Relationship between Levels of Social Support and Symptoms of PTSD and Depression among Female Survivors of Intimate Partner Violence in Kayole, Nairobi, Kenya.

by

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STUDENT’S DECLARATION

I, the undersigned, declare that this is my original work and has not been submitted to any other college, institution or university other than the United States International University, Africa, in Nairobi for academic credit.

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ABSTRACT

Studies on the social support of women survivors of Intimate Partner Violence (IPV) in the Kenyan society are minimal. This research presented and identified some mental health outcomes of Intimate Partner Violence, that is, depression and PTSD, and how they are affected by social support. Using a sample size of 193 participants from Kayole, this research explored the effectiveness of social support to the female survivors of IPV. The female survivors, 18 to 60 years, were either in the intimate relationship or had even left the relationship. With a correlational design, applying quantitative research data collection method, the data was enumerated. The Hurt Insult Threaten and Scream (HITS) screen was used to screen participants for IPV and all the respondents were either experiencing one or the other form of IPV. The result also showed that high percentage of the respondents had either depression 86 (44.6%) or PTSD 114 (59.1%) or both ranging from moderate to severe symptoms. The BDI, PCL-5 and HITS scores were positively correlated indicating that increase in HITS (IPV) scores were significantly related to increase in both PTSD and depressive symptoms. Participants with severe IPV incidences showed severe PTSD and depressive disorders, which are presented as comorbid disorders. The result also showed that those with higher scores in BDI, PCL-5 and HITS, have poorer social support system. This study also showed that there is a significant strong positive association among the different forms of social support. Poor social support implies high scores in IPV, BDI and PCL-5. Therefore, social support could be highly be explored in the treatment plan of depression and posttraumatic stress disorder (PTSD) emanating from IPV. It could be concluded therefore that in order to improve the depressive and traumatic state, one must improve the social support system.
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ABBREVIATIONS

IPV- Intimate Partner Violence
BDI- Beck Depression Inventory
PCL-5- Posttraumatic stress disorder Check List 5
SDQ- Social Demographic Questionnaire
SSQ- Social Support Questionnaire
PTSD- Post Traumatic Stress Disorder
EPM- Emotion Processing
CBD- Central Business District
NBS- National Bureau of Statistics
CHAPTER 1
INTRODUCTION AND BACKGROUND

1.1 Introduction

This chapter gives the general overview of intimate partner violence (IPV) and the background of the study, that is, the social relevance of IPV. It also highlights the problem to be studied, objectives of the study as well as the research questions. This study then brings out the impact of social support on the outcomes of IPV especially PTSD and depression.

1.2 Background to the study

Intimate partner violence is a form of violence within the domestic set up that takes place within an intimate relationship between man and wife, former spouses, boyfriend and girlfriend and dating partners (Martins, Assunção, Morais, Magalhaes & Magalhães, 2014). It is seen as coercive tactics used by one partner against the other in order to establish power and control over them (Swart, 2012). This violence is not only physical, but can also be sexual, psychological and economic.

The violence is sexual when the survivor is even powerless in the hands of the perpetrator who rapes her (Turner, Taylor & Grundy, 2004). It is psychological as it affects the mental health of the survivor leaving the survivor with sleep difficulty (Black, Basile, Breiding, Smith, Walters, Merrick and Stevens, 2010), depressed state, PTSD (Berner and Carney, 2011); anxiety disorder (Stewart, MacMillan, Wathen, 2013) and sometimes the survivor is left with guilt, shame and feeling abused (Karakurt, Smith & Whiting, 2012). The violence has also its economic toll on the victim in that, there are medical consequences which may include injuries, mobility limitations, disabilities which could be long term or short term (Black et al., 2010) which will eventually put a financial strain on the victim. At the same time, it is economical
when the survivor is forced into exile from her marital home and being denied her material support.

IPV is found the world over (Stewart et al., 2013) and it takes different forms: emotional, sexual or even physical. It is found in all cultures (Krebs, Breiding, Browne, and Warner, 2011) and across all socioeconomic groups (FIDA, 2004). In the US, IPV prevalence rate for women is 21.1% (National Institute of Justice and Centers for Disease Control and Prevention, 1998), whereas in Brazil it ranges from 26.4% to 44.8% in the different parts of the country (Pereira, D’Affonseca & Williams, 2013). The prevalence of IPV in Spain is estimated to be around 9.6% (Torres et al., 2013). In Kenya, according to Kiprotich and Ngeno (2010), violence against women is a form of discipline and women are socialized to anticipate it.

Mosby’s Medical Dictionary (2009) describes IPV as a repeated episodes of physical assault on a woman by the person with whom she lives or with whom she has a relationship, often resulting in serious physical and psychological damage to the woman. Such violence tends to follow a predictable pattern. According to the World Health Organization (WHO), IPV is any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship (WHO, 2013). These violent behaviors include: threats of and actual physical violence, sexual violence, emotionally abusive behaviors, economic restrictions, and other controlling behaviors.

Violence against the female partner constitutes a form of transmission from one generation to the next, in terms of values, beliefs, and behaviors, typical of some cultures and societies which sets the tone for the origin of a patriarchal society (Martins et al., 2014). Many survivors of IPV indicate that the relentless psychological abuse leaves them with long-lasting adverse effects that can be transmitted to their children and it seriously damages their health.
The most prevalent psychological effect of IPV among affected female survivors are depression, anxiety, post-traumatic stress disorder (PTSD), and substance use (Rees, 2011; Trevillion, 2012; WHO, 2013) resulting in low self-esteem and hopelessness. Low self-esteem, hopelessness, suicide and attempted suicide are also associated with IPV (Campbell, 2002; WHO, 2013). Moreover, these effects impact detrimentally on women’s ability to parent their children and thus impact negatively on the children, opening a window to transmit these same effects to their children (McCosker-Howard & Wood 2006). Exposure to IPV during childhood has been linked with poor emotional, social, and attainment outcomes (Kitzmann, 2003) with around six in ten IPV-exposed children exhibiting difficulties. Early exposure to inter-parental violence has also been associated with increased risk of IPV perpetration during adolescence and adulthood (Heyman & Smith, 2002). According to the American Psychiatric Association (2013), Battered Woman Syndrome and IPV have also been associated with Post traumatic stress disorder (PTSD) and traumatic grief. The trauma may lead to flashbacks or other intrusive experiences from previous traumatic events. The woman may believe that she is in danger or she is not worth living leading to low self-worth.

Male dominance in the Kenyan society is very obvious and patriarchal standards and attitudes pervade every level of the society according to Swart (2012) who also alleges that men are undisputed heads of households in Kenya. They make key decisions about most of the things at home depriving the women of social support leading them to suffer in silence which exposes them to some psychological disorders. In the Kenyan society, the violence against women is actually recognized as one way of disciplining one's partner in the society according to Kiprotich and Ngeno (2010) who also affirm that the violence is a form of socialization of which the woman anticipates as a form of discipline. The society socializes the woman to anticipate this
kind of discipline. In the past years, a number of domestic violence reported in the Kenya Media ended up in death. It is either a man kills the wife, or he kills the wife, the children, and finally kills himself. If one is fortunate not to be killed in such IPV, one may end up with mental health issues or/and maimed.

Intimate Partner Violence (IPV) against women by their partners or ex-partners has been documented as a common worldwide phenomenon (Garcia-Moreno, 2006). It occurs across all populations, irrespective of social, economic, religious or cultural groups and they vary in the patterns of violence in different populations (Zungu, Salawu & Ogunbanjo, 2010). World Health Organization (2013, 2017) research on IPV indicates that 30% of females or one in every three women globally experiences physical or sexual violence, or both, by her partner, or non-partner in her lifetime. In the same research the prevalence of violence in the relationship ranged from 23.2% in high income countries to 37.7% in south-East Asia region. In a meta-analysis on 48 population-based surveys across low, middle, and high-income countries in 2002, Krug (2002) found that between 10% and 69% of the population had experienced physical violence in their life time by a partner. This result is in line with the research made by WHO. It is also researched that among murders of women the world over, 38% are committed by intimate partners, while 7% of women all over the world have been assaulted by her intimate partner sexually (WHO, 2017).

In Europe IPV against women is a widespread public health problem and it undermines the physical, mental and social well-being of the woman. The WHO (2014) report on IPV estimated the lifetime prevalence of the violence among women with intimate partners in high-income countries of western Europe to be 19.3%, whereas central and eastern Europe
falls around 27%. The prevalence of intimate partner violence against women is 30% globally and about 23% in high-income countries.

In the United States, IPV against women is dominant among ethnic minorities. The disparities are also related to socioeconomic and foreign-born status, and the mental health outcomes aggravates the health consequences (Stockman, Hayashi & Campbell, 2015).

In South Africa, violence against the female partner is complex and has social and public health consequences (Zungu et al., 2010). Domestic violence witnessed in Kenya, it is not a natural or biological phenomenon. Kiprotich and Ngeno (2010) conducted a research on domestic violence in Kenya and affirmed Ward’s (2002) findings that domestic violence has been a longstanding problem in Kenya. There is also an engrained belief about gender roles and marriage which has been affected by this practice. The 2008 report by the Federation of Women Lawyers of Kenya (FIDA) indicated that 75% of women are abused in their relations. Where do the survivors of IPV go when the fighting or disagreement begins?

Despite intimate partner violence within the Kenyan society, most of the affected still stay in their relationships. The social support for survivors of domestic violence in Kenya is well practiced but has not been very much documented. Kiprotich and Ngeno (2010), stated in the seminar that although the extended family plays a supportive role in the intervention of IPV, they often encourage silence to protect the image of the family. The extended family at the same time plays a role in fueling the IPV. This is so due to the fact that the extended family views IPV as a normal societal norm. It is in this wise that the researcher seeks to document the effect of social support on the mental health outcome of IPV.

IPV is a public health problem which Martins, Assunção, Morais, Magalhaes and Magalhaes (2014) consider a tragic reality in many homes. IPV affects the survivor’s health both
physically and mentally. It affects the survivor directly (physical injury) or indirectly (psychological injury). A history of prolonged violent experience is a risk factor on the survivor, with time the violence escalates into different types and multiple episodes of abuses. When the abuse is severe, it has a greater impact on a woman’s physical and mental health (WHO, 2012).

Relationship triggers of IPV are many and they may include sexual infidelity, financial instability within the relationship and family settings. Considering the fact that women bear the brunt of this situation, it was logically fair to consider ways of preventing such violence. One of the ways could be through the social support. This called for an in-depth research into social support of women involved in intimate partner relationship which are violent.

Social support is seen as the behaviors of loved ones towards the needs of the individual who is dealing with a stressful situation. According to Green and Pomeroy (2007) social support plays a vital role in the recovery process from the psychological consequences of victimization. Fortin, Guay, Lavoie, Boisvert and Beaudry (2012) affirmed that social support from significant others can positively influence emotionally the response to the stressful event. The same support can also reduce the impact of stress by providing rational thoughts which may prevent or reduce inappropriate behavior responses. The lack of social support, on the other hand can be linked with the survivor’s poor adaptation and distress (Green & Pomeroy, 2007). Social support of survivors is less documented in Kenya, though Kiprotich and Ngeno (2010) affirm that extended family plays a supportive role in the intervention of IPV, they often encourage silence to protect the image of the family. The extended family, at the same time, plays a role in fueling the IPV since it views IPV as a normal societal norm.
Observation in Kenyan culture show that women generally do not separate from their partners after domestic violence. Getting out of marriage, or getting a divorce due to domestic violence is not something that is encouraged in Kenya (Kiprotich & Ngeno, 2010).

Studies have documented both the forms of IPV and the psychological effects in Kenya but less research done on the social support of IPV in Kenya. This present study therefore explored the social support system and how it relates to common psychological effects.

1.3 Statement of the Problem

The researcher’s interest in working on this study stemmed from the number of clients who sought psychological assistance for being battered by their intimate partners. There were instances of couples who, after their honeymoon, came back home reporting IPV. There were those who came to seek psychological assistance after going through some violent relationship with their partners. Many of the clients accepted violence as part and parcel of the intimate partner relationship. However, this is sad since IPV has mental and psychological consequences associated with it that include depression, anxiety, post-traumatic stress disorder (PTSD), and substance use (Rees 2011; Trevillion 2012; WHO, 2013). Unfortunately, there are less or no documented literature for the effect of social support on these consequences in Kenya. Since very little research is done in Kenya on the social support system on IPV, this study is designed to examine the relationship between levels of social support and symptoms of PTSD and depression among the survivors of IPV in Kayole, Kenya.

Kayole is one of the most popular and populous suburb of Nairobi, situated in the east lands. It is known for its notorious incidents which includes crime, notably kidnapping, armed robbery and outlawed gangs (Standard news media, May 2010). It is densely populated due to its proximity to the central business district (CBD) and low cost rental housing. Kayole, being
densely populated, has become a business hub with a number of small scale business shops like groceries, secondhand clothes and shoes as well as hardware shops strewing the Spine road, the main street of the estate. The average income of the people in Kayole according to Kenya national bureau of statistics (2009) ranges from Ksh. 4,000 to Ksh. 10,000. The income situation as at the time of this research would be different. People earn more as per social communication.

Studies that have been done have not indicated documented social support but has dwelt on the psychological effects of IPV. This study will then fill the gap that has been left by other researchers.

1.4 Objectives

The general objective of this study determined the relationship that exists between social support vis-à-vis PTSD and Depression among survivors of IPV in Kayole. This was done by addressing the social support systems available to the survivors of IPV and also to empower them and improve their quality of life. The following were the specific objectives of the study:

1. To enumerate the forms of IPV among survivors in Kayole.
2. To document the emotional and psycho-trauma symptoms among survivors of IPV in Kayole.
3. To determine the relationship between level of social support and symptoms of PTSD among survivors of IPV in Kayole.
4. To determine the relationship between level of social support and symptoms of Depression among survivors of IPV in Kayole.

1.5 Research Questions

In order to adequately cover the above stated objectives, this research answered the following questions:
1.5.1 What are the forms of IPV among survivors in Kayole?

1.5.2 What are the emotional and psycho-trauma symptoms among survivors of IPV in Kayole?

1.5.3 What is the relationship between level of social support and symptoms of PTSD among survivors of IPV in Kayole?

1.5.4 What is the relationship between level of social support and symptoms of Depression among survivors of IPV in Kayole?

1.6 Significance of the Study

The mental health outcomes from the IPV include depression and PTSD. Globally, reports have been made as to these outcomes (Rees 2011; Trevillion 2012; WHO 2013); and at the same time some research have been made on the social support globally. Unfortunately, in Kenya, social support vis-à-vis depression and PTSD is being practiced but not documented. The significance of this study therefore is to research and document the impact of social support on the survivor of IPV.

Getting out of marriage, or getting a divorce due to domestic violence is discouraged in Kenya and so it was the researchers hope to seek preventive measures to this menace in our society today and at the same time seek psychological treatment for those who become survivors of the IPV. These mental health outcomes have to be addressed realizing that IPV is global.

The research would inform beneficiaries of the consequences of IPV and encourage survivors to consult mental health personnel when going through IPV. The research highlights that social support could be useful as a basic reference tool for service providers who will use the knowledge to assist survivors.
Readers would be equipped with the fuller knowledge of the triggers of violence in relationships, the consequences that would arise due to this violence, to examine life events before entering into the intimate relationship and the role of social support in the healing process. It also provides insights into preventive measures for the survivors. The results of the study would help psychologists and mental health providers in their treatment plan to highlight the role of social support in minimizing the effect of IPV in Kayole.

The government, especially the Police Force, which enforces the laws would be guided to the knowledge that no one has the right to violate another, even if they are in intimate partner relations, since the violence could lead to mental and psychological issues. It may also be eye-opener to many who may not have considered IPV as a factor leading to mental health issues. It is the hope the researcher that the findings of this study may empower the many women who are survivors of IPV to be able to share their stories and history with others and also to help others identify signs of the advent of the violence within their relationships; and also to link up with significant others who will listen empathically to their issues.

The findings of the study would assist pastoral workers and mental health workers in developing effective interventions for survivors of IPV. It would be a call to psychotherapists treating women clients to consider looking at IPV and the subsequent outcome.

1.7 Scope of the study

Though the population was taken from Catholic Mission, St Patrick Hospital and DIWOPA Health Center in Kayole, these represented the lower class, the middle class and lower upper class. Secondly, the research dwelt on battered women who had sort medical attention due to the injuries incurred due to IPV. In order to delimit the fear of revealing pertinent personal matters, the population was assured of confidentiality.
The study focused on women aged between 18 and 60 years who had IPV experience and who live within Kayole. Social evidence of the frequency of domestic violence within Kayole triggered the researcher to look at the causes and the effects of IPV, its advent from childhood maltreatment on the part of the abused and the role of social support in relation to the levels of symptoms of depression and PTSD. IPV in the Kayole area being accepted as a way of life, informed the researcher who looked at the role social support places in relation to the levels of symptoms of depression and PTSD stemming from IPV. The gravity of IPV against women in Kayole ought to inform any psychotherapist treating women clients to consider looking at that aspect.

1.8 Assumptions of the Study

IPV is experienced in all spheres of life, across gender, age, culture and economic standard (Martins et al., 2014). Physical abuse towards women by their male companions occurs quite frequently in the Kenyan society. The assumption of the study was that many intimate relationships go through different kinds of IPV. Most relationships in Kenya go through repeated episodes of assaults on women which results in serious physical and psychological damage to the women. Such violence are not only experienced as physical assault but also sexual, psychological and economic violence like forced exile from their marital homes and sometimes losing their material support.

1.9 Operational definition.

IPV: Intimate Partner Violence. This term is synonymous with Domestic violence throughout the research. In this study IPV will be used for the survivor of the intimate partner violence or the battered partner. It should be noted that while men are also survivors of domestic violence, the concept of domestic violence in this study will typically refer to women only.
**PTSD**: Post Traumatic Stress Disorder. This is a disorder after a traumatic incident has occurred and after 30 days one begins to have flash backs or dreams of the incident.

**Social Support**: This is the behavior that significant persons exhibit towards loved ones to tone down the stressful situation an individual is going through. Social support in this paper will be assumed to be positive.

**Female survivors**: This is in reference to the female respondents who were survivors of the intimate partner violence

1.10 Chapter summary

The reality IPV in the Kenyan society cannot be taken for granted. Ways and means have to be strategized to prevent or to minimize it. Since it is incorporated in the fabric of Kenyan society and it may be very hard to eradicate it, therefore ways have to be found to prevent it from occurring so as to minimize the mental effect of IPV.

After identifying the reality of violence against women by their partners within society and subsequently identifying the possible outcomes and the role that social support can have on these outcomes, it is now appropriate to identify the literature available where this topic of Intimate Partner Violence and social support are concerned. In the chapter that follows we will examine literature from around the world, and then will narrow it down to what has been done in Kenya.
CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter reviewed some literature on IPV in general, considering the effect on the family, what are its correlates, the forms, what makes the survivors continue to stay in it, the mental health issues and it concludes with the social dimension to IPV. This study looks at a number of literature reviewed to ascertain gravity of IPV, that is, the forms of IPV, emotional and psycho-trauma symptoms of IP, in the society around the world.

This literature review was done viewing IPV from the global perspective then narrowed to the Kenyan society. It examined the IPV from the global perspective, dwelling on what has been done in America, Europe, Asia, Africa and then narrowing down to Kenya and Kayole, where the research was done.

In the review of existing literature, the variables looked at included the relationship between IPV and Depression, and at the same time, IPV and PTSD. The question as to whether there is a relationship between IPV and, PTSD and Depression was explored. Finally, available literature for the social support and its effect on intimate partner violence was looked at.

2.2 Theoretical framework

Severe IPV can provoke collective fear and uncertainty. This fear can spread rapidly and is not limited to those experiencing the event directly, but also others are affected including the family members of survivors. Psychological suffering is usually more prevalent than the physical injuries sustained during violence among intimate partners. Understanding these psychological consequences is critical for one to put efforts together in order to develop intervention that can limit the adverse psychological effects of IPV.
The IPV effects vary and at the same time specific to each individual; both psychological and physiological responses can vary widely. Social context, biological, past experiences, and future expectations interact with characteristics of the traumatic experience to produce the individual's psychological response (Fullerton et al., 2003). In general, those exposed to IPV event show increased rates of acute stress disorder, posttraumatic stress disorder (PTSD), major depression, panic disorder, generalized anxiety disorder, and substance use disorder (Kessler et al., 1995).

This study used both Psychodynamic and Cognitive Emotion Theories. Sigmund Freud, the founder of psychoanalysis (1939) focused on the influence of the unconscious on day to day experiences. That a person’s experience in childhood later on influences how he/she perceives the world around them. He discussed traumatic experiences and their resulting sequence in several writings. He talked about a protective shield or stimulus barrier that provides a threshold for the perceptions of stimulus. He argued that once a stimulus barrier is breached, the pleasure principle (id) no longer functions and the victim regresses to more primitive forms of function in order to master the stimulus. The survivor goes through a helpless experience and obsessive repetition of trauma that occurred, currently indicated as re-experiencing symptoms (Freud, 1939). The effects can be long lasting, depending on the quality of the individual’s experiences during or shortly after the incident. Fortunately, through effective, caring intervention, negative delayed stress responses to trauma can be determined (Kendall, 1989).

When coping with a critical incident, the individual involved often suppresses certain thoughts and feelings. This process allows the individual to do what must be done to maintain psychological and physical equilibriums. Survivors suffering from trauma and posttraumatic stress disorder need to confront the event again (particularly imagery) and fully accept it as a fact
(and not act in denial) in all its details; they need to talk about it and be given ample opportunity for catharsis and working through relaxation techniques, anger management and cognitive reappraisal may be called for (Felthan et al., 2004). Survivors may be encouraged to consciously let go of the traumatic event and to emerge themselves in everyday routines when appropriate.

