maak wat wys hoe mishandeling en geweld jou as persoon en jou lewe beïnvloed het. Dit sal privaat gedoen word, alhoewel in dieselfde kamer as ander deelnemers van die skuiling waar jy bly. As jy klaar is met die plakkaat, sal ek 'n foto daarvan neem. U mag hierdie plakkaat hou.

- Die volgende kontaksessie sal ‘n privaat onderhoud wees by u skuiling wat nie meer as 90 minute duur nie. In hierdie onderhoud sal jy my vertel van jou plakkaat. Indien nodig kan ons 'n derde onderhoud skeduleer. .n Opname van die onderhoud sal geneem word/ Die onderhoud sal ook uitgetik word. Sommige van wat jy sê, kan aangehaal word in die aanbieding en publikasie van hierdie navorsing.

Om jou te beskerm, sal ek die volgende verseker:

- Al u inligting sal as hoogs vertroulik hanteer word. Dit beteken dat ek al u dokumente sal merk met 'n kode in plaas van u naam. Ek sal hierdie kode gebruik wanneer ek na u verwys. Ek sal ook seker maak dat alle dokumente veilig en privaat gehou word.

- Iemand sal te alle tye tydens die studie beskikbaar wees vir berading.

- U mag enige tyd, en sonder enige boete, van die navorsing onttrek.

Let asseblief ook daarop dat u geen vergoeding (betaling) ontvang vir deelname aan die studie nie.

As u wil deelneem aan die navorsing, vul asseblief die ingeligte toestemmingsvorm in en teken dit op die volgende bladsy. U is ook welkom om my of my studie opsigter te kontak indien u enige vrae het oor die navorsing.

Vriendelike groete,

__________________________ ___________________________

Tanya La Cock (navorser)
tanya.lacock@gmail.com
078 559 9646

Tania Rauch-van der Merwe (studie opsigter)
vdmraucht@ufs.ac.za
051 401 2829

Appendix C: Informed Consent Form

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INFORMED CONSENT

By signing this you agree that you have been informed about the study and understand the Participant Information Sheet which you have read through. You understand that as a participant:

- You are participating voluntarily, and there will be no penalty if you chose to withdraw at any stage.
- You will receive no remuneration by participating in the research
- If you agree to participate, you will be given a signed copy of this document as well as the Participant Information Sheet

If you have any further questions about your rights as a research participant, you may contact the Secretariat of the *Ethics Committee of the Faculty of Health Sciences, University of the Free State* at telephone number (051) 405 3004.

Signed at …………………………………. (place), on the …………………. (date) by, ………………………. (name and surname)

____
Signature of Participant

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INGELIGTE TOESTEMMING

Deur hierdie ondertekening te aanvaar, stem jy saam dat jy ingelig is oor die studie en verstaan die Deelnemersinligtingsblad wat jy gelees het. Jy verstaan dit as deelnemer:

- Jy neem vrywillig deel en daar sal geen straf wees as jy besluit het om op enige stadium te onttrek nie.
- U sal geen vergoeding ontvang deur aan die navorsing deel te neem nie
- As u instem om deel te neem, sal u 'n getekende afskrif van hierdie dokument asook die deelnemende inligtingsblad ontvang

As u verdere vrae het oor u regte as navorsingsdeelnemer, kan u die Sekretariaat van die Etiekkomitee van die *Fakulteit Gesondheidswetenskappe, Universiteit van die Vrystaat*, skakel by telefoonnommer (051) 405 3004.

Geteken....................................... (plek), op die .... (datum) deur, ... (naam en van).

____
Handtekening van Deelneemer

Appendix D: Background Questionnaire

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BACKGROUND INFORMATION

The following questions are aimed at obtaining background information about you to provide information on the type of people participating in this research study. The information will be kept confidential.

- If any information is not applicable to you, please write **n/a**
- Please complete all the questions in pen.