The traumatic experiences that the survivors in this study were exposed to were too threatening and disturbing to be assimilated at once and they gradually surface later to be fully integrated. This is a natural process of self-healing as described by Kendall (1989). However, this study treated the fear response as mal-adaptive fear structure which forms the hyper-arousal fight, and freeze among survivors. Thus, when a normal fear structure is activated by a dangerous situation, it generates fear and leads to adaptive maneuvering by the individual (e.g., moving to safety) to avoid danger. In this study the IPV, a pathological fear structure contains associations among the stimulus, response, and meaning representations that distort reality and includes excessive response elements (e.g., avoidance of safe situations). As argued by Foa and Kozak (1986), pathological fear structures are resistant to modification coursing persistence of cognitive avoidance, as well as to cognitive biases in processing information at various stages in memory functioning (encoding, interpretation, and retrieval). The avoidance and cognitive biases interfere with the acquisition of relevant information that is inconsistent with the existing elements of the pathological fear structure, a process that constitutes the essence of recovery or emotional processing as described by the emotional processing theory (Foa & Hearst-Ikeda, 1996).

The cognitive emotional theory involved emotional processing theory. Foa and Kozak (1986) contend that emotions are a product of our cognitions. In the case of IPV, the cognitive distortions that a person has, sustain them in the relationship. They contend that emotions are
represented by information structures in memory, and anxiety occurs when an information structure that serves as a program to escape or avoid danger is activated. They defined Emotion Processing (EMP) as modification of memory structures that underline emotions. Physiological activation and habituation within and across exposure sessions are cited as indicators of EMP, and variables that influence activation and habituation of fear responses are examined. These variables and the indicators are analyzed to yield an account of what information must be integrated for EMP of fear structure.

Generally, trauma refers to severe emotional shock and pain caused by an extreme upsetting experience that can have a lasting effect. Being an overwhelming event can render one helpless and anxious. Fischer (1998) argued that trauma is a vital experience of the discrepancy between threatening factors of situations and individual possibilities of coping accompanied by feelings of helplessness and lack of security, which leads to a permanent state of shock as regards oneself and one’s worldview. A traumatic event is an event through which one or several people are massively endangered in their physical and/or mental integrity. The event can affect one directly but it can also affect a close friend or a relative.

2.3 Intimate Partner Violence

The scientific review of IPV against women showing global and regional estimates of the prevalence of IPV. In a research by WHO (2013) on estimates gathered from data extracted from 79 countries and two territories, shows that the global prevalence of physical and/or sexual IPV was 30%. European and Western Pacific regions have the lowest of 25%, the Americas were the next with 30% but lower in the tune of 23% in the high-income regions and 37% in African.
In the United States, IPV against women is dominant among ethnic minorities. The disparities are also related to socioeconomic and foreign-born status, and the mental health outcomes aggravates the health consequences (Stockman, Hayashi & Campbell, 2015).

Generally, across the world, IPV rates are underreported (Stewart et al., 2012). There are estimates which suggest that about 50% of women will be physically, sexually, psychologically violated during a point in their lives (Walker, 2000) and 28% of women in romantic relationship have already been physically abused by their partners (Scott & Babcock, 2010).

IPV is violence meted one partner against the other and could be physical, sexual, or psychological (Kelly, 2010; Krebs, Breiding, Browne & Warner, 2011). It is a pattern of abusive behaviors which includes physical, sexual, and psychological maltreatment used by one partner against the other in an intimate relationship, in order to gain power, to maintain the misuse of the power, to control, and to have authority (Torres et al., 2013). It is used to describe the physical, sexual, or psychological harm caused by a current or former partner. This physical, sexual, and psychological abuse of women by their intimate partners is common the world over (Torres et al., 2013). Research by WHO (2012) also suggests that the different types of violence coexist. The physical, sexual and emotional abuse may exist side by side in particular intimate partner relation. In multi-country study by WHO (2012), it was realized that 23–56% reported experiencing two or three of the violence spontaneously. At the same time in a quotation by WHO (2012) on a comparative analysis of data gathered from 12 Latin American and Caribbean countries showed 61–93% of women from those countries reported experiencing both physical and emotional IPV within a span of 12 months. This kind of violence occurs not only in a heterosexual relationship but also among homosexual couples (Stewart et al., 2012).
IPV can be physical, such as slapping, hitting, kicking, biting, beating and sometimes the use of a weapon. It can be psychological, which may include intimidation, humiliating and threatening (Stewart et al., 2012). It can also be forced sexual acts or other controlling behaviors like isolating the partner from family or friends, stalking, restraining access to information and finance (Stewart et al., 2012). IPV has sometimes been referred to as family violence and sometimes domestic violence. Such definitions are very general since family violence and domestic violence may include violence against children as well as the partners. IPV is violence from one partner against the other. The purpose of the violence could be coercive control. Krebs et al. (2011) affirm that the survivors of intimate partner violence (IPV) are often subjected to multiple types of victimization including psychological aggression, stalking, physical violence and sexual violence.

Historically, men are seen to be the perpetrators of the violence and it is the stereotypical (Stewart et al., 2013). It is noted today that bilateral violence (common couple violence) is common than previously thought, although women experience the extreme burden of morbidity and death linked to IPV (Stewart et al., 2013). According to Kiprotich and Ngeno (2010), violence against women in Kenya is a form of discipline that society socializes women to anticipate it. Thus women largely bear the brunt of the IPV not only because of their economic disadvantage but also because of a deep-seated societal attitude. Though women may be disadvantaged, and are thought to be docile in the relationships, it not necessarily the case. Many a time, it is thought that the women in these violent relationships do nothing in self-defense, however, Heise et al. (1999) argue that what might be interpreted as a survivor’s passivity, may in fact be her calculated way of protecting herself and her children. The woman can also be violent in her relationship, often in self-defense (WHO, 2012). They are not necessarily passive
recipients of the violence meted out, rather they often adopt strategies to protect themselves and their children. Though they partially defend themselves, it also suggests an in-depth research into social support of women involved in intimate partner relationship which are violent.

2.4 Universal nature of IPV

Intimate partner violence is a common phenomenon which occurs in all settings and it is encountered in all countries, different cultures, different religions, and people of different socioeconomic strata in the world (Stewart et al. 2012). The greatest global weight of IPV is borne by the female partner (WHO, 2012). IPV takes many forms; it could be emotional, sexual or even physical. Physical and sexual violence by partners who are intimate could cause adverse effects on the individual, mentally and physically. These individuals’ ability to live healthy and productive lives can also be affected (Krebs et al., 2011). Apart from it being in all cultures, it is also affirmed by Cohen and Maclean (2003) and Federation of Women Lawyers of Kenya or FIDA (2004) that it exists across all socioeconomic groups. They also confirmed that poverty coexists in combination with other risk factors for IPV. People of all races, culture and religion can be perpetrators of violence against women (FIDA 2004). This is confirmed by Pereira, D’Affonseca and Williams (2013) who acknowledge violence in family is a phenomenon which is worldwide and it constitutes very serious risk in the human development. It also violate human rights. According to Black et al. (2011), IPV remains a universal and at the same time a social issue. In their research Karakurt, Smith and Whiting (2014) identified some of the violent acts that the women go through to include rape, incest, physical violence, and emotional abuse. At the same time, women are more likely to be terrorized, injured, or killed within IPV, regardless of their ethnicity, race, or socio-economic status (Johnson, 2008). IPV results in unreasonable physical, emotional, and economic costs, and sometimes death (WHO, 2002).
Intimate partner violence has had range of research literature for the last half-century, particularly in different areas including criminal justice, psychology, and the social sciences (Barner & Carney, 2011). It is a highly multidimensional world health issue. The violence does not only affect the two parties but affects all members of the family and it is also found among same-sex couples (Leppäkoski et al., 2013).

Generally, across the world, IPV rates are underreported (Stewart et al., 2012). Whereas some parts of the world have taken a strong stand to get rid of it in the society, other communities are very mute to it though not in favor of it. There are estimates which suggest that about 50% of women will be physically, sexually, or psychologically violated during a point in their lives (Walker, 2000) and 28% of women in romantic relationship have already been physically abused by their partners (Scott & Babcock, 2010). However, Cerulli, Veale Polieshuck, Raimondi, and Chin (2012) in their research estimate that 12–25 % of all women attending healthcare centers and emergency departments are there due to IPV. It is clear that percentages differ across the board.

In WHO (2012) multi-country study on violence against women, data was collected from 24,000 women involved in IPV from 10 countries. These women represented different cultures, countries, religion and geographical backgrounds. The study results affirmed IPV is widespread. All the participants have had one or the other or all of the violence in their relations. The violence was severe physical violence, sexual violence, one or more emotionally abusive acts.

In a Mexican study by Frías and Agoff (2015) on IPV, based on the 2006 National Survey on the Dynamics of Household Relationships, they showed that violence affects a significant number of women. 10.7 % of Mexican women who are currently married, cohabiting, separated, or divorced have been subjected to sexual IPV, and 23.7 % have experienced physical
violence at the hands of their current or previous partner. Stockman et al., (2013), in their review of literature showed that HIV (AIDS) and IPV remain major public health problems in the USA and the Caribbean, particularly among women of color, and at the same time the number of IPV survivors are higher among African-American women than their White counterparts.

Despite the fact that IPV occurs regardless of geographical location, the extent of IPV varies from one country to the other. According to the WHO (2005) study on the Multi-country Study on Women's Health and Domestic Violence against Women, made a comparative study of 10 countries and showed a vast differences between violence to Japanese women as compared to Ethiopian women. It was found out that 3.8% of Japanese women, compared to 53% of Ethiopian women, experienced IPV in the last 12 months of the time of the research. In a comparative analysis made by WHO (2012) of nine countries including Cambodia and Zambia, considering demographic and health survey revealed different violent experiences, physical and sexual violence, meted against women in intimate partner relations. Whereas physical violence is 18% in Cambodia, it was 48% in Zambia. Sexual violence was ranging from 4% to 17%.

In the US, the morbidity and mortality associated with IPV are ranked very high and very significantly in the national public health issue. A joint team of the Violence Against Women Office and the Centers for Disease Control and Prevention came out with a report that in a lifetime IPV prevalence rate for women will be 21.1% (National Institute of Justice and Centers for Disease Control and Prevention, 1998). It is reported that 35.6% of women in the United States have reported at least once, about its occurrence in their lifetime (Black et al., 2011). It is a public health issue. In their research on the studies conducted in Brazil, Pereira, D’Affonseca and Williams (2013) showed that physical violence against women ranges from 26.4% to 44.8% in
the different parts of the country. The prevalence of IPV in Spain is estimated to be around 9.6%. (Torres et al., 2013).

In their report Kiprotich and Ngeno (2010) acknowledged the Kenyan Demographic health survey which states that 39% of women surveyed have been abused by a partner. The dominance of men is also attested to in the larger society where men are heads of households (Swart, 2012) and at the same time, hold positions of power bringing out the patriarchal standards and attitudes pervading every level of Kenyan society. There is an engrained belief about gender roles and marriage which has been affected by this practice. This is attested to by drastic increase in the reported cases of violence from 299 in 2006 to 400 in 2008 (Kiprotich and Ngeno, 2010) confirming that domestic violence has been a longstanding problem in Kenya.

IPV is deeply rooted in societal inequalities (Karakurt, et al., 2014). It is a consistent social problem that has serious implications on the health of women. Women are the most frequent targets of this phenomenon and the perpetrator is usually the partner of the woman or someone close within the family, and often is a male (Pereira et al., 2013). Most of the data collected focuses on IPV perpetrated by men against women in heterosexual relationships (Stewart et al., 2012). IPV can not only be found amongst heterosexual couples but can also be found among Lesbian, gay, bisexual and transgender (LGBT) relationships. In their research, Stewart et al., (2012) showed that the abusive characteristics among the LGBT are similar to those of heterosexual relationships and they occur at the same rate or even at a higher rate than the heterosexual relationships.

It can be concluded that IPV spans across countries, cultures, gender and age. It is a problem which is under-recognized which has an enormous impact on the physical and mental health, and the well-being of many women, men and also children. It is also linked to risky
health behaviors like alcohol and other substance abuse. The next paragraphs will dwell on the causes of IPV.

2.5 Correlates of IPV

The Mosby's Medical Dictionary (2009) outlines the steps that the violence takes: The abuse usually begins with verbal argument graduating into verbal abuse. This episode can begin with any subject whatsoever in the house. As time goes by the violent situation intensifies in regularity and severity. Then any less provocation is enough to start an attack.

Apart from these steps, there are other causes that stimulates IPV, one of which is societal sanctions which is found in the ecological factors to violence. The ecological model of understanding violence proposes four factors that assist in generating violence in relationships. They are individual, relationship, community and societal influences (WHO, 2012). On the individual level, the factor exhibit itself when the man feels he is older than her and has to dominate the relationship, when both or one may have experienced or witnessed violence as a child, the presence and abuse of alcohol and other harmful drugs and finally acceptance of violence as a way of intimate partner life. Factors associated with the female partner high likelihood of experiencing violence in her relationship include exposure to violence between parents in her childhood (Gilbert et al., 2009) low education and exposure to other abuses.

The relationship factor which affects both the survivor and perpetrator include conflict and dissatisfaction in the relationship, economic distress stemming from low education, extra-marital relationship on both sides and sometimes higher education level on the part of the woman (WHO, 2012). Community and societal factors have been found across studies as factors promoting IPV especially in the areas where manhood is equated to dominance and aggression. In communities where the women are poor due to the low social and economic structure of the
women (Barnett, 2000; WHO, 2012) who have to depend solely on the men, such society have dominance of IPV. In societies where legal sanction against IPV is not upheld and where there is a broad social acceptance of violence as a way of solving conflict within the community and where male dominance and patriarchal activities are widely held beliefs about gender roles, violence perpetuate intimate partner relations (Kiprotich & Ngeno, 2010; WHO, 2012).

Societal sanctions against IPV which are weak can perpetuate the violence. The survivor with low income, society that is stuck to traditional gender norms, a community which has low status of women, and social norms, these are supportive of violence (Stewart et al., 2012). Attaining higher standard of education and social status are important components of marital power and yet they are factors for causes of IPV. IPV is high among couples where the wife has a higher social status and better education than the husband. This point is attested to by the research made by Jin and Keat (2010) examining IPV among Chinese immigrants and the important role power plays in IPV. In conclusion, it was evident that the husbands’ perceived loss of power influenced their attitude towards violence. The imbalance of power was also cited as one of the factors contributing to high rate of IPV in Kerala. The women of Karala are better educated and well employed than the average Indian woman (Jin, Doukas, Beiting & Viksman, 2014). Kerala is one of the most progressive states where opportunities for higher education and employment for women is on the ascendancy. Despite the advancement IPV remains high (Jin et al., 2014).

Abusive relationships are governed by patriarchal values which gives little or no power at all to women (Barnett, 2000). Controlling partners, more often than not, deny their women access to social support networks such as friends, family, and community agencies, thus making it difficult for them to get out of the abusive relationship. (Barnett, 2000). Cultural factors play
essential role in the causes of IPV. Collectivist cultures which are patriarchal exhibit strong
gender roles which gives the men the power to control women’s behavior. Most collectivist
cultures link masculinity to dominance, honor and aggression. Violence is accepted as a way of
resolving conflict. Women in such cultures are urged to endure rather than reject IPV (Stewart et
al., 2012). In families where the mothers have experienced high levels of psychological abuse,
the stress that comes out of this increases the risk of the children internalizing the problems
(Tajima et al., 2011).

Exposure of violence to a child can raise the risk of being a victim or a perpetrator in
his/her future relationship and at the same time, a perpetrator on the children. This is known as
intergenerational cycle of abuse (Stewart et al., 2012). In the USA, the annual estimates of
children exposed to violence range from approximately 3 million to 18 million children though
the often cited estimate is 3.3 million according to women who report (Tajima et al., 2011).
Children who are exposed to IPV are at higher risk of outcomes, some being short term and
others being long term. The exposure of children to IPV may occur in variety of ways. Some
children visually witness the violence among their parents or may overhear as the violent
exchange goes on. Other children may only see the aftermath of violent incident when one of the
parents is injured (Tajima et al., 2011).

Exposure to IPV among adolescent is extremely common and this exposure is linked to a
wide range of psychopathological outcomes, including posttraumatic stress disorder (PTSD)
(Kilpatrick et al., 2000, 2003). Sundermann and DePrince (2015) in their research quoted a
number of studies which suggest that younger age at onset of maltreatment can be translated into
more risk for later mental health issues like anxiety and depression. Exposing a child to incidents
which are psychological, physical, sexual, financial, or emotional abuse between intimate
partners will be considered child maltreatment (Gilbert et al., 2009). Children who are exposed to IPV are more likely to maltreat their own children and may have violent intimate relations either as survivors or perpetrators (Stewart et al., 2012).

Other research also shows that children who witness IPV are often the victims of forms of maltreatment known as poly-victimization which has a wide and broad effects on children (Lee & Hoaken, 2007). The survivor’s childhood maltreatment can be linked to the IPV (Valdez, Ban Hong & Lilly, 2013). The association between IPV against women and health consequences for children include anxiety, depression and poor school performance among others. When the children get old they in turn either become perpetrators or victims. WHO (2012) research acknowledges that a common factor associated with male perpetration and female experience, is the children who are exposed to IPV against the mother.

There are recent researches that have identified a link associating childhood maltreatment to recent re-victimization in adulthood in the form of IPV (Valdez, Lim & Lilly, 2013). In their research on survivors of IPV, they explored how childhood experiences affect factors that increase risk for IPV and identified two trajectories of childhood maltreatment associated with processes that increase risk for IPV victimization in adulthood. The two are emotional trauma and physical trauma within childhood.

The trajectory of emotional trauma included internalized feelings of guilt. An internalized negative view of self (low self-efficacy) coupled with fear of loneliness leave these women vulnerable to tolerating the physical abuse at the hands of their partners in adulthood. And the trajectory of physical trauma includes experiences of physical abuse, sexual abuse, and witnessing violence (Valdez et al., 2013). In other words, children who experience emotional abuse, neglect from caregivers, alcoholic caregivers, and those who experience emotional trauma
are likely to be vulnerably expose to future IPV. The same apply to those who are physically and sexually abused who eventually in their adult life may be desensitized to violence and may normalize the IPV experience.

Krebs et al. (2011) confirm that IPV survivors are often subjected to multiple types of victimization including psychological aggression, stalking, physical violence and sexual violence. Some of the women stay in multiple abusive relationships. They may leave one abusive relationship to another with the hope and desire for love, affection and company. However, very few studies have examined whether multiple types of abuses e.g., physical abuse, sexual abuse, psychological abuse can lead to greater mental health difficulties among survivors of IPV. Given the view that young people who experience one type of maltreatment very frequently experience another type of maltreatment (Valdez et al., 2013).

Other women expect within their romantic relationships to be abused because of learnt helplessness in the face of abuse stemming from their childhood (Valdez et al., 2013). In their study, Barner and Carney (2011) found out that learnt helpless is acquired through long term IPV which may generate into psychopathology such as post-traumatic stress disorder (PTSD) or major depressive disorder (MDD). It could even be said that these survivors may have internalized negative views of themselves and of others, mistrusting others and opening up to tolerate abuses within romantic relations reasoning that romantic relations should always be abusive. According to Walker (2009), there are four general characteristics of victims of IPV: They believe the violence is their fault; they do not have the ability to place the responsibility of the violence somewhere else; they have constant fears for their lives and the lives of their children; and they have irrational belief that the abuser knows everything around them.
Survivors of IPV are likely to feel guilt, shame and even blame themselves for being abused (Karakurt, Smith & Whiting, 2014). This can translate into the survivor having a negative self-images and not likely to exit abusive relationship. In some situations, the self-esteem is damaged if the friends and significant others blame the survivor for not preventing her abuse (Eddleston et al., 1998). These negative reactions can possibly be related to mental health issues such as depression, PTSD or anxiety that are common among survivors of IPV.

There has been very recent research done in South Africa which established a causal relationship between IPV and HIV risk. People who go through such violence in intimate relationship are exposed to different inhuman and intimidating acts leading the abused to sink down in her esteem. According to Stockman et al. (2013), abused women and those with more gender inequity in their relationships were those who were at higher risk of contracting HIV infections. Though this may look plausible, additional research ascertain the causal link between IPV and HIV.

Downey, Irwin, Ramsay, and Ayduk (2004) have suggested that the child exposure to maltreatment and early rejection leads the victim to become extra vigilant to rejection from others. Due to this, any ambiguous or minimal indicators of rejection is perceived as a threat, which may trigger a defense mechanism which is demeaning to interpersonal response.

Other researchers also show that children who witness IPV are often the victims of forms of maltreatment. This multiple forms of maltreatment, otherwise known as Poly-victimization has great significance and wide and broad effects on children’s development (Lee & Hoaken, 2007). The children develop biases or distortions in interpreting and responding to social information.
According to Walker (2009), some men within the relationship, subject their partners to abuses in order to establish control, causing the survivor to experience low self-esteem and depression. Another area of concern is attachment. It is necessary to look at the basic tenets of attachment theory originated by Bowlby (1970) and later used by Mary Ainsworth for her studies of children’s attachment to their caregivers (Tie & Poulsen, 2013). Bowlby (1970) presented the attachment theory to describe the formation of bonds between children and their caregivers. These attachments were later organized into three types by Ainsworth: secure, insecure and avoidant (Tie & Poulsen, 2013). They later posited that these infant attachment styles form the basis for the formation of romantic attachment in adulthood. It takes this form: Firstly, people who are securely attached have confidence in the significant people in their lives who will be there for them at all times and will not abandon them in times of distress. They find support and comfort in their attached figures, “the secure base” from which to branch out and freely explore the outside world. Secondly, people who are insecurely attached feel the need to be with their partners at all times, fall in love easily and are in great panic when there is separation. According to Shurman and Rodriguez (2006), those with insecure attachment patterns are linked to IPV. Thirdly, people with avoidant attachment avoid emotional closeness with partners, and dislike attempts by partners to make such contact. Johnson (2004) in support of the third point, adds that the people with avoidant attachment tend to be jealous and have intense sexual attraction.

Rape is possibly the strongest adverse experience one endures within the intimate partner relationship context. In their study, Turner, Taylor and Gundy (2004) agreed that rape is associated with lower self-esteem. There are also other documents which associate rape to trauma and low self-esteem.
2.6 What keeps the survivors in the abusive relationship?

What stands out as a question for society is why some women stay in abusive relationships. Heise et al. (1999) advanced various reasons why women may stay in the abusive relationship. The reasons advanced include fear that the partner may retaliate, no alternative means of economic survival, the concern of the children’s upbringing, the fear of losing children in case of divorce, fear of not getting support from friends and family if she leaves the relationship, the stigma involved in divorce and the hope that the partner will reform.

Recent research in the dynamics of IPV highlights challenges women face in achieving safety though a number of women flee IPV, others leave and return successively (Barnett, 2000). Most victims of IPV feel the abuse would stop; unfortunately, according to Mosby's Medical Dictionary (2009), the longer the women stay in the relationship, there is a higher likelihood of more serious injuries. Just as there are steps by which the IPV intensifies, there are at the same time phases that the survivors of IPV go through. Different survivors respond differently to the situation of the IPV. Some stay on hoping the situation may change. Different documentation on women’s responses to IPV suggests particular factors might influence women’s vulnerability and reactions to psychological treatment (Rogers & Follingstad, 2014) and physical maltreatment influencing their response to the abuse. According to Walker (2009), there are four phases that the survivor goes through in order to emancipate herself and they are: Denial, Guilt, Enlightenment and Responsibility. These phases permeate the life of the IPV survivor.

In the denial phase, the person who is subjected to IPV will not only avoid admitting the abuse to her friends and significant others, but she will not acknowledge the hurt and brutality that she is suffering from. Factors that contribute to such denial are many as the survivor does not realize that she is being abused by her partner and that she is in an abuse relationship.
(Walker, 2009). In their research Bliss et al. (2008) found out that some African Americans rely heavily on faith-based leaders who encourage them not to disclose IPV since it betrays the collective cause of racism. These faith-based leaders reinforce patriarchy by applying the bible wrongly to convince women that men are the head of the house and should control the household. This may lead her to fail to recognize there exist a problem between her and her partner. Other factors may include manipulative behavior coupled with the coercion from the perpetrator. Sometimes the survivor believes that denial is the appropriate way to avoid further violence and brutality (Walker, 2009).

The victim experiences guilt and feelings of extreme disgrace. She believes she is the cause of the abuse that the perpetrator has subjected her to. The abuser, in many cases, convinces the survivor that the physical violence is a result of the survivor’s negative behavior, thus the brutalization as a disapproval for the particular behavior (Walker, 2009). In his research among African American women who have had experience of IPV, Barnett (2000) affirmed that many of the women stay in the relationship due to feelings of guilt in leaving the relationship, shame involved in separation, and love they had for the partner; the desire for a partner and a father figure or a father for their children. The woman’s economic instability and the fear of violence that will be directed towards them and their children after she has left (Barnett, 2000) are part of the factors for staying.

When the abuse continues for some time, the victim graduates to the third phase which is the enlightenment phase. This is where the victim realizes that she is not to be blamed for the abuse she has experienced. She comes to understand that she does not deserve that abuse. She realizes that the abuser has no right to abuse her even if her behavior is displeasing to him. In this phase the victim accepts that her partner is violent and abusive. It must be realized that though
she has come to the knowledge yet she will continue to live in the relationship using different reasons to justify her decision of committing herself to saving her marriage. The abuse will not get better as she expects, it will increase in severity (Walker, 2009).

Considering the number of challenges that the survivor of IPV goes through, one may question whether there can be a change or self-renewal for the survivor. There are a number of factors that may influence a woman’s readiness or ability to change. The woman’s belief as to whether the relationship is abusive or not (Bliss et al., 2007), that is, once the survivor acknowledges that her partner has been abusive and violent, and that the IPV is the fault of the perpetrator and she stops giving reasons of saving her relationship and children, then begins to take responsibility for her life and the life of her children, her safety and the safety of her children. When she is able to realize that if she continues in the IPV the outcome would be suffering or unhappiness of her children (Barnett, 2000) and Psychiatric symptoms (Bliss et al., 2008) or death will be her lot (Scott & Babcock, 2010).

One other aspect that keeps the survivor in the relationship is the insecure attachment patterns that are linked to IPV (Shurman & Rodriguez, 2006). The insecure attachment makes it difficult for the IPV survivor to leave the abusive relationship leading to attachment anxiety which intensifies and this is very different from the normal fear of separation (Bartholomew & Allison, 2006). A belief system that a woman may hold prior to the onset of abuse may lead to an increased vulnerability once the violence occurs and this may lead to the survivor staying in the relation (Valdez et al., 2013).

In the research made among the African American women by Bliss et al. (2008), it was reported that many African American IPV survivors stay in the relationships due to feelings of pride; also the pressure to maintain the stereotype of “the strong Black woman”; the fear of
blame; the anxiety involved in securing adequate finance care for herself and her children. The Mexican family discourages women from seeking formal help in connection with IPV, ultimately contributing the re-victimization and defenselessness of the woman. The gender inequality in the social structure also condones to the violence because it holds the woman responsible for keeping the family together (Frías & Agoff, 2015).

Many survivors who go through physical abuse many times escape from their homes in order to seek refuge elsewhere sometimes for days or weeks. WHO (2012) multi-country study acknowledges that women leave for some days when they are physically abused by their partners. The woman may leave for good when the severity of the violence escalates, when she realizes the partner won’t change, and that the violence is affecting the children.

In conclusion it can be said that there is a multitude of reasons and challenges that the survivor of IPV faces which makes her remain in the relationship. Despite the many barriers, many survivors eventually leave the relationship, often after multiple attempts and years of violence. From the above it can be said oppression from the partner, social isolation from the community, fear of not being able to support herself financially, the constant violence coupled with the negative psychological sequelae, negative belief system and racial pride make it hard for the survivor to extricate herself from IPV.

2.7 Psychological effects of IPV

IPV is associated with a wide range of negative outcomes. In the current research, the researcher explored IPV as a risk factor which has separate psychopathology outcomes, like posttraumatic stress disorder (PTSD), and depression. While emphasis is often on helping women leave violent relationships so as to keep them safe from further violence, it must be noted that not all women choose to leave their partners. Before narrowing down to this two, PTSD and
Depression, we walked down other mental health issues emanating from IPV in wider strokes. The end result of the research on the health consequences of IPV would bring out the gravity of mental health damage that IPV causes and it would be helpful for clinicians, government law enforcement agencies, pastoral agents and NGOs to regard the seriousness of IPV.

IPV has serious mental and physical health effects, including death (WHO, 2013). According to Scott and Babcock (2010), IPV has a negative effect on the mental health of its victims and a number of research are now being done to address the development of mental health problems in relation to IPV in order to minimize and protect against its negative effects. IPV is associated with depression, anxiety, PTSD, alcohol and other substance abuse, sleep disorders, psychosomatic disorders, and suicidal ideations and acts and sometimes self-harm (Jordan, Campbell & Follingstad, 2010). People going through IPV are exposed to risky behaviors, including alcohol, drug abuse and smoking. WHO (2005) noted that depression can be the outcome of a lifelong exposure to IPV. Feelings of shame and guilt, constant humiliation by the partner, entrapment, and lack of control of the situation leads to the development of poor self-esteem and depression. Studies have shown that women going through the IPV experience attempt suicide more often than those who are not going through the IPV experience and 35% of the survivors reported previous suicide attempts (Pico-Alfonso et al., 2006). Kilpatrick (2004) affirms the accession that IPV has numerous mental health consequences for women which include depression, anxiety, posttraumatic stress disorder (PTSD), substance abuse, and low self-esteem, with depression and PTSD being the most prevalent mental health disorders associated with IPV (Jordan et al., 2010).

It is believed that when the relationship end the IPV will end with it. However, it is unfortunate because IPV does not necessarily stop when a relationship ends. According to
Stewart et al. (2012) when violence reduces or is eliminated, the physical and psychological health both improve. However, the end of the relationship does not mean that the violence and harassment are over. The wounds and scars of domestic abuse runs deep. The traumatic experience of what one has gone through can stay with one for a very long time (Walker, 2009). In the Canadian criminal reporting survey in 2009, it was noted that women accounted for 76% of all victims of criminal harassment like stalking by a former partner which continue to have health and economic impacts on women (Milligan, 2009).

Alcohol use is also prominent in the health issues where IPV is concern. Alcohol use in IPV perpetrators and survivors is reported the world over with the alcohol use intensifying both the occurrence and the severity of IPV (Stewart et al., 2012). Alcohol use affect both cognitive and physical functions reducing self-control and crippling the individual from negotiating peaceful resolution to conflicts within relationships (Room, Babor & Rehm, 2005). Excessive alcohol use can intensify financial difficulties straining relationships which may lead to infidelity. At the same time the survivor’s ability to perceive abuse and to resist and escape from it is minimized. Alcohol use can also be perceived as a survival method, coping mechanism or self-medicating by the survivor (Wingood, DiClemente & Raj, 2000).

It can be noted that there are many negative consequences that survivors of IPV face which intensifies the challenge the survivor faces in leaving the relationship. These negative consequences are several as affirmed by Whitaker and Lutzker (2009) and they include depression, suicidal ideations, alcohol or drug use, posttraumatic stress disorder, chronic anxiety, irritation, sleep and/or eating disturbances, low self-esteem which leads to extreme dependency. These consequences exhibit themselves in frequent somatic complaints (Barnett, 2001). Stewart et al. (2012) affirm this assertion by enumerating a number psychiatric disorders that are
associated with IPV which are depression, anxiety disorder, PTSD, chronic pain, eating disorders, sleep disorders, psychosomatic disorders, alcohol and other substance abuse, suicidal thoughts and ideations, personality disorders, psychosis, and health risk behaviors.

At this juncture the study will now build on existing literature on the field of IPV, focusing on two mental health effect (Depression and PTSD) resulting from such violence that prior research has identified and to dwell on what the effect of social support can bring to the survivors.

2.7.1 IPV and Depression

One mental health outcome often examined in relation with IPV is depression. The primary mental health responses of women experiencing intimate partner violence (IPV) is depression. In the research of Karakurt et al. (2014), it was noted that one of the major negative effect of IPV is an increased likelihood of clinical depression. Depression negatively affects sleep, causes adverse effect in appetite, diminished interest or pleasure in most activities, significant weight loss, psychomotor agitation, fatigue and loss of energy, suicidal ideation or suicide attempts (American Psychiatric Association, 2013).

In the research by Torres et al. (2013), they indicated that IPV is a public health issue having a significant impact on mental health, in the areas of depression and post-traumatic stress disorder (PTSD). Martins, Assunção, Caldas and Magalhães (2014) noticed that IPV victims are exposed to physical, psychological, and social harms which causes deep psychological harm. The victims may more often than not develop anxiety and depression. They may also develop several chronic somatic complaints including stomach ache, headaches and fatigue. Kilpatrick et al. (2000, 2003) found out that exposure to IPV increased the risk of PTSD, depression, and substance abuse, as well as comorbidity between these outcomes. In the research by Pinnaa,
Johnson and Delahantyc (2014), they realized that PTSD and Major Depressive Disorder (MDD) are two highly comorbid and debilitating disorders experienced by more than half of IPV survivors. Jordan et al. (2010) found that when psychological aggression increases, depressive symptoms become more evident and that increases suicidality. This is even made stronger when there are more violent episodes within the IPV such as battering and sexual assaults.

Depression and anxiety may also be seen in physical health outcomes (Rogers & Follingstad, 2014). Several researches have been done to explore the relationship that exist between IPV and physical health issues. Hazen, Connelly, Soriano and Landsverk (2008) realized that psychological abuse is significantly related to somatization, and at the same time, Coker, Smith, Bethea, King and McKeown (2000) found out that several physical dysfunctions including chronic pain, are associated with psychological IPV. Some of the negative consequences of IPV such as anxiety, PTSD, low self-esteem, depression, hopelessness, suicidal ideations, intensify the challenge the woman faces in leaving the relationship (Barnett, 2001).

Data gathered from a sample of African American women indicated that suicide attempts were significantly more among IPV survivors (Kaslow et al., 2000). In conclusion it can be said that IPV that it is well-established that (IPV) is widespread with severe consequences including PTSD and depression (Campbell, 2002).

### 2.7.2 IPV and PTSD

The current study explores the relationship between IPV and PTSD symptoms. Though IPV may trigger PTSD, other traumatic events can also trigger the PTSD symptoms. According to Scott and Babcock (2010), PTSD symptoms are often linked to traumatic experiences. One of these experiences is IPV. Even though physical and psychological IPV has often been associated with PTSD, not all IPV survivors develop PTSD symptoms (Jones, Hughes & Unterstaller, 2001)
At the same time, IPV can be linked with a number of medical and psychological symptoms and disorders, including depression, PTSD, Anxiety, low self-esteem, sleep disorder and a number of others (Campbell, 2002). In their study, Finley, Baker, Pugh and Peterson (2010) found that high levels of trauma symptoms, like dissociation, sexual problems, and sleep disturbance, predicted lower relationship satisfaction.

It is well-established that IPV is widespread with severe consequences including PTSD and depression (Campbell, 2002). Data collected in America, nationally representative samples of IPV on physical assault, shows that women’s lifetime prevalence rate is over 22% according to the research conducted by Bliss et al. (2008). In the research by Torres et al. (2013), they indicated that IPV is a public health issue having a significant impact on mental health, in the areas of depression and post-traumatic stress disorder (PTSD). Their research also showed that PTSD has been recognized as one of the most prevalent mental health sequel of IPV with prevalence ranging between 31 and 84%. Zlotnick, Donna and Capezza, (2011) in their research affirmed that there is a consistency in clinical samples of mental health that indicates most frequently associated IPV are linked to posttraumatic stress disorder.

According to Kilpatrick (2004), the development of PTSD is particularly likely for survivors who have been assaulted sexually. Some survivors of IPV may have a number of PTSD symptoms, but may not necessarily meet full diagnostic criteria for a clinical diagnosis of PTSD. Also, the extent to which female victims develop PTSD or other anxiety disorders depends on the extent and severity of the exposure to abuse (Karakurt et al., 2014).

Another commonly reported mental health issue for women who experience IPV is PTSD. A study by Mertin and Mohr (2001) suggested 40 to 60% of female victims suffer from PTSD. The development of PTSD involves exposure to actual or threatened death, serious injury
sexual violence, and all of these followed by fear and helplessness to handle the situation. Some of the common symptoms of PTSD include: re-experiencing the threatened event which comes in the form of flashbacks, dreams and nightmares; avoidance of venue or avoiding the reminders of the venue the incident took place, emotional numbing and increased physical arousal (American Psychiatric Association, 2013).

According to Rogers and Follingstad (2014), the most commonly mental health issue that comes out of IPV is PTSD especially when there is direct relation to more severe physical abuse. There are those who have also suggested that psychological abuse can also lead to PTSD. In the American Psychiatric Association (2013), IPV has also been associated with PTSD. The symptoms include intrusive memories of the event, intense physiological distress, that is, struggling with emotional upsets when exposed to cues that resemble the event, difficulty falling asleep, feelings of detachment, exaggerated startle response, and hyper vigilance. With PTSD one may be, struggling to get rid of intrusive memories of the traumatic experience. There is also the situation where one may also feel numb, disconnected, and unable to trust others. Those who go through IPV are exposed to severe trauma due to the violence. The reaction of a victim will be due to the flashbacks and other intrusive experiences from previous traumatic events. In this case the woman may believe that she is in danger or she is not worthy living.

There are studies that have found a relationship between insecure attachment styles and PTSD in a variety of populations. With respect to attachment anxiety, IPV and symptoms of PTSD have a stronger relation in conditions where there is high fear of being unloved or rejected by the intimate partner (Scott & Babcock, 2010). This implies that those who go through IPV with high attachment anxiety, have the greater risk of developing more severe PTSD symptoms.
Conceptually, psychological abuse will not necessarily lead to PTSD unless it is accompanied by physical harm. Psychological abuse which leads to threat to kill the other is expected to induce anxiety-arousal due to fear (Rogers & Follingstad, 2014). So, it is more likely to expect psychological abuse to induce a state of anxiety rather than PTSD though PTSD is possible. It can be expected that anxious arousal may be manifested when the IPV survivor is in fear of the next physical or sexual attack by her partner.

Campbell and Follingstad (2010) observed that the frequently identified mental health outcome among IPV survivors across physical, sexual, and psychological abuse is anxiety. Although anxiety is reported more among survivors of IPV than their non-battered counterparts, there are still findings which are contradictory to findings of anxiety related to psychological abuse. This is probably because not all forms of psychological abuses instill fear (Rogers & Follingstad, 2014). The relationship between anxiety, anxiety-arousal due to fear is a complex issue and can be further explored.

Shorey, Febres, Brasfield and Stuart (2012) examined among women arrested for domestic violence the prevalence of generalized anxiety disorder (GAD) and panic disorder. Their findings demonstrated a large percentage of women who go through IPV have a higher rate of GAD and panic disorder. Studies show that anxiety functions as a protective factor against IPV in severely violent perpetrators. It serves a brakes on the impulse to violence (Fowler & Westen, 2011). Anxiety here then relates to fear/avoidance behaviors. Anxiety may suppress aggression in general and IPV in particular.

In summary, there are many studies done on IPV which reinforce the link between IPV, depression and PTSD (including it, anxiety). These outcomes of IPV can be associated with significant difficulties later on in life. More research is needed in order to assess the relationship
between IPV and social support for survivors of IPV. IPV survivors often suffer from occurring
depression and PTSD, though in the research of Stein and Kennedy (2001) depression and PTSD
were found to be comorbidity as an aftermath of IPV. These symptoms can be minimized when
social support plays a significant role. A better knowledge of this variable would allow designing
more effective therapeutic strategies to cope with IPV.

2.7.3 IPV and Social Support

While significantly, physical and mental health issues associated with IPV have been
well explored, little research has been done to examine the effect social support has on the
survivors. Social support according to Wills and Fegan (2001), refers to the behaviors that love
ones exhibit to tone down the stressful situation that an individual is going through. Social
support and satisfaction associated with it, may have a moderating effect on experiencing the
distress (Wills & Fegan, 2001). Fortin, Guay, Lavoie, Boisvert and Beaudry (2011) affirm that
social support, as well as the satisfaction associated with the help received, may have minimized
effect on the stress that is being experienced. Below, we review research on outcomes associated
with IPV and social effect on survivors.

Many a time, social support is assumed to be positive, though there is growing awareness
of the complexity in the way acts of support are perceived by the survivor and how these acts
affect outcome (Fleet & Hiebert-Murphy, 2013). It is worthwhile to examine both the positive
and negative aspects of social support since some may be wanted and some may be perceived as
harmful. Most of the studies made on social support, though very scanty, indicate that the
survivors of IPV do underestimate the social support that is available to them (Fortin et al.,
2011). Others do not underestimate the social support, yet others are agnostic to it. Women who
are socially supported by family and friends have significantly lower levels of distress according
to Thompson et al. (2000). At the same time social support can lessen the impact of IPV on the mental and physical health of survivors (Fortin et al., 2011).

In a research made in the shelter for battered women in Canada for 137 women, Goodkind et al. (2003) noticed that 91% of the women stated that they have spoken to a loved one about the abuse. Their findings showed that negative reaction from family and friends were less frequent than the positive ones. The native reactions included not believing the survivor, blaming the survivor, or being too frightened themselves to intervene. The positive reactions were listening, asking questions, providing feedback and facilitating helpful activities. It must be noted that in the Goodkind et al. (2003) study, the emotional support received was not linked to depression. In their research, Fortin et al. (2011) identified a number of literature which had the mediating effects of social support on mental and physical health. It was identified that higher levels of emotional support were linked better physical and mental health. At the same time social support acted as a moderator on the impact of IPV.

Support from loved ones can positively influence the perception of the survivor’s environment, emotional response and the outcome related to the event (Fortin et al., 2011). Loved ones can also provide possible solutions to the survivor’s predicament by facilitating the use of rational thoughts, whereby preventing inappropriate behavior and reducing responses that can aggravate the stress. Loved ones can also help reduce the perceived importance of the incident.

In the research of Fortin et al. (2011), they found out that social support plays a vital role in recovering from the psychological effects linked to the violence. It was also realized that the lack of support from the environment of the survivor can be associated with the survivor’s poor adaptation and distress (Green & Pomeroy, 2007). The social support network may involve the
faith and religious leaders. Many people turn to their faith and religious leaders for support in moments of crisis. These religious leaders often serve as counselors or therapists helping on issues that are to be taken care of by mental health professionals (Choi, 2015). The clergy offer counseling for all types of problems including spiritual, marital, IPV and divorce. Research shows that the clergy or religious leaders are the first to be looked for when a survivor needs assistance on IPV (Choi, 2015). The rate at which survivors seek counseling from their religious leaders vary from one study to the other. According to Fuchsel (2012), it ranges from 28 to 60 %.

In the study of the Canadian population on IPV and social support, the study turned to look at social support from the point of view of who between the genders will seek social support in times of IPV. The study results showed that the feminine counterpart are those who seek informal social support as compared to their male counterpart (Fortin et al., 2011). Other researches that have been made dwelt on age in seeking social support. Rickwood et al. (2007), in their study showed that it may appear that young intimate male partners were less likely to seek support than older partners especially where there are symptoms of depression.