Question	Answer	
1. Participant Number		
2. Year of birth		
3. Highest level of education *(please tick the appropriate one)*	Primary school	
	Grade 8 (standard 6)	
	Grade 9 (standard 7)	
	Grade 10 (standard 8)	
	Grade 11 (standard 9)	
	Grade 12 (Matric)	
	Certificate	
	Diploma	
	University Degree	
4. Home Language		
5. What other languages can you speak?		
6. Nationality (what country do you come from?)		
7. Current relationship status *(please tick the appropriate one)*	Single	
	In a relationship	
	Engaged	
	Married	
	Divorced	
	Widowed	
	Other *(explain below)*	
8. How many children do you have?		
9. How old are your children?		
10. Where are your children staying at the moment?		
11. In how many abusive relationship have you been?		
12. For how long were you in your last relationship.		

Thank you!

Appendix E: Briefing for Collage

1. **Greetings**

   Hello, my name is Tanya. Thank you once again for agreeing to participate in this study. Is everyone satisfied that they understand the study?

   (Chance to respond)

2. **Explanation:**
   - Today we are going to make a collage and after that, in the next month I will have two interviews with you.
   - A collage is a group of words or pictures stuck randomly on a page. These words or pictures show how you think and feel about something. There is no right or wrong way of making a collage.

3. **Instruction:**
   - You are survivors of intimate partner abuse and violence. On the tables you will see cardboard, magazines, glue scissors and a variety of other craft objects. I want you to use these objects to make a collage.
   - <u>Your page is folded in half. If you use the front and the back of your page you now have four sections. In each section show one of the following:</u>

     1) *Occupational Balance*: What did your everyday look like in terms of what you did during the day? What did you do for work, rest and play (free time/hobbies) as well as looking after yourself and your home?
     2) *Occupational Alienation*: What made you feel powerless, frustrated and alone because you could not do what you felt you needed to do? This can be physical needs or internal (emotional or spiritual) needs, needs for others or for yourself
     3) *Occupational Deprivation*: What contributed (gave) or took away from your freedom to choose what activities you that you want to do. What contributed (gave) or took away from your freedom to choose to do many different activities/things?
     4) *Occupational Marginalisation*: What made you feel as if you were “put in a box’? As if that what is happening to you could be expected as something that is supposed to be that way and something you deserve and normal?

You also have a separate A4 page. Here I want you to demonstrate - How do you see your future?

- In the interviews, I will ask you to tell me more about the collage.

4. **Logistics**

- I am going to be with you while you work on your collage. You may stop at any time. When you are finished, I will take a picture of the collage for myself. I will not show the pictures to anyone.
- You may keep your collage and finish it in your own time if you want to.
- When I have the interview with you, I want you to bring your collage. I am going to ask me to tell me about your collage.

- Feel free to help yourself to the refreshments I have made prepared for you.
- I will be here if you have any questions.

___________(social worker) is also available if you want to talk to her

Appendix F: Interview Scheme

The following prompts will be used to direct the interview as needed. Not all will be used if the required information is offered spontaneously. Any of the techniques mentioned in 5 will be used to obtain a clearer understanding when needed

1. **Greeting**
   - Introduce Self
   - Confirm that the client is still willing to participate and that the interview will be 90minutes long.
   - Remind the participant that they may quit at any time and that a social worker is available to provide counseling.
   - Provide the client with receive 5 minutes to familiarize themselves with their poster before the interview starts.

2. **Interview**

Ask the participant:

- How did you experience making the collage?
- Will you please tell me more about the parts in your collage?
- Will you please tell me your story?

3. **Conclusion**
   - Ask the participant if they would like to add anything.
   - Thank the participant
   - Make an appointment for a follow up interview if necessary.
   - Remind participant that a social worker is available for debriefing.

Interviewing techniques that may be used

- Detail orientated probes
- asking for elaboration
- Clarification (through paraphrasing)
- Allowing for silence

Appendix G: Template for Note Taking

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<tr><td colspan="3">Participant Code:</td><td colspan="3">Venue:</td></tr>
<tr><td colspan="2">Date</td><td colspan="2">Start Time:</td><td colspan="2">End Time:</td></tr>
<tr><th>Time</th><th>Situation/ Topic</th><th colspan="2">Actions Observed</th><th colspan="2">Reflection</th></tr>
<tr><td></td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
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