Social support has also been identified as a protective measure in different stressful situations (Beeble et al., 2009). In IPV, support from loved ones help elevate emotional response and reduces the impact of the violence when the loved ones bring out rational thoughts which calms the effect of the violence on the survivor’s well-being (Beeble et al., 2009). In their survey of survivors of IPV, Coker et al. (2003) realized that survivors who had greater positive social support had better physical and mental health than those who had fewer positive social supports. Very few research suggest that social support may be a protective factor against the continuation of partner violence (Fleet & Hiebert-Murphy, 2013). In other words, social support does not necessarily stop the violence but may reduce the causes of the violence. Due to this
conceptualization, it is always important to consider a number of ways that the survivor may perceive the support, including the possibility of it being unwanted, ineffective, or manipulative (Fleet & Hiebert-Murphy, 2013).

Social support can also have negative consequences; though very little research has been made on the negative effect of social support. In the study of Goodkind et al. (2003) it was noticed that even though there were negative reactions from the social support network, those were very few as compared to the positive reactions. From everyday observance, sometimes family members (social network) especially mothers and mothers-in-law, endorse the traditional gender norms which are sometimes detrimental to the survivor. The negative effect of this social network brings to light that the survivor’s family cannot always be considered as a source of unconditional support in all cases of IPV (Frías & Agoff, 2015). Unfortunately, the clergy may also play a role in the negative social support. According to the study of Choi (2015), a number of religious leaders give advice that support the violence (substantiating their point wrongly from the Bible) which more often than not lead the survivor to withdraw from the church to suffer silently alone. In the same study, it was realized that some clergy instead of condemning the violence, will often encourage the survivor to learn to forgive the perpetrator while silencing the survivor. In the study made by Choi (2015), there were other observations made about the reluctance of the clergy members to condemn the perpetrators of IPV. Some clergy members view the perpetrator of IPV as a low spiritual person who needs spiritual intervention. Due to such belief, the clergy’s guide on IPV is to help the perpetrator to grow spiritually and thus the survivor to help heal this spiritually low person reconciliation on improved communication, forgiveness, praying, and the survivor’s submission to her man. Separation and divorce is hardly
recommended in situations of IPV by some clergy; separation and divorce go contrary to their religious belief of keeping the family together.

In the context of IPV where the family and friends avoid the survivor perhaps because of the fear of the perpetrator, they may distance themselves and see the abuse as a private matter (Beeble et al., 2009). In such cases, the members of the social network may be perceived as unsupportive. On the other hand, positive social support may empower the survivors to access other resources to end or to decrease in violence (Fleet & Hiebert-Murphy, 2013). It should also be noted that not all survivors who receive positive social support will initially see a decrease or cessation of violence. Some may not be empowered enough to take action on their own. In this wise, clinical psychologist may have to encourage them to reinforce their support systems and at the same time, helping them to identify their own support systems available to them.

2.8 Conceptual framework

The framework (Figure 2.1) depicts a direct relationship between exposure and outcome variables as a causal relation. The arrow from exposure to effect modifiers indicated that severity of the outcome variables (lack of social support, PTSD, anxiety, depressive) varied according to the age and gender of the respondents. While arrow from exposure to confounders indicate that the severity of outcome variables will be determined by the current status of the confounder variables; at same time the confounders can cause the outcome mental problems. Therefore, in the analysis of the data the effect of the exposure variable was modeled controlling for the confounders to predict indicator variables in the study. Thus these identified confounder variables indicate a relationship with both exposure and outcome variables. On one hand, the confounders could cause outcome in the study.
Figure 2.1: Conceptual Framework. Source: Author (May 2017)

2.9 Chapter Summary

Very few studies have been done to examine the role of positive social support in couples who have remained together after the IPV has stopped (Fleet & Hiebert-Murphy, 2013). Identifying the level of social support in the survivor’s life would add to the current body of evidence and practices that are centered on reducing IPV if not eradicating it. This study aims at examining the social support of survivors of IPV who have remained in the relationship and at the same time those who have left the relationship.

Whereas literature from around the world shows that social support networks and institutions of counseling are instrumental in stopping IPV (Zakar et al., 2012; Fleet and Hiebert-Murphy, 2013), there are no studies using representative samples that make it possible to
evaluate the extent of social support in the reduction or eradication of IPV in Kenya. At the end of their studies Fleet and Hiebert-Murphy (2013) stated clearly that more research is needed to understand the role of social support in IPV not only with family and friends but also with formal support of counsellors and physicians. It is on this note that the researcher will like to follow up on the level of social support vis-à-vis Depression and PTSD; expanding it to types of social support and to determine which type will be helpful in promoting safety of the survivor. From the literature gathered so far, a foundation has been formed for further exploration on how IPV affects the survivors’ mental health and by extension quality of life as survivors carry out everyday activities. The social support dimension can now be looked at vis-à-vis IPV.
CHAPTER 3
METHODOLOGY

3.1 Introduction

This chapter described the research design and study population. It showed the sample size calculation and stated the sampling techniques. It gave details of the research instrument used to collect data and described data management and analysis plan. Finally, the ethical considerations were outlined to best fit the research.

Generally, there was a cordial atmosphere when the questionnaires were being administered. The pre-test was done in Soweto and the observation was that a number of the respondents found it hard to understand the social support questionnaire and this gave the researcher a hint to dwell longer in explaining the social support questionnaire to the actual respondents in Kayole. The researcher went into Kayole, met the respondents individually as the questionnaires were being administered. His interaction with them kept them at ease.

3.2 Research Design

The study used a correlational design, applying quantitative research data collection method to enumerate the data. With the quantitative research method, the researcher was able to critically analyze the information obtained from the raw data gathered in the study questionnaires. The approach ascertained the number of participants who were going through or had gone through IPV, their mental health status and determined the level of social support of the survivors of IPV within the Kayole community. It helped find the correlation between social support and levels of depression and PTSD among the study population.
3.3 Study Site

This study was conducted in Kayole, a suburb of Nairobi (capital of Kenya). Kayole is approximately 10.8km towards the East of Central Business District of Nairobi. It forms part of the larger Embakasi constituency, covering the area of Matopeni and Komarock, known as the Embakasi central constituency (Figure 3.1). The population of the Embakasi central constituency is 185,948 (softkenya.com, 2012). It is a densely populated and the estimated total number of women above 18 years and eligible to vote is 90,089 according to Kenya National bureau of Statistics (2009).

Kayole is one of the most popular and populous estates in Nairobi. It is famous for the several negative incidents of crime, notably kidnapping, armed robbery and outlawed gangs (Standard news media, May 2010). It is densely populated due to its proximity to the central business district (CBD) and low cost rental housing. Kayole has a cluster of tall storey buildings owned by private individuals who rent it out.

Most research done in Kenya on IPV were done in slum areas such as Kibera which is a very low income community in Nairobi (Mweru, 2015; Boyce, 2017). Kayole is neither a slum nor an affluent community, though it is densely populated. It is a lower middle economic class society and so using Kayole as a study site brought a fresh outlook to this research. From among the places where data was collected within Kayole was the Catholic Mission. The other areas where data was collected were St Patrick Medical Center, the Kayole Chief’s camp and the DIWOPA health center. The Catholic Mission has counseling facilities where many people going through psychological issues go for assistance.
3.4 Study Population

The study population is the target population of which Kothari (2004) describes as the total number of items about which information is desired. In this study therefore, the target population were adult women aged between 18 and 60 years, residing in Kayole and who are in intimate heterosexual relationships for at least two years, either officially married or in “come-we-stay” and/or in boyfriend/girlfriend relationship. The ages 18 to 60 years were chosen since 18 is marriageable age adopted by the Kenyan parliament in 2014, the Marriage Act 2014.

Those church members who do not reside in Kayole were excluded from participating. The study recruited participants from four main sources: Catholic Church attendees, cases reported to the area administrative chiefs or their assistants and adult women seeking medical attention at the St. Patrick Medical center and the Catholic health center (DIWOPA) located in Kayole. Unfortunately, actual numbers for each place of data collection was not recorded.
3.5 Sample

A sample, being a set of entities drawn from a population with the aim of estimating characteristic of the population (Cramer and Howitt, 2004) related to the population was used for the study. The population of women in Kayole who are aged above 18 years are 90,089 (Kenya national Bureau of statistics, 2009). The women residing in Kayole who were recruited were determined according to their heterosexual relationships and whether they had experienced IPV. WHO estimates indicate that 10-69% of women have experienced IPV (WHO, 2013). From WHO estimate, the number to be recruited would have been 144 but the number of participants recruited was 193.

3.6 Sampling Technique

The researcher used both purposive and snowball sampling techniques to recruit women participants who had experienced IPV in their heterosexual relationships. Purposive sampling is a type of non-probability sampling technique whereby a researcher deliberately chooses the informant due to the qualities the informant possesses (Bernard, 2002). The main goal of using purposive sampling was to focus on the particular characteristics of the survivors of IPV, in order to answer the research questions. The researcher therefore found participants who were willing to provide the information by virtue of knowledge or experience (Bernard, 2002; Lewis & Sheppard, 2006). For example, in homogeneous sampling, units are selected based on their having similar characteristics or traits. In the case of this research, the researcher targeted women with IPV issues as respondents and since the issue of IPV was thought to be sensitive, the affected persons were called in seclusion to discuss the problem.
The researcher identified some survivors purposively at the church and the health centers, when they came seeking intervention at these outlets. The announcement was made in the church and others placed on the bulletin boards of the church and health centers. Two Sunday afternoons were chosen for those who came purposefully. For those who were referred to from the health centers, a period of two weeks was given to them. When those interested in the research came purposefully to school compound where the questionnaires were going to be administered, the researcher met them in groups as they came requested them to do the HITS screen to access those experiencing IPV. When they qualify for the IPV, the other questionnaires were administered to them. They were requested to introduce others going through IPV. They contacted those going through the IPV experiences who also came the following week. With that the snowballing was set in place. The researcher found outcomes to the contrary, they never saw IPV as something secretive but rather as the norm of their relational or marriage lives. Once recruited into the study, the researcher requested the subjects to refer to other subjects who have or are experiencing IPV through snowballing process.

Snowball sampling, is a recruitment method that employs research into participants' social networks to access specific populations (Browne, 2007). Snowball sampling is often used because the population under investigation is ‘hidden’. In this study the target population was hidden due to the sensitivity of the IPV topic which is usually concealed in a family setting (Browne, 2007). This research considered the recruitment technique of snowball sampling, which used interpersonal relations and connections to get to the target population. Snowball sampling informed the individuals who were being recruited in a study on how to act and interact prior to the study process. Consequently, the snowball sampling did not only result in the
recruitment of IPV participants, but it also helped participants to account for what was going on in their lives (Browne, 2007).

3.7 Sampling Procedure

To facilitate recruitment process, the researcher created the awareness about IPV as a community entry strategy. Advertisement displayed on the Catholic Church bulletin boards. These bulletin boards are strategically situated and are well visited by both Church attendees and outsiders. The advisement indicated recruitment sites for the study: the Catholic Mission, St. Patrick Medical center and Catholic Mission Health facility. On the Catholic Church compound is the Health Centre which caters for the bigger population of Kayole and this was where some of the data was collected. The Social workers of the Catholic Mission were trained as research assistants. They gathered data from those who came to seek support in the Church Compound.

Messages being developed about IPV and the purpose of the study on a Church Missalette. The Missallettes are flyers with the day’s bible readings, distributed to the Christians on Sundays. In the missallettes was indicated the recruitment sites and study dates.

Sensitized health care providers of DIWOPA health Center and St Patrick Hospital about IPV and created awareness of the use their facilities for data collection. Sensitized the area Chiefs and their assistants about IPV, the study purpose and recruitment sites. This was an important approach to the community entry, in that administratively, it created awareness to the whole community as it was taken as an activity through the Chiefs “Barazas” where the effects of IPV was discussed as an open forum.

3.8 Inclusion and Exclusion Criteria

The inclusion criteria for participants in the study were adult females who were experiencing IPV and those who had experienced IPV in their heterosexual relationships and
consented voluntarily to participate in the study. Female adults not willing to participate voluntarily in the study were excluded and also those with extreme severe symptoms of distress who came for treatment in the health centers or to the area chief or his assistants or to any administrative arm in the area were excluded. Persons below 18 years as well as adults aged above 60 years were also excluded from the study. Women participants of the church who live outside the study area were also excluded.

3.9 Data Collection Instruments.

The data collection instruments administered to participants in the study included, Socio-demographic questionnaire (SDQ), the Hurt, Insult, Threaten and Scream screen (HITS), Beck’s depression inventory (BDI), Posttraumatic stress disorder check list 5 (PCL-5) and the social support questionnaire (SSQ).

3.9.1 Socio-demographic Questionnaire (SDQ)

A socio-demographic questionnaire (SDQ) was developed by the researcher which was used in the collection of data relating to respondents’ background (Appendix II). The variables within the SDQ were associated with: types of IPV which will be measured in objective one, the severity of psychological effects, measured in objective two and levels of social support measured in objectives three and four. The information gathered from the SDQ brought out the age bracket that are more likely affected by IPV, the level of education of those open to such violence and also the knowledge as to whether marital status and type of employment affect IPV and social support.

3.9.2 The Hurt Insult Threatened Scream (HITS) screen

The HITS (Appendix III) is a screening tool which was easy to use. HITS is an acronym for Hurt, Insult, Threatened, and Scream. The tool has four questions to assess risk for Intimate
Partner Violence (IPV). The questions were asked to know how often the survivor’s partner hurts, insults, threatens or screams at her. The survivor had five different answers to select from; which were: never (1), rarely (2), sometimes (3), fairly often (4) and frequently (5). The scores were ranged between 4-20 points. The scores are calculated as such: 1 point for 1, 2 points for 2… and 5 points for 5. Any total score above 10 points indicated severe suffering from abuse. The HITS screen was used in measuring objective one.

IPV, if not addressed would get worse and lead to serious mental health issues and so ways have to be adopted to detect IPV. One of the ways was through screening of those who came to participate in the study with the HITS screen. The HITS screen is an IPV Screening Questionnaire (Clinical Research and Methods, 1998) that has been specifically developed for efficient screening of individuals in intimate partner violent relationship. This tool was utilized to capture personal/individual and types/forms of IPV in response to information for objective one.

HITS screen according to Sherin et al. (1998) has good internal consistency of alpha of 0.87 and construct validity of Cronbach’s alpha of 0.80 for the 4 items. It is today used globally. Places where it has been used and being used include Europe, South and North America, China, the Middle East and Africa.

3.9.3 Beck’s Depression Inventory (BDI)

This instrument assessed the prevalence and severity of depression among the IPV survivors. The Beck Depression Inventory (BDI- 1961, BDI-II -1996) created by Beck is a 21-question multiple-choice self-report inventory each with four possible responses which measure the intensity, severity and depth of depression in patients with psychiatric diagnoses (Appendix V). Factor analysis, a statistical method used to determine underlying relationships between variables has also supported the validity of the BDI.
The BDI can be interpreted as one syndrome (depression) composed of three factors: negative attitudes toward self, performance impairment, and somatic (bodily) disturbance. In its current version the questionnaire is designed for individuals aged 13 and above, and is composed of items (1 to 13) relating to symptoms of depression such as hopelessness and irritability, cognitions such as guilt or feelings of being punished, as well as physical symptoms (items 14 to 21) such as fatigue, weight loss and lack of interest in sex. This test was administered by the researcher on the respondents who have experienced IPV in the last year. It took 10 to 15 minutes to complete the test.

For people who have been clinically diagnosed, scores from 0 to 13 represent normal, scores of 14 to 16 indicate mild depressive symptoms, scores of 17 to 28 indicate moderate depression, and scores of 29 and above indicate severe depression. The BDI has been widely used to assess the symptoms of depression among clinical and normal populations. It has been shown to be a reliable and valid measure. For the same tool, Beck, Steer and Garbin (1988) reported a split- half reliability of .93. In Kenya, it has been widely used in research and has been found to have sound psychometric properties (Muriungi & Ndetei, 2013). BDI has been used in Kenya by Musau and Wasanga (2011) in assessing depression among internally displaced persons at Mai Mahiu camp in Rift Valley Province. A study by Aboge et al. (2015) on the prevalence of depressive symptoms among sensory and physically challenged persons living with HIV/AIDS attending clinics in Nyanza province used BDI tool to test depression. However, the researcher has not come across information on the test of BDI validity in Kenya. The internal consistency is 0.9 and the test retest range is from 0.73 to 0.96., this makes BDI-II a relevant psychometric instrument, showing high reliability, capacity to discriminate between depressed
and non-depressed respondents. This tool was used to measure the levels of depression among the survivors of IPV in response to objectives two and four.

3.9.4 Post Traumatic Stress Disorder check list-5 (PCL-5).

The PTSD Check List-5 (National Center for PTSD, 2013) was used to measure the severity of PTSD and trauma history in relation to objectives two and three of this study. The same can be used to measure the underlying construct of PTSD and to establish a provisional diagnosis of PTSD (Blevins et al., 2015).

The PCL-5 has a 20 item measure that assesses the severity of PTSD in individuals assessing the twenty DSM-5 symptoms of PTSD. The purposes of PCL-5 include monitoring changes in symptom during and after treatment (Wortmann et al., 2016), individual screening of PTSD and making provisional diagnosis of PTSD. In the research by Blevin et al. (2015) investigating the psychometric properties of the PCL-5, they tested 278 trauma-exposed college students and the results indicated the PCL-5 has an excellent test-retest reliability with internal consistency. It also has a convergent and discriminant validity and it is psychometrically strong and sound; and it fits very well into the DSM-5 PTSD symptom criteria.

PCL-5 provides a lot of information about the presence/absence of the PTSD diagnosis as well as overall severity of the disorder. An additional advantage of the PCL-5 is its sound psychometric structure with high inter-rater reliability from 0.92 to 1.00 test retest reliability from .77 to .96 and content validity of alpha of 0.94. In this study the researcher used the PCL-5 (Appendix IV) for individual screening of PTSD and making provisional diagnosis of PTSD, using the worst month (lifetime) to assess the survivors. This tool was used in Kenya among psychiatric patients during the development of DSM-5 (APA 2013).
The PCL-5 is a self-reported measure (Bovin et al., 2015) which was used by the participants as part of the research study. The 20 items are rated on a 5-point scale (0=Not at all; 1= A little bit; 2= moderately; 3= Quite a bit, and 4= extremely). The PCL-5 can be scored in three different ways and the interpretation be done by a clinician. In this current study, the second option was applied. This option made use of the DSM-5 symptoms cluster which was obtained by summing the scores within a given cluster, that is, cluster with items 1-5, cluster with items 6-7, cluster with items 8-14, and cluster with items 15-20. Consistently high scores on a particular cluster indicated significant and problematic areas for the individual, to warrant further assessment, treatment, and follow-up (Kilpatrick, Resnick, & Friedman, 2013). It took between 5 and 10 minutes to have the test administered.

3.9.5 Social Support Questionnaire (SSQ).

The diversity of social support was measured using the following social support dimensions: intimacy, social integration, nurturance, self-worth, alliance and guidance. These measures were assessed using SSQ (Appendix VI) which has 27 items that quantifies these dimensions of perceived availability of and satisfaction with social support. This tool was administered in 30 minutes per participant. The social support questionnaire is highly reliable and valid (Heitzmann & Kaplan, 1988). This instrument served objectives three and four.

These questionnaires provided the data sets for analysis as conceptualized in the conceptual framework. SDQ, HITS, BDI, PCL-5 and SSQ questionnaires were used for the purpose of collecting data. These questionnaires were self-administered by the subjects. After screening the women, the researcher distributed the questionnaires to the respondents with assistance from the research assistants. The respondents were assured of high confidentiality of their responses. This method was preferred because it allowed for clarifications during data
collection (Kombo & Tromp, 2006). This method of data collection also offered the researcher the opportunity to interact with respondents, a move that enhanced higher response rate and prompt data collection.

3.10 Pre-test

Pre-testing was done to check on the validity, reliability, practicability and sensitivity of the tools before it was used for actual data collection. It also established the clarity of questions, ease of use, and time taken to administer the instruments. During the pre-test some clarities were made more especially with the SSQ tool. According to Mugenda and Mugenda (2003) pretesting is done on a different population, but with similar characteristics with the study population. In addition, Mugenda and Mugenda (2003) suggested that 10% of the sample may be utilized for pretesting purposes. Therefore, a sample of 14 participants which is 10% of the sample size of the main study was used. The participants were chosen on the basis that they are exposed to IPV. The pre-testing was carried out in Soweto Catholic Parish in Nairobi County. This parish was chosen for the pre-testing due to its similarity in social demography as Kayole. Thus, the above mentioned study instruments were pre-tested prior to the main study. With the pre-test done in Soweto, the researcher observed that a number of respondents found it hard to understand the social support questionnaire so the researcher dwelt longer in explaining the social support questionnaire to the actual respondents in Kayole.

3.11 Data Collection Procedures

Upon getting approval from the USIU Institutional Review Board (IRB), the researcher had a meeting with the Chief of Kayole to inform him of the intended research. The aim of the visit was to make the Divisional/regional heads aware of the aim of the research study, and for the researcher to be officially permitted to carry out the study. The chiefs, assistant chiefs, head
of Catholic Health Centre and Parish Priest of the Catholic Parish in Kayole helped the researcher to find a contextual information concerning the research population. Though the majority of the respondents came from the catholic Mission.

From the population sites, the researcher identified the local chief who educated the community about the study rationale in his “Baraza”. This made the researcher gain community entry easily and also facilitated the identification of respondents. The researcher also requested the chief to announce about the research. Advertisement were displayed on the Catholic Church bulletin boards, about fliers and information and the two Health Centers about the purpose of the study and when it was commencing.

The research assistants recruited from the Health Centers, as well as the social workers of the Catholic Mission in Kayole were trained on the research protocol and data enumeration methods. The assistants were also informed to start recruiting the participants using the purposive and snowball sampling methods for the study. On the material days of data collection, the researcher together with the research assistants availed themselves at the study sites (at the Church and the two Health Centers). They met the respondents who came purposefully for the study.

Consent forms were made available to the research assistants who guided those willing to participate in the research by obtaining informed consent from them. Private rooms were set aside for the respondents to fill out the questionnaires. After the questionnaires were filled, the researcher checked if all relevant information had been filled and then sent the data to the data entry site; this process was secured by the researcher.
3.12 Data Management and Analysis

In the study, data management comprised of two stages, namely, data entry by clerks; and data analysis by the researcher, with the help of a statistician. Both descriptive and inferential statistics were used to describe the characteristics of the study population and correlation of the study variable. A test of statistical significant difference of 0.05 (5% margin of error) was set.

After the questionnaires were filled and checked to be well completed, they were transported to the researcher’s office for data entry. The data was first sorted and coded afresh. The data entry template was formulated with assistance of a data analyst. After the coding, the data was given to two clerks for double entry using access package of windows XP version 10. Data cleaning was done before the data was exported to the SPSS version 21 analysis packages.

Exploratory data analysis techniques were used to describe the social demographic characteristics; forms of IPV; the prevalence depressive disorder and PTSD; and finally the social support system within the society.

In order to ascertain the distribution of the different variables and to compare them within the study participants as a group, an inferential statistics using correlation efficient was applied. At the same time analyses were made to inferentially determine the predictors among affected survivors who develop Depressive disorder and PTSD using regression models on either continuous or binary variables.

In order to adequately address the research questions, the following statistical procedures were employed:

i. In the question “What are the forms of IPV among survivors in Kayole?” The researcher used descriptive statistic in tabulating the procedures, utilizing the SSQ and SDQ.
ii. the question of emotional and psycho-trauma symptoms among survivors of IPV in Kayole? The researcher described and tabulated procedures, utilizing the SSQ and SDQ, including the BDI and the PCL-5.

iii. In the question “Is there a relationship between level of social support and symptoms of PTSD among survivors of IPV in Kayole?” the research implored the use of Correlational Statistics using SPSS.

iv. Finally, the question “Is there a relationship between level of social support and symptoms of Depression among survivors of IPV in Kayole?” the Correlational Statistics Specific, SPSS was used.

### 3.13 Ethical Considerations

The researcher followed the five APA principles of ethics in human research, as outlined by the American Psychological Association Code of Conduct and Ethical Principles (2010) namely; informed consent, beneficence and maleficence, fidelity and responsibility, Integrity, Justice, Respect for peoples right and dignity.

Detailed explanations of the ethical considerations and data management are attached to the appendices (see appendix 1– Informed Consent Form). Before the commencement of the study the researcher obtained approval for research from the USIU-IRB. An informed consent form was issued to the respondents to either sign or put an ink thumb print. The researcher then made the respondents aware of the purpose, benefits and risks of the study, the expected duration of the study, the rights of participation or withdrawal from the research in order for them to make an informed decision to participate or not. Thus, the respondents were made aware about participation in this study to be entirely voluntary and respondents were free to decline to participate.
Principle A of the APA code of ethics which talks about Beneficence and Non-maleficence which means “above all do no harm” was applied and the participants were free from any physical and psychological harm. The researcher, however, was sensitive to the participants’ emotions when using probing questions that could psychologically harm the participants. In this wise, the researcher evaluated the risk/benefit ratio. Participants were therefore informed that recounting of their experiences may be reminders of their past painful experiences. Knowing that this may cause some discomfort, however, the therapists (researcher) provided psychological first aid.

Participants were assured of trust as the researcher was aware of the professional and scientific responsibilities to the community. The researcher made available appropriate psychosocial support for those who experienced difficulties as a result of responding to the questionnaires. After screening, none of the participants was referred to Mama Lucy Hospital, Nairobi West Hospital, Mathari Hospital (for psychiatry) or even Kenyatta National Hospital due to PTSD or depression, though provisions have been made to this effect. This fits very well into the Principle B of the APA code of ethics which expects Fidelity and Responsibility on the part of the researcher.

The Integrity of the information was upheld, in that the researcher gathered accurate, honest and truthful information. This fits into the APA principle C. The information provided by participants, was not shared with anyone. As the study was conducted in private rooms; there were intrusion of privacy with regard to information that were provided. Anonymity, which is the inability to link information to participants, were therefore upheld. The data obtained from the research instruments were stored in hard copies and later computerized. Several back-up copies were made in software. Analyzed information were stored securely in both hard and soft
wares. Any data stored in the computer were stored with password, to protect the participants. All information was kept confidential and respondents were assured of anonymity and confidentiality. They were assured that in case of publication of the study findings there will be no identifiers because the questionnaires are coded.

Reasonable judgment and precautions were taken to eliminate potential biases, and to stick to the boundaries of the researcher’s competence. This, in other words, included the participants’ right to fair treatment and privacy. The right to fair treatment which includes that the selected participants’ inclusion was based on the requirements of research, non-prejudicial treatment of participants who refused to take part or those who withdrew. The participants had access to the researcher at any point in the study to clarify information. Sensitivity to and respect for the participants’ beliefs, habits, lifestyles, culture and emotions were also upheld. Courteous treatment was rendered at all times to fulfill the APA code of ethic principle D.

Prospective participants were not coerced into taking part in the study. Participants had the right to decide whether to participate without incurring any penalty. By so doing the researcher fulfilled principle E of the APA code of ethics which respects human dignity, right to self-determination and full disclosure. Participants were approached and the purpose of the study explained. No remuneration was offered and they were informed of the opportunity to withdraw at any stage of the research. Verbal consents were obtained. Individuals who refused to participate were not forced. Respondents were free to withdraw from the study at any point without consequences or any loss of benefits. The benefits included becoming aware of their condition and getting free treatment from the research and receive snacks voucher as a token of participation. In addition, the researcher discussed about stigmatization which sometimes occurs
after some diagnosis of mental health issues. Psychological education was given on how such stigma must be handled.

### 3.14 Chapter Summary

After getting in touch with the relevant authorities in the population sites, the researcher gathered the information through the data collection instruments and other information regarding the research design, study population and other relevant information to pursue the research.
CHAPTER 4
DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Introduction

This chapter focused on the presentation of data from the quantitative data collection, analysis and finally the interpretation of data. It presented and discussed the findings of the study. The study recruited 193 female survivors of IPV residing in Kayole as respondents. They responded to all the five questionnaires administered, namely: HITS, SDQ, PCL-5, BDI and SSQ. These instruments were administered with the help of four trained research assistants.

The results were analyzed according to study objectives that determined: forms of IPV; interpersonal social support evaluation; emotional and psycho-trauma symptoms; relationship between levels of social support and mental health symptoms, that is, relationship between level of social support and symptoms of PTSD; and relationship between level of social support and symptoms of depression among female survivors of IPV in Kayole.

The emotional and psycho-trauma related symptoms examined included PTSD and depressive symptoms. Frequencies and percentages were used to describe the demographic data, interpersonal social support and psycho-trauma symptoms of IPV of female survivors used in the study. Correlations and chi-square bivariate statistics were used to assess the relationships between socio-demographics, PTSD and depressive symptoms and interpersonal social support.

4.2 Presentation, Analysis and Interpretation

4.2.1 Characteristics of the study

Questionnaires were administered to 200 IPV survivors, which was higher than the expected number of 144 participants. Seven out of the total number were rejected: four due to incompleteness while three were above the cut-off age, 60 years. The remaining 193
questionnaires were well filled, coded, and the raw data entered into the software for analysis. The return rate was 134% since with the snowballing the number that came exceeded the number required. Data was analyzed based on the study objectives by applying univariate and bivariate statistics using SPSS version 21.0 for windows.

4.2.2 Social demographic characteristics of the respondents

All the 193 respondents had been in relationship for at least two years. The descriptive statistics of the background characteristics including age, marital status, level of education and employment status were presented. The results showed a mean age of 36.7 years, ranging from ages 18 to 58 years (age range of 40 years) and standard deviation of 9.7 years. The age was evenly distributed as presented in Figure 4.1. Age was further clustered into 5 year intervals, and the results showed a mode of 28-37 years olds representing 71 (36.8%) of the respondents as presented in Figure 4.2.

![Figure 4.1: Age distribution in years](image)
Regarding correlation level, in the area of education, all the respondents except one, have had one formal education or the other. The lowest formal educational level being primary school level and the highest educational level was the university. Table 4.1 presents highest levels of education attained by respondents.

A high number, 81 (42.0%) of the respondents, had attained secondary level of education followed by 65 (33.7%) who had attained college level of education. Only one had no formal education while 28 (14.5%) and 18 (9.3%) had primary and University education respectively.
Table 4.1: Levels of education attained

<table>
<thead>
<tr>
<th>Level of education attained</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No education</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Primary education</td>
<td>28</td>
<td>14.5</td>
</tr>
<tr>
<td>Secondary education</td>
<td>81</td>
<td>42.0</td>
</tr>
<tr>
<td>College education</td>
<td>65</td>
<td>33.7</td>
</tr>
<tr>
<td>University education</td>
<td>18</td>
<td>9.3</td>
</tr>
<tr>
<td>Total</td>
<td>193</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The researcher aimed at ascertaining the marital status of the respondents which ranged from single, married, divorce or separated to widowed. Figure 4.3 presents marital status of respondents. More than half, 105 (54.4%) were married, while a quarter, 47 (24.4%) indicated to be single which included widows.

![Figure 4.3: marital status](image)

A number of the respondents were employed either permanently or on casual basis. About half of the respondents 95 (49.2%) indicated that they were casual workers while 56
(29.0%) were in formal employment. Cumulatively 151 (78.2%) of them were working and the rest had no employment as presented in Figure 4.4.

![Figure 4.4: Type of employment](image)

4.2.3 Evaluation of the Objectives

There are some mental and psychological consequences associated with IPV which include depression and PTSD (WHO, 2013). With the use of the quantitative research method, this study examined how levels of social support can affect symptoms of PTSD and depression among women survivors of IPV living within Kayole.

4.2.3.1 Forms of intimate partner violence

The first objective of this paper determined the forms of IPV at Kayole. These were identified using the HITS questionnaire; a screening and assessment tool that has been used globally in screening forms of IPV without making the respondents uncomfortable. This universal screening tool was used because its administration is quick, feasible, relatively brief and nonthreatening. It helped remove the sense of isolation and shame from the respondents. It
gave the respondents room to think about their IPV relationship behaviors. It also helped them revisit their histories of violence and victimization, and also removed the taboo and stigma around sexual and physical abuse, as the respondents talked about it openly and freely.

The forms of IPV captured were: physical hurt (which includes physical slaps, beatings, rape, the use of knives, bottles, whips and other materials), Insults and talking down on, threats of physical harm, and screaming at and being cursed at by the partner. Tables 4.2-4.5 present types/forms of trauma survivors’ encounter in their intimate relations.

Physical violence was recorded to be a common form of IPV among the survivors of Kayole. As shown in table 4.2, slightly above two-thirds of respondents, that is 131 (67.9%), had been hurt physically by their intimate partners; 40 (20.7%) indicated rarely, 49 (25.4%) indicated sometimes, 18 (9.3%) fairly often while 24 (12.4%) frequently.

Table 4.2: Physically hurt by intimate partner

<table>
<thead>
<tr>
<th>How often IPV physically occurs</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>62</td>
<td>32.1</td>
</tr>
<tr>
<td>Rarely</td>
<td>40</td>
<td>20.7</td>
</tr>
<tr>
<td>Sometimes</td>
<td>49</td>
<td>25.4</td>
</tr>
<tr>
<td>Fairly often</td>
<td>18</td>
<td>9.3</td>
</tr>
<tr>
<td>Frequently</td>
<td>24</td>
<td>12.4</td>
</tr>
<tr>
<td>Total</td>
<td>193</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Verbal abuse was the most frequent and another common form of IPV. As tabulated in table 4.3, majority of respondents, 157 (81.3%), had been hurt verbally by their intimate partners; 51 (26.4%) indicated rarely, 48 (24.9%) sometimes, 29 (15.0%) fairly often and 29 (15.0%) frequently.
Table 4.3: Verbally hurt by intimate partner

<table>
<thead>
<tr>
<th>How often verbal violence occurs</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>36</td>
<td>18.7</td>
</tr>
<tr>
<td>Rarely</td>
<td>51</td>
<td>26.4</td>
</tr>
<tr>
<td>Sometimes</td>
<td>48</td>
<td>24.9</td>
</tr>
<tr>
<td>Fairly often</td>
<td>29</td>
<td>15.0</td>
</tr>
<tr>
<td>Frequently</td>
<td>29</td>
<td>15.0</td>
</tr>
<tr>
<td>Total</td>
<td>193</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 4.4 shows the tabulation of threats by intimate partner. It was represented as 35 (18.1%) of them indicating rarely, 32 (16.6%) sometimes, 22 (11.4%) fairly common and 14 (7.3%) frequently. Cumulatively 103 (53.4%) were in relationship that had threat as a form of violence.

Table 4.4 Threats by intimate partner

<table>
<thead>
<tr>
<th>How often threatening occurs</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>90</td>
<td>46.6</td>
</tr>
<tr>
<td>Rarely</td>
<td>35</td>
<td>18.1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>32</td>
<td>16.6</td>
</tr>
<tr>
<td>Fairly often</td>
<td>22</td>
<td>11.4</td>
</tr>
<tr>
<td>Frequently</td>
<td>14</td>
<td>7.3</td>
</tr>
<tr>
<td>Total</td>
<td>193</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Another common form of verbal violence that occurs among persons in a sexual relationship in Kayole is being screamed at and cursed. As tabulated in table 4.5, about two thirds of respondents, 122 (63.2 %) of them, had been screamed at or cursed by their intimate partners. 39 (20.2%) indicated rarely, another 39 (20.2%) sometimes, 24 (12.4%) fairly common and 20 (10.4%) frequently.
Table 4.5: verbally hurt by intimate partner

<table>
<thead>
<tr>
<th>How often screaming or cursing occurs</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>71</td>
<td>36.8</td>
</tr>
<tr>
<td>Rarely</td>
<td>39</td>
<td>20.2</td>
</tr>
<tr>
<td>Sometimes</td>
<td>39</td>
<td>20.2</td>
</tr>
<tr>
<td>Fairly often</td>
<td>24</td>
<td>12.4</td>
</tr>
<tr>
<td>Frequently</td>
<td>20</td>
<td>10.4</td>
</tr>
<tr>
<td>Total</td>
<td>193</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The HITS screen also served as an entry point for those who had made the inclusion criteria for the study; they were then introduced to the two main psychological tests to be done, being the effects that are likely to occur in such violence. Though getting a score below 10 points did not qualify one to see a counselor, it however, still indicated that there was a form of violence in that relationship.

4.2.3.2 Emotional and psycho-trauma symptoms

In order to ascertain and document the emotional and psycho-trauma symptoms amongst the female survivors, two psychological tests were administered to the respondents. The tests were the Posttraumatic Stress Disorder checklist-5 (PCL-5) and the Beck Depression Inventory (BDI) which were used to determine the answer to objective two which sought to document the emotional and psycho-trauma symptoms among survivors of IPV in Kayole.

The PTSD Check List-5 (PCL-5) measured the severity of PTSD and trauma history. The PCL-5 has 20-item questions and corresponds with the DSM-5 PTSD symptom criteria. The total symptom severity score, ranges from 0 to 80. This is obtained by the sum of the score of each of the 20 questions. The cut-off point is 33. Scores above 33 indicate the severity of the symptoms. In the study, the researcher used the PCL-5 for the worst month (lifetime) of the respondents.
Post-Traumatic Stress Disorder (PTSD) symptoms include re-experiencing, avoidance, emotional reaction and hyper-arousal. Over half of respondents had moderate to extreme re-experiencing PTSD related symptoms. Re-experiencing PTSD symptoms delineated by respondents are tabulated in Table 4.6. Some 116 (60.1%) had repeated, disturbing, and unwanted memory symptoms while 101 (52.3%) had repeated, disturbing dream symptoms and another 102 (52.8%) had sudden feelings or acting as if the IPV were actually happening again (as if reliving the violence). About 144 (74.6%) who form the majority of the respondents had repeated very upsetting feelings when something reminded them about the IPV and 119 (61.7%) had repeated strong physical reactions when something reminded them of the IPV.

*Table 4.6: Re-experiencing symptoms*

<table>
<thead>
<tr>
<th>Types of re-experiencing symptoms</th>
<th>Severity of the symptom occurrence</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeated, disturbing, and unwanted memories of the stressful experiences</td>
<td>Not at all: 32 (16.6%)</td>
<td>Rarely: 45 (23.3%)</td>
</tr>
<tr>
<td>Repeated, disturbing dreams of the stressful experience</td>
<td>Not at all: 61 (31.6%)</td>
<td>Rarely: 31 (16.1%)</td>
</tr>
<tr>
<td>Suddenly feeling or acting as if the stressful experience were actually happening again (as if reliving the event)</td>
<td>Not at all: 51 (26.4%)</td>
<td>Rarely: 40 (20.7%)</td>
</tr>
<tr>
<td>Feeling very upset when something reminded you of the stressful experience</td>
<td>Not at all: 29 (15.0%)</td>
<td>Rarely: 20 (10.4%)</td>
</tr>
<tr>
<td>Having strong physical reactions when something reminded you of the stressful experience</td>
<td>Not at all: 41 (21.2%)</td>
<td>Rarely: 43 (22.3%)</td>
</tr>
</tbody>
</table>
Avoidance PTSD symptoms delineated by respondents are tabulated in Table 4.7. Over half of respondents had moderate to extreme avoidance PTSD related symptoms. Some 120 (62.2%) respondents avoided memories, thoughts, or feelings related to the IPV, 105 (54.4%) had trouble remembering important parts of the IPV experiences and 121 (62.7%) avoided external reminders of the stressful IPV experiences (for example, people, places, conversations, activities, objects, or situations).

Table 4.7: Avoidance symptoms

<table>
<thead>
<tr>
<th>Types of avoidance symptoms</th>
<th>Severity of the symptom occurrence</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoiding memories, thoughts, or feelings related to the stressful experience</td>
<td>Not at all</td>
<td>193</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moderately</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quite a bit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td></td>
</tr>
<tr>
<td>Trouble remembering important parts of the stressful experience</td>
<td>Not at all</td>
<td>193</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moderately</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quite a bit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td></td>
</tr>
<tr>
<td>Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)</td>
<td>Not at all</td>
<td>193</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moderately</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quite a bit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td></td>
</tr>
</tbody>
</table>

Emotional reaction of PTSD symptoms depicted by respondents are tabulated in Table 4.8. Over half of respondents had moderate to extreme emotional reaction of IPV related symptoms. Some 119 (61.2%) had strong negative beliefs about themselves, about others or about the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me). A majority 137 (71.0%) blamed themselves or someone else for the stressful (IPV) experience or what happened after intimate violence occurred, another 85 (44.0%) had strong negative feelings such as fear, horror, anger, guilt, or shame, while 118 (61.1%) had lost
interest in activities that they used to enjoy. A further 115 (59.6%) had feelings of distant or
cutting off from other people or isolation, 108 (56.0%) had trouble experiencing positive feelings
like being unable to feel happiness or have loving feelings for people close to them, a further 106
(54.9%) had irritable behavior, angry outbursts, or acted aggressively and 83 (43.0%) took too
many risks or did things that could cause them harm.

Table 4.8: Emotional reaction symptoms

<table>
<thead>
<tr>
<th>Types of emotional reaction symptoms</th>
<th>Not at all</th>
<th>Rarely</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having strong negative beliefs about self, other people, or the world</td>
<td>37 (19.2%)</td>
<td>34 (17.6%)</td>
<td>22 (11.4%)</td>
<td>43 (23.8%)</td>
<td>54 (28.0%)</td>
<td>193</td>
</tr>
<tr>
<td>Blaming self or someone else for the stressful (IPV) experience or what happened after it IPV</td>
<td>29 (15.0%)</td>
<td>41 (21.2%)</td>
<td>36 (18.7%)</td>
<td>47 (24.4%)</td>
<td>54 (28.0%)</td>
<td>193</td>
</tr>
<tr>
<td>Having strong negative feelings such as fear, horror, anger, guilt, or shame</td>
<td>35 (18.1%)</td>
<td>38 (19.7%)</td>
<td>19 (9.8%)</td>
<td>35 (18.1%)</td>
<td>31 (16.1%)</td>
<td>193</td>
</tr>
<tr>
<td>Loss of interest in activities that you used to enjoy</td>
<td>45 (21.8%)</td>
<td>33 (17.1%)</td>
<td>24 (12.4%)</td>
<td>40 (20.7%)</td>
<td>54 (28.0%)</td>
<td>193</td>
</tr>
<tr>
<td>Feeling distant or cut off from other people or isolated</td>
<td>45 (23.3%)</td>
<td>33 (17.1%)</td>
<td>28 (14.5%)</td>
<td>41 (21.2%)</td>
<td>46 (23.8%)</td>
<td>193</td>
</tr>
<tr>
<td>Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)</td>
<td>44 (22.8%)</td>
<td>41 (21.2%)</td>
<td>26 (13.5%)</td>
<td>37 (19.2%)</td>
<td>45 (23.3%)</td>
<td>193</td>
</tr>
<tr>
<td>Irritable behavior, angry outbursts, or acting aggressively</td>
<td>52 (26.9%)</td>
<td>35 (18.1%)</td>
<td>37 (19.2%)</td>
<td>30 (15.5%)</td>
<td>39 (20.2%)</td>
<td>193</td>
</tr>
<tr>
<td>Taking too many risks or doing things that could cause you harm</td>
<td>78 (40.4%)</td>
<td>32 (16.6%)</td>
<td>25 (13.0%)</td>
<td>25 (13.0%)</td>
<td>33 (17.1%)</td>
<td>193</td>
</tr>
</tbody>
</table>
Hyper-arousal PTSD symptoms presented by respondents are tabulated in table 4.9.

Over half of respondents had moderate to extreme hyper-arousal PTSD related symptoms. Some 104 (53.9%) were “super alert” or watchful or on guard, another 91 (47.2%) had jumpy or easily startled feelings, while 109 (56.9%) had difficulty in concentrating and 102 (52.8%) had trouble falling or staying asleep.

*Table 4.9: Hyper-arousal symptoms*

<table>
<thead>
<tr>
<th>Types of hyper-arousal symptoms</th>
<th>Severity of the symptom occurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
</tr>
<tr>
<td>Being “super alert” or watchful or on guard</td>
<td>47 (24.4%)</td>
</tr>
<tr>
<td>Feeling jumpy or easily startled</td>
<td>56 (29.0%)</td>
</tr>
<tr>
<td>Having difficulty concentrating</td>
<td>53 (27.5%)</td>
</tr>
<tr>
<td>Trouble falling or staying asleep</td>
<td>66 (34.2%)</td>
</tr>
</tbody>
</table>

The BDI-II can be divided into two main parts composed of items (1 to 13) relating to symptoms of depression such as hopelessness, suicidal thoughts and irritability, cognitions such as guilt or feelings of being punished, as well as physical symptoms (items 14 to 21) such as fatigue, weight loss, sleep disturbance and lack of interest in sex. Though divided into two main parts, they can still be categorized into different depressive symptoms such as mood, pessimistic, pleasure, self-esteem, suicide behavior, cognitive processing, psychomotor, vegetative and somatic symptoms. Depressive symptoms depicted by respondents are tabulated in Table 4.10 according to BDI. Results revealed that the respondents had clinical significant mood symptoms (moderate to extremely severe). Some 112 (63.2%) exhibited sadness, 131 (67.9%) guilt, 101 (52.3%) crying and 123 (63.7%) were irritable. Further, more than two thirds of the respondents had lost interest in a number of activities. Some 135 (69.9%) were dissatisfied in things they did
or used to do, while 123 (63.7%) felt like they were getting punished, 125 (64.8%) had lost interest in other people around them and 142 (73.6%), had lost interest in sexual activities.

Vegetative depressive symptoms were very prevalent among the respondents. Some 113 (58.5%) had sleep difficulties, 117 (60.6%) had appetite problems while 50 (25.9%) had lost weight.

Suicidal behavior was significant. Some 37 (19.2%) had suicidal thoughts, but would not carry it out, 3 (1.6%) wished to kill themselves and 10 (5.2%) would kill themselves had they a chance.

Table 4.10: First three categories of depressive screening, vegetative and suicidal symptoms

<table>
<thead>
<tr>
<th>Types of re-experiencing symptoms</th>
<th>Not at all</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood symptoms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sadness</td>
<td>71 (36.8%)</td>
<td>85 (44.0%)</td>
<td>12 (6.2%)</td>
<td>25 (13.0%)</td>
<td>193</td>
</tr>
<tr>
<td>Guilty</td>
<td>62 (32.1%)</td>
<td>69 (35.8%)</td>
<td>41 (21.2%)</td>
<td>21 (10.9%)</td>
<td>193</td>
</tr>
<tr>
<td>Crying</td>
<td>92 (47.7%)</td>
<td>28 (14.5%)</td>
<td>9 (4.7%)</td>
<td>64 (33.2%)</td>
<td>193</td>
</tr>
<tr>
<td>Irritability</td>
<td>70 (36.3%)</td>
<td>68 (35.2%)</td>
<td>37 (19.2%)</td>
<td>18 (9.3%)</td>
<td>193</td>
</tr>
<tr>
<td>Loss of Pleasure Symptoms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissatisfied in things I do or I used to do</td>
<td>58 (30.1%)</td>
<td>101 (52.3%)</td>
<td>18 (9.3%)</td>
<td>18 (8.3%)</td>
<td>193</td>
</tr>
<tr>
<td>Feelings of being punished</td>
<td>70 (36.3%)</td>
<td>44 (22.8%)</td>
<td>7 (3.6%)</td>
<td>72 (37.3%)</td>
<td>193</td>
</tr>
<tr>
<td>Loss of interest in other people</td>
<td>68 (35.2%)</td>
<td>73 (37.8%)</td>
<td>38 (19.7%)</td>
<td>14 (7.3%)</td>
<td>193</td>
</tr>
<tr>
<td>Vegetative symptoms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lost interest in sex</td>
<td>51 (26.4%)</td>
<td>76 (39.4%)</td>
<td>35 (18.1%)</td>
<td>31 (16.1%)</td>
<td>193</td>
</tr>
<tr>
<td>Sleep difficulties</td>
<td>80 (41.5%)</td>
<td>60 (31.1%)</td>
<td>39 (20.2%)</td>
<td>14 (7.3%)</td>
<td>193</td>
</tr>
<tr>
<td>Appetite problems</td>
<td>76 (38.9%)</td>
<td>91 (47.2%)</td>
<td>17 (8.8%)</td>
<td>10 (5.2%)</td>
<td>193</td>
</tr>
<tr>
<td>Weight Loss</td>
<td>119 (61.7%)</td>
<td>48 (24.9%)</td>
<td>16 (8.3%)</td>
<td>10 (5.2%)</td>
<td>193</td>
</tr>
<tr>
<td>Suicide Behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thoughts of killing oneself</td>
<td>143 (74.1%)</td>
<td>37 (19.2%)</td>
<td>3 (1.6%)</td>
<td>10 (5.2%)</td>
<td>193</td>
</tr>
</tbody>
</table>
Depressive symptoms further delineated and tabulated in Table 4.11 according to BDI. Over half of respondents had moderate to extreme pessimistic symptoms. The results showed that 98 (50.8%) were discouraged about their future, while 109 (56.5%) felt like they were failures in their life. A high proportion had low self-esteem with 114 (59.1%) being disappointed in themselves. 116 (60.1%) criticized themselves and 75 (38.9%) had poor self-image. Psychomotor symptoms were present in 109 (56.5%) who could not work physically like before, while 135 (69.9%) felt exhausted most times. A further 107 (55.4%) could not make decisions cognitively on their own effectively and lastly, 121 (62.7%) had psychosomatic symptoms.

*Table 4.11: Other categories of depressive symptoms*

<table>
<thead>
<tr>
<th>Types of re-experiencing symptoms</th>
<th>Not at all</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pessimistic symptoms</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discouraged about future</td>
<td>95 (49.2%)</td>
<td>57 (29.5%)</td>
<td>16 (8.3%)</td>
<td>25 (13.0%)</td>
<td>193</td>
</tr>
<tr>
<td>Feeling a failure</td>
<td>84 (43.5%)</td>
<td>51 (26.4%)</td>
<td>43 (22.3%)</td>
<td>15 (7.8%)</td>
<td>193</td>
</tr>
<tr>
<td><strong>Loss of self esteem</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disappointed in myself</td>
<td>79 (40.9%)</td>
<td>92 (47.7%)</td>
<td>10 (5.2%)</td>
<td>12 (6.2%)</td>
<td>193</td>
</tr>
<tr>
<td>Self-criticism</td>
<td>77 (39.9%)</td>
<td>54 (28.0%)</td>
<td>30 (15.5%)</td>
<td>32 (16.6%)</td>
<td>193</td>
</tr>
<tr>
<td>Poor self-image</td>
<td>118 (61.1%)</td>
<td>41 (21.1%)</td>
<td>31 (16.1%)</td>
<td>3 (1.6%)</td>
<td>193</td>
</tr>
<tr>
<td><strong>Psychomotor symptoms</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannot work like before</td>
<td>84 (43.5%)</td>
<td>75 (38.9%)</td>
<td>30 (15.5%)</td>
<td>4 (2.1%)</td>
<td>193</td>
</tr>
<tr>
<td>Tiredness</td>
<td>58 (30.1%)</td>
<td>94 (48.7%)</td>
<td>32 (16.6%)</td>
<td>9 (4.7%)</td>
<td>193</td>
</tr>
<tr>
<td><strong>Cognitive Functioning</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty in decision making</td>
<td>86 (44.6%)</td>
<td>34 (17.6%)</td>
<td>62 (32.1%)</td>
<td>11 (5.7%)</td>
<td>193</td>
</tr>
<tr>
<td><strong>Psychosomatic symptoms</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical health problems</td>
<td>72 (37.3%)</td>
<td>83 (43.0%)</td>
<td>22 (11.4%)</td>
<td>16 (8.3%)</td>
<td>193</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severity of the symptom occurrence</th>
<th>Not at all</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
<th>Total</th>
</tr>
</thead>
</table>

| Discouraged about future          | 95 (49.2%) | 57 (29.5%) | 16 (8.3%)   | 25 (13.0%)| 193   |
| Feeling a failure                 | 84 (43.5%) | 51 (26.4%) | 43 (22.3%)  | 15 (7.8%) | 193   |
| Disappointed in myself            | 79 (40.9%) | 92 (47.7%) | 10 (5.2%)   | 12 (6.2%) | 193   |
| Self-criticism                    | 77 (39.9%) | 54 (28.0%) | 30 (15.5%)  | 32 (16.6%)| 193   |
| Poor self-image                   | 118 (61.1%)| 41 (21.1%) | 31 (16.1%)  | 3 (1.6%)  | 193   |
| Cannot work like before           | 84 (43.5%) | 75 (38.9%) | 30 (15.5%)  | 4 (2.1%)   | 193   |
| Tiredness                         | 58 (30.1%) | 94 (48.7%) | 32 (16.6%)  | 9 (4.7%)   | 193   |
| Difficulty in decision making     | 86 (44.6%) | 34 (17.6%) | 62 (32.1%)  | 11 (5.7%)  | 193   |
| Physical health problems          | 72 (37.3%) | 83 (43.0%) | 22 (11.4%)  | 16 (8.3%)  | 193   |
The HITS screen indicates that any score above 10 points indicates severe suffering from abuse. The HITS questionnaire results presented in Figure 4.5 indicates the reality of violence meted on the female respondents within Kayole. The HITS screen results presented in Figure 4.5 has a mean score of 9.78 with a standard diversion of 4.4, which indicates that all females recruited had been exposed to IPV. Since the cut-off point for the HITS screen is 10 points and above, then the prevalence of IPV in Kayole is 46.6%.

![Figure 4.5: Distribution of HITS total scores](image)

In-depth scrutiny was done to assess the severity of PTSD and figure 4.6 presents severity of PTSD symptoms. The level of PTSD is very high; using a cutoff point of 30 for a respondent to meet the full criterion for PTSD. The mean score in this result 39.9 is much higher than the cutoff point with a standard deviation of 20.7. This result cumulatively indicates that 128 (66.3%) respondents had symptoms that meet the DSM 5 criterion for PTSD.
Table 4.12 tabulates the severity of PTSD symptoms among respondents. The level of PTSD is extremely high. Some 14 (7.3%) respondents had mild PTSD symptoms, 25 (13.0%) moderate and 89 (46.1%) severe PTSD symptoms that meet DSM-5 criterion for PTSD. This result cumulatively indicates that 114 (59.1%) respondents had PTSD symptoms that meet the DSM criteria for moderate to severe clinical PTSD.

**Table 4.12: Levels of PTSD symptoms severity**

<table>
<thead>
<tr>
<th>PTSD symptoms severity</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-29</td>
<td>65</td>
<td>33.7</td>
</tr>
<tr>
<td>30-35</td>
<td>14</td>
<td>7.3</td>
</tr>
<tr>
<td>36-44</td>
<td>25</td>
<td>13.0</td>
</tr>
<tr>
<td>45 and above – Severe</td>
<td>89</td>
<td>46.1</td>
</tr>
<tr>
<td>Total</td>
<td>193</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4.13 tabulates the severity of depressive disorder symptoms among respondents measured by BDI. The level of depression is extremely high. 38 (19.7%) had mild depressive
symptoms, 42 (21.8%) moderate and 44 (22.8%) severe depressive symptoms that meet DSM-5 criterion for depressive disorder. This result cumulatively indicates that 124 (64.2%) respondents had depressive symptoms that meet the DSM-5 criterion for depressive disorder.

Table 4.13: Levels of depressive symptoms severity

<table>
<thead>
<tr>
<th>Depressive symptoms severity</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-13- Normal</td>
<td>69</td>
<td>35.8</td>
</tr>
<tr>
<td>14-19 – Mild</td>
<td>38</td>
<td>19.7</td>
</tr>
<tr>
<td>20-28 – Moderate</td>
<td>42</td>
<td>21.8</td>
</tr>
<tr>
<td>29 and above – Severe</td>
<td>44</td>
<td>22.8</td>
</tr>
<tr>
<td>Total</td>
<td>193</td>
<td>100</td>
</tr>
</tbody>
</table>

Figure 4.7 presents severity of depressive disorder symptoms distribution on a normal histogram distribution. The level of depressive disorder is very high; using a cutoff point of 14 for a respondent to meet the full criteria for DSM-5 depressive disorder. The mean score in this result 19.5 is much higher than the cutoff point with a standard deviation of 13.2. This result cumulatively indicates that 86 (44.6%) respondents had moderate to severe symptoms in depressive disorder criteria that meet the DSM-5 criterion for clinical depressive disorders.
4.2.3.3 Levels of social support

The research questions on objective 3 and 4 are tackled here. The question relating to objective 3 is the relationship between social support and symptoms of PTSD and objective 4 is the relationship between social support and symptoms of depression. After the screening of the respondents, the researcher distributed the social support questionnaires with the help of research assistants. This offered the researcher the opportunity to interact with respondents, a move which ensured a higher response rate and prompt data collection. Social health outcome measures were assessed using the social support questionnaire (SSQ) that documented the perception and actuality that the respondent was cared for, had assistance available from other people, and that they were part of a supportive social network. These supportive health outcome measures were classified as emotional (e.g., nurturance), tangible (e.g., financial assistance), informational (e.g., advice), or companionship (e.g., sense of belonging) and intangible (e.g., personal advice). The SSQ classifies social health outcome measures: appraisal, tangible, self-esteem, and belonging to
a social network. This SSQ measures the perception respondents hold, including the perception that they have assistance available, actual received assistance, or the degree to which a person is integrated in a social network.

Table 4.14 presents frequency distribution of SSQ total scores and its classification; appraisal, tangible, self-esteem, and belonging to a social network. The mean, median and variance in the total score and sub-tests are skewed to the right indicating high scores of the respondents and showing that the respondents have good support system.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>141.06</td>
<td>48.91</td>
<td>32.51</td>
<td>32.66</td>
<td>43.40</td>
</tr>
<tr>
<td>Median</td>
<td>151.00</td>
<td>53.00</td>
<td>35.00</td>
<td>35.00</td>
<td>48.00</td>
</tr>
<tr>
<td>Variance</td>
<td>514.98</td>
<td>64.27</td>
<td>29.36</td>
<td>27.77</td>
<td>52.94</td>
</tr>
<tr>
<td>Skewness</td>
<td>-2.36</td>
<td>-2.31</td>
<td>-2.30</td>
<td>-2.34</td>
<td>-2.28</td>
</tr>
<tr>
<td>Std. Error of Skewness</td>
<td>.175</td>
<td>.175</td>
<td>.175</td>
<td>.175</td>
<td>.175</td>
</tr>
<tr>
<td>Range</td>
<td>130</td>
<td>45</td>
<td>30</td>
<td>30</td>
<td>40</td>
</tr>
<tr>
<td>Minimum</td>
<td>26</td>
<td>9</td>
<td>6</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Maximum</td>
<td>156</td>
<td>54</td>
<td>36</td>
<td>36</td>
<td>48</td>
</tr>
</tbody>
</table>

**Relationship between social support-demographic characteristics, IPV, PTSD and depressive disorder.** Associations between socio-demographic characteristics and common health problems was analyzed to determine the relationship between social-demographic characteristics and health conditions by conducting bivariate analysis using correlations and chi-square statistical tests. The relationships between trauma related disorders were analyzed
applying the bivariate statistics (PTSD and depressive disorders). The results are tabulated in tables 4.15 to 4.17.

**Social demographic and IPV.** Table 4.15 shows the association between respondents who meet the criterion of IPV and socio-demographic characteristics. A cross tabulation between the key socio-demographic characteristics and respondents who indicated had IPV revealed that age had a statistical significant difference; older age categories had more respondents meeting the IPV criterion compared to the younger age category, \( p=0.049 \). This could indicate either the younger aged category was not very much open to share the violence in their relationships or this study has proven to the contrary that older aged group has violent relationship which is contrary to the assumption of society that there is no violence in older age relationships.

Divorced/Separated respondent 26 (76.5%) had a higher prevalence of meeting IPV criterion, this was statistically significant \( (p=0.001) \). This indicated IPV could be the likely cause of divorce or separation. Level of education attained was a statistically significant factor; respondents had a higher prevalence of meeting IPV criterion. 23 (79.3%) had no education or only primary education, making it statistically significant \( (p<0.001) \). This indicated lower education attainment could be likely cause of respondent being abused by the intimate partner as compared to higher education attainment.
Table 4.15: IPV and Associated Socio-demographic Characteristics

<table>
<thead>
<tr>
<th>Covariate</th>
<th>Presence of IPV</th>
<th>( \chi^2 ) statistics</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No (53.4%)</td>
<td>Yes (46.6%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>103/193</td>
<td>90/193</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 18-27 years</td>
<td>70.6% (24/34)</td>
<td>29.4% (10/34)</td>
<td>5.303</td>
</tr>
<tr>
<td>Between 28-37 years</td>
<td>52.1% (37/71)</td>
<td>47.9% (34/71)</td>
<td></td>
</tr>
<tr>
<td>Between 38-47 years</td>
<td>49.0% (25/51)</td>
<td>51.0% (26/51)</td>
<td></td>
</tr>
<tr>
<td>Between 48-60 years</td>
<td>45.9% (17/37)</td>
<td>54.1% (20/37)</td>
<td></td>
</tr>
<tr>
<td>Type of work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent</td>
<td>58.9% (33/56)</td>
<td>41.1% (23/56)</td>
<td>1.020</td>
</tr>
<tr>
<td>Causal</td>
<td>50.5%(48/95)</td>
<td>49.5%(47/95)</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>54.4% (22/42)</td>
<td>47.6% (20/42)</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>57.1% (60/105)</td>
<td>43.9% (45/105)</td>
<td>15.789</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>23.5%(8/34)</td>
<td>76.5%(26/34)</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>66.0%(31/47)</td>
<td>34.0%(16/47)</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>57.1% (4/7)</td>
<td>42.9% (3/7)</td>
<td></td>
</tr>
<tr>
<td>Education level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary/no education</td>
<td>20.7% (6/29)</td>
<td>79.3% (23/29)</td>
<td>23.793</td>
</tr>
<tr>
<td>Secondary</td>
<td>51.9% (42/81)</td>
<td>48.1% (39/81)</td>
<td></td>
</tr>
<tr>
<td>College</td>
<td>60.0% (39/65)</td>
<td>40.0% (26/65)</td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>88.9%(16/18)</td>
<td>11.1%(2/18)</td>
<td></td>
</tr>
</tbody>
</table>

**Social demographics and PTSD.** Table 4.16 tabulates association between respondents who meet the criterion of PTSD and socio-demographic characteristics. A cross tabulation between highest education attained socio-demographic characteristics indicated a statistically significant relationship. Respondents who had severe trauma related issue that met PTSD criterion were 23 (79.3%), they had no education or only primary education, and this was statistically significant (p=0.012). This indicated that lower education attainment could likely be the cause of respondent being abused by the intimate partner and which may have developed into PTSD as compared to higher education attainment, particularly university education.
Table 4.16: PTSD and Associated Socio-demographic Characteristics

<table>
<thead>
<tr>
<th>Covariate</th>
<th>PTSD</th>
<th></th>
<th></th>
<th>(\chi^2)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td></td>
<td>statistics</td>
<td>value</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>53.4% (103/193)</td>
<td>46.6% (90/193)</td>
<td>2.2</td>
<td>0.546</td>
<td></td>
</tr>
<tr>
<td>Between 18-27 years</td>
<td>50.0% (17/34)</td>
<td>50.0% (17/34)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 28-37 years</td>
<td>35.2% (25/71)</td>
<td>64.8% (46/71)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 38-47 years</td>
<td>41.2% (21/51)</td>
<td>58.8% (30/51)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 48-60 years</td>
<td>43.2% (16/37)</td>
<td>56.8% (21/37)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Type of work</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent</td>
<td>42.9% (21/56)</td>
<td>57.1% (32/56)</td>
<td>1.020</td>
<td>0.600</td>
<td></td>
</tr>
<tr>
<td>Causal</td>
<td>41.1% (39/95)</td>
<td>58.9% (58/95)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>38.1% (16/42)</td>
<td>61.9% (26/42)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>46.7% (49/105)</td>
<td>53.3% (56/105)</td>
<td>6.476</td>
<td>0.091</td>
<td></td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>26.5% (9/34)</td>
<td>73.5% (25/34)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>42.6% (20/47)</td>
<td>57.4% (27/47)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>14.3% (1/7)</td>
<td>85.7% (6/7)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Education level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary/no education</td>
<td>20.7% (6/29)</td>
<td>79.3% (23/29)</td>
<td>11.032</td>
<td>0.012*</td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>45.7% (37/81)</td>
<td>54.3% (44/81)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>College</td>
<td>36.9% (24/65)</td>
<td>63.1% (41/65)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>66.7% (12/18)</td>
<td>33.3% (6/18)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Social demographics and depression.** Table 4.17 tabulates association between respondents who met the criterion of depressive disorder and socio-demographic characteristics. A cross tabulation between highest education attained and socio-demographic characteristics indicated a statistically significant relationship; of the respondents who had higher scores on BDI that met DSM-5 criterion for depressive disorder, 18 (62.1%) had no education or only primary education, this was statistically significant (p=0.002) compared to 1 (5.6%) who had University education. This indicated lower education attainment is more likely to cause of respondent being abused by the intimate partner and develop depression as compared to higher education attainment, particularly university education.
Table 4.17: Depressive disorder and Associated Socio-demographic Characteristics

<table>
<thead>
<tr>
<th>Covariate</th>
<th>Depressive disorder</th>
<th>(\chi^2)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No (53.4%)</td>
<td>Yes 46.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>103/193</td>
<td>90/193</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 18-27years</td>
<td>64.7% (22/34)</td>
<td>35.3% (12/34)</td>
<td>4.008</td>
</tr>
<tr>
<td>Between 28-37 years</td>
<td>50.7% (36/71)</td>
<td>49.3% (3571)</td>
<td></td>
</tr>
<tr>
<td>Between 38-47 years</td>
<td>49.0% (25/51)</td>
<td>51.0% (26/51)</td>
<td></td>
</tr>
<tr>
<td>Between 48-60 years</td>
<td>64.9% (24/37)</td>
<td>35.1% (13/37)</td>
<td></td>
</tr>
<tr>
<td>Type of work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent</td>
<td>66.1% (37/56)</td>
<td>33.9% (19/56)</td>
<td>3.905</td>
</tr>
<tr>
<td>Causal</td>
<td>56.2% (50/95)</td>
<td>43.8% (45/95)</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>47.6% (20/42)</td>
<td>52.4% (22/42)</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>56.2% (59/105)</td>
<td>43.8% (46/105)</td>
<td>4.171</td>
</tr>
<tr>
<td></td>
<td>41.2% (14/34)</td>
<td>58.8% (20/34)</td>
<td></td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>63.8% (30/47)</td>
<td>36.2% (17/47)</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>57.1% (4/7)</td>
<td>42.9% (3/7)</td>
<td></td>
</tr>
<tr>
<td>Education level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary/no education</td>
<td>37.9% (11/29)</td>
<td>62.1% (18/29)</td>
<td>16.865</td>
</tr>
<tr>
<td>Secondary</td>
<td>53.1% (43/81)</td>
<td>46.9% (38/81)</td>
<td></td>
</tr>
<tr>
<td>College</td>
<td>55.4% (36/65)</td>
<td>44.6% (29/65)</td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>94.4% (17/18)</td>
<td>5.6% (1/18)</td>
<td></td>
</tr>
</tbody>
</table>

**Relationship between levels of social support with HITS scores, PTSD and depressive symptoms.** To determine the relationships between levels of social support and mental health symptoms (PTSD and depressive disorder) in relation to IPV, data of these specific variables was computed as continuous numerical. Analysis of the specific computed variables (social support, HITS score, PTSD and Depressive disorder symptoms) applied Pearson coefficient \(r\), a simple statistical bivariate test to assess their relationships. The Pearson coefficient \(r\) determines the degree (strength) of the relationship and its value ranges from -1 to +1; a value of 0 implies no relationship, value of 1 is perfect positive correlation and -1 is a
perfect inverse correlation. Values between: 0.5 and above indicate strong correlation, 0.3 and 0.5 moderate correlation and 0.1-0.3 weak correlation.

**Relationship between levels of social support and social-demographic variables.** All the social demographic variables were set into a Likert scale on a continuous increasing manner to present severity as an exposure variable. For education attainment: 0=no education, 1=primary level, 2=secondary level, 3=college and 4=university education. For marital status: 0=married, 1=single, 2=divorce or separated and 3=widowers. For employment: 2=not employed, 1=casual employment and 0=permanent employment; while actual age for each respondents was recorded as a continuous in ascending manner. Correlations matrix were run to determine the relationship between levels of social support scores and social-demographic variables that were manipulated into continuous incremental variables.

The relationship between levels of social and socio-demographic data is presented in table 4.18. Highest educational attainment was positively correlated with: total support scores at $r=0.200$, this is a significant association, $p=0.005$; belonging support scores at $r=0.205$, $p=0.004$; self-esteem scores at $r=0.176$, $p=0.014$; tangible support scores $r=0.195$, $p=0.007$ and appraisal support scores $r=0.180$, $p=0.012$. Employment status was negatively correlated with age, the older the respondent the more likelihood of not being employed $r=-0.210$ indicating a significant association of $p=0.003$. Similarly, education status was negatively correlated with type of employment, the respondent who had no education, were more likely not to be employed $r=-0.162$ indicating a significant association of $p=0.025$. Further there were significant strong positive associations between forms of social support: appraisal support was positively associated with tangible support $r=0.958$, $p<0.001$; appraisal support was positively associated with self-esteem support $r=0.948$, $p<0.001$; appraisal support was also positively associated with
belonging support $r = 0.964 \ p<0.001$. Tangible support was positively associated with self-esteem support $r = 0.926, \ p<0.001$; tangible support was also positively associated with belonging support $r = 0.941, \ p<0.001$. Lastly belonging support was positively associated with self-esteem support $r = 0.942, \ p<0.001$. These findings indicate that different forms of social support for respondents, augment each other and therefore the highly significant strong association of near 1 ($>0.9$). Also high educational attainment and employment status were associated with good social support.
### Table 4.18: Correlation between Socio-demographic Characteristics and Social Support

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest Education level attained</td>
<td>R</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p-value</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td>R</td>
<td>.162*</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>p-value</td>
<td>.025</td>
<td></td>
<td>88</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of employment</td>
<td>R</td>
<td>.180*</td>
<td>001</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>.012</td>
<td></td>
<td>88</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age in years</td>
<td>R</td>
<td>.079</td>
<td>35</td>
<td>.210**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>.272</td>
<td></td>
<td>61</td>
<td>003</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appraisal Support</td>
<td>R</td>
<td>.195**</td>
<td>37</td>
<td>-.099</td>
<td>42</td>
<td>.958**</td>
<td></td>
<td>.926**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>.007</td>
<td></td>
<td>10</td>
<td>.173</td>
<td>62</td>
<td>.000</td>
<td></td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tangible Support</td>
<td>R</td>
<td>.176*</td>
<td>11</td>
<td>-.071</td>
<td>21</td>
<td>.948**</td>
<td>.926**</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>.014</td>
<td></td>
<td>83</td>
<td>.329</td>
<td>69</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-esteem Support</td>
<td>R</td>
<td>.205**</td>
<td>57</td>
<td>-.088</td>
<td>66</td>
<td>.964**</td>
<td>.941**</td>
<td>.942**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>.004</td>
<td></td>
<td>34</td>
<td>.224</td>
<td>64</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Belong Support</td>
<td>R</td>
<td>.200**</td>
<td>31</td>
<td>-.089</td>
<td>51</td>
<td>.984**</td>
<td>.974**</td>
<td>.967**</td>
<td>.980**</td>
<td>1</td>
</tr>
<tr>
<td>p-value</td>
<td>.005</td>
<td></td>
<td>68</td>
<td>.216</td>
<td>81</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

r: Pearson correlation
P-value: *. Correlation is significant at the 0.05 level (2-tailed); **. Correlation is significant at the 0.01 level (2-tailed).

**Relationship between levels of social support, HITS, PCL-5 and BDI scores.** The relationship between levels of social support with HITS, PCL-5 and BDI scores are presented in table 4.19. Total scores of BDI scale are negatively correlated with: appraisal scores $r = -0.206$,
p = 0.004, tangible support score, r = -0.204 and p = 0.005, self-esteem scores r = -0.200 and p = 0.011 and full social support score, r = -0.209 and p = 0.003. Total BDI scores were positively correlated with PTSD scores at r = 0.642, this is a significant association with p < 0.001. Similarly, the HITS scores that assessed IPV are positively correlated with BDI and PCL-5 scores (r = 0.535 and r = 0.468) indicating a significant association of p < 0.001 and p < 0.001 respectively. These findings indicate that increase in BDI scores indicative increasing severity in depressive disorders are associated with poorer social support system. Further BDI, PCL-5 and HITS scores are positively correlated indicating that increase in HITS scores are significantly related to increase in both PTSD and depressive symptoms. Therefore, high scores on HITS indicates severe IPV incidences which cause the development of both PTSD and depressive disorders, which are presented as comorbid disorders. This is confirmed in the positive correlation between PCL-5 and BDI symptoms, indicating that PTSD is comorbid with depressive disorder.

**Table 4.19: Correlation between Social Support, HITS, PCL-5 and BDI Scores**

<table>
<thead>
<tr>
<th></th>
<th>Appraisal Support scores</th>
<th>Tangible Support scores</th>
<th>Self-esteem scores</th>
<th>Belong Scores</th>
<th>Social Support scores</th>
<th>BDI Scores</th>
<th>PTSD scores</th>
<th>HITS scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI Scores R</td>
<td>-0.206**</td>
<td>-0.204**</td>
<td>-0.200**</td>
<td>-0.183*</td>
<td>-0.209**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>.004</td>
<td>.004</td>
<td>.005</td>
<td>.011</td>
<td>.003</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD scores R</td>
<td>-0.023</td>
<td>-0.041</td>
<td>-0.023</td>
<td>0.06</td>
<td>-0.027</td>
<td>0.642**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>.752</td>
<td>.574</td>
<td>.750</td>
<td>.929</td>
<td>.709</td>
<td>&lt;0.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total HITS scores R</td>
<td>-0.066</td>
<td>-0.084</td>
<td>-0.044</td>
<td>-0.050</td>
<td>-0.065</td>
<td>0.535**</td>
<td>0.468**</td>
<td>1</td>
</tr>
<tr>
<td>p-value</td>
<td>.361</td>
<td>.247</td>
<td>.544</td>
<td>.487</td>
<td>.368</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td></td>
</tr>
</tbody>
</table>

*r: Pearson correlation

P-value: *. Correlation is significant at the 0.05 level (2-tailed); **. Correlation is significant at the 0.01 level (2-tailed).

**Relationship between HITS scores, PTSD and depressive disorder.** Table 4.20 presents the association between HITS scores that indicate severe IPV problem and PTSD
according to DSM-5 criterion. A cross tabulation between the HITS score and DSM-5 diagnosis of clinical PTSD revealed that severe IPV incidence had a statistical significant difference with regard to PTSD; where the proportion of respondents with high score on HITS (above 9) indicating IPV. 72/90 (80.0%) had PTSD compared to a lower proportion of respondents with a lower score on the HITS indicating no IPV 42/103 (40.8%) who had PTSD, p<0.001. This indicated that respondents who had severe IPV relationships were more likely to develop PTSD.

**Table 4.20: IPV and Associated PTSD**

<table>
<thead>
<tr>
<th>Covariate</th>
<th>PTSD</th>
<th>( \chi^2 ) statistics</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No (n=79)</td>
<td>Yes (n=114)</td>
<td></td>
</tr>
<tr>
<td>Intimate Partner Violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No IPV</td>
<td>59.2% (61/103)</td>
<td>40.8% (42/103)</td>
<td>30.563</td>
</tr>
<tr>
<td>Yes presence of IPV</td>
<td>20.0% (18/90)</td>
<td>80% (72/90)</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.21 presents the association between HITS score that indicate severe IPV problem and depressive disorder according to DSM-5 criterion. A cross tabulation between the HITS score and DSM-5 diagnosis of clinical depressive disorder revealed that IPV had a statistical significant difference with regard to depressive disorder; where the proportion of respondents with high score on HITS (above 9) indicating IPV 58/90 (64.4%) had depressive disorder compared to lower proportion of respondents with a lower score on the HITS indicating no IPV 28/103 (27.2%) who had depressive disorder, p<0.001. This indicated that respondents who had severe IPV relationships were more likely to develop depressive disorder.
Table 4.21: IPV and Associated Depressive Disorder

<table>
<thead>
<tr>
<th>Covariate</th>
<th>Depressive Disorder</th>
<th>$\chi^2$ statistics</th>
<th>$p$-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No (n=79)</td>
<td>Yes (n=114)</td>
<td></td>
</tr>
<tr>
<td>Intimate Partner Violence</td>
<td>72.8% (75/103)</td>
<td>27.2% (28/103)</td>
<td>25.505</td>
</tr>
<tr>
<td>No IPV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes presence of IPV</td>
<td>35.6% (32/90)</td>
<td>64.4% (58/90)</td>
<td></td>
</tr>
</tbody>
</table>

4.3 Factors that predict persistence of PTSD and depressive symptoms.

Results computed by use of logistic regression to predict the risk factors for development of PTSD are presented in table 4.22. Respondents who had severe IPV incidences as scored on HITS scale were 5.459 times more likely to have PTSD than those with no severe incidences of IPV (OR=5.459; 95% CI: 2.725-10.937; $p<0.001$). This means that respondents with severe IPV incidences were more likely to have PTSD.

Table 4.22: Multivariable Analysis of PTSD and the associated trauma related disorders

<table>
<thead>
<tr>
<th>Covariate</th>
<th>OR (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.860</td>
<td>0.383</td>
</tr>
<tr>
<td>Educational level</td>
<td>0.929</td>
<td>0.721</td>
</tr>
<tr>
<td>Marital status</td>
<td>1.428</td>
<td>0.049</td>
</tr>
<tr>
<td>Employment status</td>
<td>0.970</td>
<td>0.896</td>
</tr>
<tr>
<td>IPV severity</td>
<td>5.459</td>
<td>&lt;0.001**</td>
</tr>
<tr>
<td>Social Support</td>
<td>0.998</td>
<td>0.743</td>
</tr>
<tr>
<td>Reference</td>
<td>1.099</td>
<td>0.49</td>
</tr>
</tbody>
</table>

Results computed by use of logistic regression to predict the risk factors for depressive disorder are presented in table 4.23. This result indicates that respondents with severe IPV incidences and PTSD had depressive disorder. Respondents who had severe IPV incidences were 2.612 times more likely to have depression as compared to those with no severe IPV incidences (OR=2.612; 95% CI: 1.282-5.322; $p=0.008$). This means that respondents with severe
incidences of IPV were more likely to have depression. The analysis also shows that respondents with PTSD were more likely to have depression compared to those without PTSD (OR=6.150; 95% CI: 12.880-13.133; p<0.001). This means that respondents who had PTSD were 6.1150 more likely to have depression.

Table 4.23: Multivariable Analysis of Depressive disorder and the associated PTSD and socio-demographic characteristics

<table>
<thead>
<tr>
<th>Covariate</th>
<th>OR (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>95% CI</td>
</tr>
<tr>
<td>Age</td>
<td>0.953</td>
<td>0.669-1.358</td>
</tr>
<tr>
<td>Educational level</td>
<td>0.717</td>
<td>0.464-1.108</td>
</tr>
<tr>
<td>Marital status</td>
<td>0.884</td>
<td>0.602-1.297</td>
</tr>
<tr>
<td>Employment status</td>
<td>1.430</td>
<td>0.872-2.344</td>
</tr>
<tr>
<td>IPV severity</td>
<td>2.612</td>
<td>1.282-5.322</td>
</tr>
<tr>
<td>Social Support</td>
<td>0.995</td>
<td>0.980-1.010</td>
</tr>
<tr>
<td>PTSD</td>
<td>6.150</td>
<td>2.880-13.133</td>
</tr>
<tr>
<td>Reference</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.4 Summary of Key Findings

Intimate partner violence has a number of negative consequences associated with it. Understanding the survivors’ experiences, the different psychological outcomes and identifying ways of minimizing the negative outcome was embarked upon in this study. Whereas the findings of this study affirms other studies made earlier, there were some significant findings which has enriched the study. The expected number of participants for the research was 144, however, 200 came forward to participate. All the participants had been exposed to IPV and this was revealed from the HITS screen.

The respondents who were employed were 151(78.2%), which meant that they could at least, take care of their economic needs and yet most of them were in the abusive relationships. Despite the violence in the relationship, 54.4% of the respondents who were married have still
remained in the marriage relationship and have no intentions of getting out of the abusive relationship. Some of the respondents were either divorced or separated; this had a higher prevalence meeting IPV criterion. It also indicated IPV could likely be the cause of divorce or separation.

The violence meted to them include physical hurt (slaps, beatings, rape, the use of knives, bottles, whips and other materials) emotional hurts (Insults and talking down on), threats of physical harm, and screaming at and being cursed at by the partner, with highest and frequent form of abuse being verbal. Some of these violence was so severe that a respondent remarked that the HITS screen Likert scale could be raised up to 20. Due to the violence and lack of love and affection, some of the respondents reported engaging in extra marital affairs.

The level of education had significant relationship with behavior in this study as respondents with no education or primary education had a higher prevalence of meeting IPV criterion. Education status was negatively correlated with type of employment. The respondents with no education or primary education, also had higher scores on BDI that met DSM-5 criterion for depressive disorder and a higher score PCL-5 that met the DSM-5 criterion for PTSD, as compared to those with higher education like University. This indicated lower education attainment is more likely to cause of respondent being abused by the intimate partner and develop depression or/and PTSD as compared to higher education attainment, particularly university education. Employment status was negatively correlated with age, the older the respondent the more likelihood of not being employed. Not being employed meant dependence on the partner economically.

The level of PTSD was very high among the respondents as 66.3% of them had symptoms that met the DSM-5 criterion for PTSD. At the same time, in the area of depression,
over half of the respondents had moderate to extreme depressive symptoms, however, what was highly significant and stood out very strongly was 25.9% of the respondents had suicidal ideations. As many as 124 had the BDI measurement to the level of extremely high, and had depressive symptoms that meet the DSM criterion for depressive disorder.

Social Support in general was positively associated with appraisal, tangible, belonging and self-esteem support. Those with high educational attainment and employment status were associated with good social support. The highest educational attainment was positively correlated with the general social support scores.

Those with high scores in BDI, those with symptoms of depression were found to have poorer social support systems. The same was true with those with high score in PCL-5, those with symptoms of PTSD were found to have poorer support system. The total BDI scores were positively correlated with PTSD scores. The HITS scores that assessed IPV, were positively correlated with BDI and PTSD scores. The poorer the Social Support system, the higher the indication of severity in depressive disorders. BDI, PTSD and HITS scores were positively correlated. Increase in HITS scores were significantly related to increase in both PTSD and depressive symptoms. Therefore, high scores on HITS indicates severe IPV incidences leading to the development of both PTSD and depressive disorders, which were presented as comorbid disorders.

4.5 Chapter Summary

Intimate partner violence (IPV) is a major public health issue associated with adverse health consequences for survivors. These health issues include PTSD and depressive disorders and they are prevalent in the Kayole society. The chapter contained data presentation, analysis and interpretation. The study was to recruit 144 respondents but rather recruited 193 respondents,
that is 137%. Data was analyzed based on the study objectives using SPSS version 21.0 for windows for the quantitative data.

The study revealed the forms of IPV which included physical hurt, insults threats and screaming. The study also established an entry mode which was through the HITS screen. With the HITS screen it was realized that all the participants were going through different forms of violence in different measures. It was revealed that over half of the respondents 114 (59.1%) had moderate to extreme PTSD related symptoms and at the same time over half of the respondents had moderate to extreme BDI 124 (62.4%) of which both meet the DSM-5 criteria for moderate to severe clinical disorders.

Further BDI, PTSD and HITS scores were positively correlated indicating that increase in HITS scores were significantly related to increase in both PTSD and depressive symptoms. Therefore, high scores on HITS indicates severe IPV incidences which cause the development of both PTSD and depressive disorders, which are presented as comorbid disorders. This is confirmed in the positive correlation between PTSD and BDI symptoms, indicating that PTSD is comorbid with depressive disorder. The respondents are able to cope with these severe incidents of IPV due to good social support systems. The frequency distribution of SSQ total scores and its classification; appraisal, tangible, self-esteem, and belonging to a social network indicated in the mean, median and variance of the total score and sub-tests were skewed to the right, indicating the respondents have good support system.

The study also revealed other coping mechanisms to include; making fun of the violent relationships, talking about it among the lady folks, care and support from the communities, and believing in God.
CHAPTER 5
DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presented the summary of the findings and then discussed and concluded study objectives and finally gave the recommendation for further research. It further summarized the knowledge gathered from the study as to the role of social support and the effect it has on the symptoms of PTSD and depression. This was the significant contribution to the literature of the role of social support in intimate partner violent relationship in Kenya and field of couple therapy in general.

Violence in relationships have negative mental outcomes and this was demonstrated in the research and which has been unfolded in this chapter. The significant others within the life of the participants, served as great and healthy support for the respondents.

5.2 Discussion of results

The outcome of the social demographic information will first be discussed, and then a further discussion per objective in the light of the extant literature will follow.

5.3.1 Respondent’s Social Demographic Information.

The social demographic responses vis-à-vis IPV revealed that older age categories had more respondents meeting the HITS criterion indicating high IPV as compared to the younger age category whose p value was 0.049. In a research done in the United States by Zink et al. (2005) confirmed that IPV is prevalent among older aged women than younger women. 76.5% of the respondents in the current study were either divorced or separated and they had a higher prevalence of meeting IPV criterion. The present study showed that the strongest predictor of the separation or divorce was the violence meted on the female partner. In a research done in the US
courts in 1986 on 129 women who were divorced in Philadelphia and Pennsylvania, it was found that violence was the significant determining factor for divorce (Kurz, 1996). The p value where marital status was concern was 0.001.

Whereas the older age categories had more respondents meeting the IPV criterion compared to the younger age criterion, the highest number of participant in the current research was age group of 28-37 years olds representing 37% of the respondents. The results of women in this age range indicated that the society has socialized them to accept and anticipate violence as a form of discipline. This collaborates the assertion of Kiprotich and Ngeno (2010) which indicated that the IPV is a form of socialization in the Kenyan society. Further, related to the current study findings is the strong gender roles giving men power to control women’s behavior. This is affirmed by Stewart et al. (2012), that most collectivist cultures link masculinity to dominance, honor and aggression.

In the area of education, all the respondents except one, had formal education. This meant that 99.5% of the respondents were educated and 90.2% of them had achieved higher formal education from secondary school to University level. This demonstrates that education is not a deterring factor to IPV. Attaining higher education as a female is an important component of marital power and yet it does not deter IPV. This point is attested to by the research made by Jin et al. (2014) about the women of Karala who are better educated and well employed than the average Indian woman yet despite the advancement in education, IPV remains high.

The marital status of the respondents ranged from single, married, divorce or separated to widowed. More than half of the respondents 105 (54.4%) were married while the rest 88 (45.6%) were either single, separated, divorced or widowed. Despite the violence in the relationship, more than half of the respondents were still living in the abusive marriage, and had no intension
of getting out. This affirms the assertion by Barnett (2000) that abusive relationships are governed by patriarchal values which gives little or no power to women. It would be more reasonable for a woman to pull out of the relationship, however, they stay because most of them are often denied access to social support networks such as friends, family, and community agencies, thus making it difficult for them to get out (Barnett, 2000).

Some of the respondents said they remained in the abusive relationship because of the children. Social observation shows in a patriarchal society, children belong to the husband’s family and therefore a woman separating from her husband meant she is leaving her children in the hands of her in-laws. In the case the husband remarries, these children will suffer under the care of a step mother.

Also as a patriarchal society, dowry in form of a bride price is paid to the woman’s family, and in most African society, usually this exchange in form of money, cows and other monetary gains are never paid back; the relationship is sealed to stay on even in occurrence of divorce. These survivors of IPV are likely to feel guilt, shame and even blame themselves for being abused (Karakurt, Smith & Whiting, 2014). Furthermore, cultural factors play an essential role in these women staying on in the abusive marriage relationship as explained above. According to Stewart et al. (2012) collectivist cultures which are patriarchal exhibit strong gender roles which give men the power to control women’s behavior. Women in such cultures are urged to endure rather than reject IPV. This could be the reasons why the women stay in relationships even when there is violence.

Another factor that may make the women stay in abusive relationships is the status of marriage within the Kenyan communities. The Kikuyus among the respondents reported that to be divorced or being separated from one’s marriage was not accepted lightly in the Kikuyu
culture. The community calls those women names such as “guchokio” (loosely interpreted as a “returnee”). The woman would thus opt to stay in the abusive relationship rather than getting out and be looked down upon by the society.

About 88 (45.6%) of the respondents in the study were in the single state of life (single-24.35%, separated, divorced- 17.62% or widowed- 3.63%). According to the study, with the exception of the widows, they could be staying in this single state due to the violence that was involved in the relationship. The current study also realized that when the violence in the relationship is eliminated, the physical and psychological health improve. However, even in the absence of violence, these survivors carry with them the wounds and scares of the violence that they have gone through. A number of the respondents had deep knife wounds, scares and bruises. One of the respondent had even been stabbed by the partner and had to be admitted and stitched several times on her belly.

The high prevalence of depression 124 (64.3%) and PTSD 114 (59.1%) confirms the psychological scars carried by the respondents. This is affirmed by Stewart et al. (2012) that when the relationship ends, the IPV will end with it. However, the end of the relationship does not mean that the violence and harassment are over. The wounds and scars of domestic violence runs deep. The traumatic experience of what one has gone through can stay with one for a very long time (Walker, 2009).

Majority of the respondents (78.2%) made a livelihood either as permanent employees or on casual basis. It then begs the question why ladies in such abusive relationships remain when they can take care of themselves. Married members of the Kenyan society are more respected than the non-married members. Valdez et al. (2013) say the belief system that a woman may hold prior to the onset of abuse may lead to an increased vulnerability once the violence occurs and
this may lead to the survivor staying in the relation. The societal, expectations make the women stay in such relationships.

Another reason IPV survivors would stay in the abusive relationship despite their economic power, is due to fear associated with the traumatic experience. They may be anxious about the partner following, stalking and attacking them if they leave. These traumatic experiences that the survivors were exposed to were too threatening and disturbing but they gradually surface later and are fully integrated confirming Kendall’s (1989) postulation that this is a natural process of self-healing. This is because when fear is activated by a dangerous situation, it will lead to adaptive maneuvering by the individual to safety. The current pathological fear structure arises where the associations of the stimulus response, and meaning become a distorted reality. As argued by Foa and Kozak (1986), pathological fear structures are resistant to modification causing persistence of cognitive avoidance. This explains why despite their academic and economic backgrounds; survivors still stay in the relations re-experiencing the trauma. This also affirms the Psychodynamic theory of Sigmund Freud. The survivor goes through a helpless experience and obsessive repetition of trauma that occurred, that is re-experiencing symptoms (Freud, 1939). The effects can persist long after the violence has stopped, depending on the severity of the individual’s experiences of the abuse during or shortly after the incident (Kendall, 1989, WHO 2012).

One other aspect that keeps the survivor in the relationship is the insecure attachment patterns that are linked to IPV (Shurman & Rodriguez, 2006). Many of the respondents could not leave their relationship and this could be occasioned by insecure attachment which makes it difficult for the IPV survivor to leave the abusive relationship. Downey et al. (2004) confirm this that the child exposure to maltreatment and early rejection leads the victim to become extra
vigilant to rejection from others. With respect to attachment anxiety, IPV and symptoms of PTSD have a stronger relation in conditions where there is high fear of being unloved or rejected by the intimate partner (Scott & Babcock, 2010). This implies that those who go through IPV with high attachment anxiety have the greater risk of developing more severe PTSD symptoms. Some women go into the relationship expecting to be abused stemming from their childhood. They may have experienced their mothers going through the abusive relations and so grow up expecting the same within their romantic relationships. These survivors have internalized negative views of themselves, mistrusting others and opening up to tolerate abuses within romantic relations reasoning that romantic relations should always be abusive. This point is strengthened by Valdez et al. (2013) and Barner and Carney (2011) who say the abuse is accepted and expected by the survivors because of learnt helplessness in the face of abuse stemming from their childhood. This is also confirmed by Beck’s (1967) theory, cognitive behavioral theory, which states that psychological issues arise as a result of maladaptive, faulty or irrational belief about ourselves, our world and others leading to distorted thoughts and judgements. Some of the ladies venture into the relationship with the distorted belief that violence is part of the love relationship.

Some of the IPV survivors also go into the relationship carrying with them the early maladaptive schemas. Schemas can be defined broadly as core beliefs of self, others and the world developed during childhood which guides one’s life today and it is dysfunctional to a significant degree (Padesky, 1994). The schema that marriage will and should always have violence.

Respondents who were either unemployment or have low income were 39 and they were completely dependent on their partners. As a result, their partners use the economic power as a
means to threaten the survivors who accept the violence as their lot in the relationship. This study strengthens the point made by Stewart et al. (2012) that those with low income, together with a society that is stuck to traditional gender norms, a community which has low status of women, and social norms, are supportive of violence. This study at the same time affirms the point by Frías and Agoff (2015) that gender inequality in the social structure also condones violence because it holds the woman responsible for keeping the family together. There is inequality in that these ladies earn very little and depend on their partners who may be the major breadwinners of the family.

Level of education attained was a statistically significant factor as respondents who had no education or primary education 29 (79.3%) had a higher prevalence of meeting IPV criterion. With higher education, the survivor improves her cognitive skills and employment chances. This raises the chances of gaining some employment, thus reducing the economic burden and dependence on the male partner. This indicates that lower education attainment, could mean no job opportunities leading to the female partner depending solely on the male partner and this could likely be the cause of the respondent being abused by the intimate partner as compared to those with higher education attainment. The female partner’s physical and economic dependency on her male partner makes it hard for her to leave the abusive relationship increasing vulnerability for continued abuse. Kalmuss and Straus (1982) confirm this postulation as they indicated that the female partner’s dependency on the male partner economically and emotionally increases the likelihood of violence in the relationship.

From these findings, it would be said that oppression from the partner, social isolation from the community, fear of not being able to support herself financially, the constant violence
coupled with the negative psychological sequelae, negative belief system, insecure attachment pattern and low education make it hard for the survivor to extricate herself from IPV.

5.3.2 Objective 1: The forms of IPV among survivors in Kayole.

The survivors were able to identify the types/forms of IPV such as slaps, beatings, rape, the use of knives, bottles, whips and use of other materials. The rest of the forms of IPV included insults and talking down on, threats of physical harm, screaming at and being cursed at by the partner. According to WHO (2012) these different types of violence often exist side by side.

Verbal abuse was identified as the most frequent and common form of IPV. It is an act by which an individual is attacked by the partner negatively using words or silence as a weapon. Some of the verbal abuses that were encountered by the respondents included name calling, shaming, use of hurtful words, being labelled as a liar and sometimes information being deliberately withheld from them. Majority of respondents, 81.3%, had been hurt verbally by their intimate partners. Verbal abuse is very prevalent and can be traumatizing. Though verbal abuse may not leave physical stigmata, this causes deep mental bruises causing the self-esteem to erode as it has been affirmed by Hartwell-Walker (2016). Most of the survivors found it hard to end the relationship with the verbal abusers since most of them depended on the abuser for financial support. A number of the survivors considered this form of abuse as insignificant in relation to the other forms of abuses by their partners. According to Schumacher and Leonard (2005), verbal abuse earlier in the relationship is documented as a precursor of subsequent physical abuse later in the relationship. Verbal abuse is a severest form of psychological abuse. In this study it can be postulated as to be a precursor as it does not leave any physical wound and therefore one may take it for granted the social support become unable to empathize.
Physical violence was identified as the second highest form of abuse of IPV among the survivors of Kayole. It constituted 67.9% of the respondents. This result is consistent with previous studies by Torres et al. (2013) and WHO (2012) which indicated that physical, sexual, and psychological abuse of women by their intimate partners is common the world over. The third highest form of violence among the respondents was threats. More than half (53.4%) of the respondents had been threatened by their intimate partners with dire consequences.

The current research found the abuses in the order as verbal, followed by physical and then threats. This descending order in this study is an incidental finding.

5.3.3 Objective 2: The emotional and psycho-trauma symptoms among survivors of IPV in Kayole

The respondents showed evidence of re-experiencing, avoidance, emotional reaction and hyper-arousal attitude towards the painful incidents in their life. Those with re-experiencing symptoms ranging from moderate to severe which constituted repeated, disturbing, and unwanted memories of the stressful experiences 116 (60.1%); repeated, disturbing dreams of the stressful experience 101 (52.3%); suddenly feeling or acting as if the stressful experience were actually happening again 102 (52.9%); feeling very upset when something reminded you of the stressful experience 144 (74.6%) and having strong physical reactions when something reminded you of the stressful experience 109 (56.5%).

Avoid symptoms were experienced as avoiding memories, thoughts, or feelings related to the stressful experience 120 (62.3%); trouble remembering important parts of the stressful experience 105 (54.4%); avoiding external reminders of the stressful experience 121 (62.5%).

Emotional reaction symptoms were exhibited as having strong negative beliefs about self, other people, or the world 119 (63.2%); blaming self or someone else for the stressful (IPV)
experience or what happened after it 137 (71.1%); having strong negative feelings such as fear, horror, anger, guilt, or shame 85 (44%); loss of interest in activities that you used to enjoy 118 (61.1%); feeling distant or cut off from other people or isolated 115 (59.5%); trouble experiencing positive feelings 108 (56%); Irritable behavior, angry outbursts, or acting aggressively 106 (4.9%); and taking too many risks or doing things that could cause you harm 83 (43.1%).

Hyper arousal symptoms were exhibited as being “super alert” or watchful or on guard 104 (53.9%); feeling jumpy or easily startled 91 (47.2%); having difficulty concentrating 109 (56.5%) and trouble falling or staying asleep 102 (52.9%).

These are symptoms that meet the full criteria for PTSD in the DSM-5 which points to the fact that this study is in conformity with the American Psychiatric Association (2013), which documents that IPV is associated with PTSD. The detailed symptoms according to DSM-5 include intrusive memories of the event, intense physiological distress, i.e. struggling with emotional upsets when exposed to cues that resemble the event, difficulty falling asleep, feelings of detachment, exaggerated startle response, and hyper vigilance. These symptoms were exhibited in the respondents pointing to the fact that women abused by their partners suffer higher levels PTSD, an accession supported by WHO (2012) and Karakurt et al. (2014).

Identifying the emotional symptoms related to psycho-traumatic event was done across a wide spectrum. Even those who did not meet full criteria for PTSD, results indicated that they may suffer symptoms that strongly impact their behavior, judgment, work performance, and ability to connect with others. The emotional symptoms related to the traumatic events caused by their partners was difficult because of the various ways by which “trauma” was expressed by the
survivors. Torres et al. (2013), affirmed that IPV has a significant impact on mental health, especially in the areas of post-traumatic stress disorder (PTSD).

Over half of respondents in the study had moderate to extreme forms of PTSD which were categorized as re-experiencing, avoidance, emotional reactions and hyper-arousal PTSD related symptoms of trauma. These symptoms appeared in different forms and they were in conformity with DSM-5 (2013). Clearly evidenced in the study was the fact that over half of the respondents have the symptoms of PTSD confirming the study by Rogers and Follingstad (2014), that the most commonly mental health issue that comes out of IPV is PTSD especially when there is direct relation to more severe physical abuse.

This current study supports the accession made by Karakurt et al. (2014), that one of the major negative effect of IPV is an increased likelihood of clinical depression. This is affirmed by the depressive symptoms exhibited by the respondents. The emotional symptoms were categorized into different depressive symptoms such as: mood, pessimistic, pleasure, self-esteem, suicide behavior, cognitive processing, psychomotor, vegetative and somatic symptoms. These were clinically significant since they ranged from moderate to extremely severe.

Mood symptoms that were exhibited by the participant from moderate to extremely were sadness 122 (63.2); guilty 131 (67.9%); crying 101(52.4%); and irritability 123 (63.7%). Loss of pleasure symptoms included dissatisfied in things I do or used to do 137 (69.9%); feelings of being punished 123 (63.7%); loss of interest in other people 125 (64.8%) and loss of interest in sex 142 (73.6%). Vegetative symptoms were exhibited as sleep difficulties 113 (58.6%); appetite problems 118 (61.2%); and weight loss 74 (38.2%). Suicide behavior was exhibited a number of respondent as thought of killing oneself 50 (26%). Pessimistic symptoms exhibited by the respondents ranging from moderate to extreme were as discouraged about the future 98 (50.8%)
and feeling like a failure 109 (56.5%). Loss of self-esteem where shown in disappointed in self 114 (59.1%); self-criticism 116 (60.1%); and poor self-image 75 (38.8%). Psychomotor symptoms were exhibited in the following as those who could not work as before 109 (56.5%); tiredness 135 (70%). Cognitive functioning symptom was exhibited in difficulty in decision making 107 (55.4%). Those who showed psychomatic symptoms were shown in physical health problems and were 121 (62.7%).

Further, more than two thirds had lost interest in a number of activities including interest in sexual activities and others have gotten involve in risky behaviors such as extra-marital sex. They were also dissatisfied in things they used to love like taking care of the family, praying and going out to meet friends and felt like being punished when they do them.

The vegetative depressive symptoms were highly significant among the respondents where they had sleep difficulties, problem with appetite and loss of weight. Suicidal behavior was also noted to be highly significant. This confirms WHO (2012) multi-country study reports which says that attempted suicide were significantly higher among those who go through IPV. In the current research some of the respondents have thoughts of killing themselves but would not act on it; some wanted to kill themselves but could not get the chance to do it. Jordan et al. (2010) strengthens this point by alleging that IPV is associated among other mental outcomes suicidal ideations and acts and sometimes self-harm. Over half of the respondents had moderate to extreme pessimistic symptoms of PTSD, which exhibited itself in the respondents being discouraged in their future, feeling of being failures in life, disappointed in themselves, having poor self-image leading to low self-esteem and being disappointed in themselves.

Psychomotor symptoms of depression were also exhibited and some could not do physical work as they used to, most of them felt exhausted most of the time and more than half
had cognitive issues. They could not make decisions on their own effectively and others had psychosomatic symptoms. Kilpatrick et al. (2000, 2003) also confirmed this in their research.

5.3.4 Objective 3: The relationship between level of social support, SDQ and symptoms of PTSD among survivors of IPV in Kayole

Social support questionnaire (SSQ) was used to measure social health of the respondents. This documented the perception and actuality that the respondents were cared for, had assistance available from other people, and that they were part of a supportive social network. The SSQ measured the perception respondents hold, including perception that they have assistance available, actual received assistance, or the degree to which a person is integrated in a social network. The measurements were classified as emotional (e.g., nurturance), tangible (e.g., financial assistance), informational (e.g., advice), or companionship (e.g., sense of belonging) and intangible (e.g., personal advice).

The relationship between levels of social support and socio-demographic showed that highest educational attainment was positively correlated with: total support scores at $r= 0.200$, this is a significant association, $p= 0.005$; belonging support scores at $r= 0.205$, $p= 0.004$; self-esteem scores at $r= 0.176$, $p= 0.014$; tangible support scores $r= 0.195$, $p= 0.007$ and appraisal support scores $r= 0.180$, $p= 0.012$.

Further there were significant strong positive associations between forms of social support: appraisal support was positively associated with tangible support $r= 0.958$, $p<0.001$; appraisal support was positively associated with self-esteem support $r= 0.948$, $p<0.001$; appraisal support was also positively associated with belonging support $r= 0.964$ $p<0.001$. Tangible support was positively associated with self-esteem support $r= 0.926$, $p<0.001$; tangible support
was also positively associated with belonging support \( r = 0.941, p < 0.001 \). Lastly belonging support was positively associated with self-esteem support \( r = 0.942, p < 0.001 \).

These findings indicate that different forms of social support for respondents, augment each other and therefore the highly significant strong association of near 1 (> 0.9). Also the higher the educational attainment leads to employment status which is associated with good social support.

Associations between socio-demographic characteristics and trauma related disorders were analyzed applying the bivariate statistics. Over three-quarters (79.3%) of the respondents who met the criterion for PTSD were examined linking them to highest education attained and it indicated a statistically significant relationship. Those with no education or only primary education had statistical significance \( p = 0.012 \). Low education, high IPV. Those with severe trauma related issues that met the PTSD criterion, had either no education or only primary education. This indicated that lower education attainment could be the likely cause of respondent being abused by her intimate partner thereby developing PTSD, as compared to those with higher education attainment, particularly university education. Severe poverty and lower household income stemming from lower education could have given rise to the higher IPV.

It is evident in this study that those with lower education or no education at all had poorer social support system, where \( p = 0.012 \). Those with severe trauma related issues emanating from IPV that met the PTSD criterion, had either no education or only primary education. This indicated that lower education attainment could be the likely cause of respondent being abused by her intimate partner thereby developing PTSD, as compared to those with higher education attainment, particularly university education. Therefore, those with poorer social support system developed PTSD emanating from the IPV. This is because the survivors keep all their issues to
themselves and tend to believe things will change rather than seek help from significant others. The poorer the social support system the higher the IPV.

At the same time, this study has also revealed that respondents with severe IPV incidences and PTSD had depressive disorder \( p < 0.01 \). There is a correlation between IPV and PTSD, and a correlation between IPV and depression. The use of logistic regression predicts the risk factors that respondents who had severe IPV incidences were 2.6 times more likely to have depression as compared to those with no severe IPV incidences. The analysis also showed that respondents with PTSD were more likely to have depression as compared to those without PTSD. Those with severe IPV are very likely to have a comorbidity of PTSD and depression symptoms. This affirms the findings by Stein and Kennedy (2001) who concluded in their research on female victims of IPV that PTSD and depression symptoms are often the aftermath of IPV and that they co-exist.

5.3.5 Objective 4: The relationship between level of social support and symptoms of depression among survivors of IPV in Kayole

It is evident from this study that the highest education attained and socio-demographic characteristics showed a statistically significant relationship. The respondents with higher scores on the BDI-II that met DSM-5 criterion for depressive disorder had no education or had primary education, as compared to those with University education. This indicated lower education attainment was more likely the cause some of respondent being abused by the intimate partner. The development of depression is an emotional reaction to the abusive nature of the survivor’s intimate relations, occurring more to those with poor educational attainment as compared to higher education attainment, particularly university education. This can be postulated therefore that poor education attainment is a predictor for severe emotional reaction as the survivors have
few opportunities for alternative source of income, social support and other community supportive structures.

The association between HITS score that indicate severe IPV problem and depressive disorder according to DSM-5 criterion revealed that IPV had a statistical significant difference \( r = -0.29 \) and \( p = 0.03 \) with regard to depressive disorder; where the proportion of respondents with high score on HITS (above 9) indicating IPV 64.4% (58/90) had depressive disorder compared to lower proportion of respondents with a lower score on the HITS indicating no severe IPV 27.2% (28/103) who had depressive disorder. This indicated that respondents who had severe IPV relationships were more likely to develop depressive disorder. In other words, there were those who had lower IPV relationship but had depression. There were those who had depression stemming out of the IPV. Those with IPV and had depressive disorder was 64.4% (58/90). Those with no severe IPV but depression was 27.2% (28/103). This points to the fact that severe IPV relationship could have been more likely the cause of the developed depression.

The relationship between levels of social support with IPV (HITS) and BDI scores were indicative of increasing severity in depressive disorders associated with poorer social support system. The study findings in objective 4 clearly indicated that those with lower education or no education at all had poorer social support system. Those with severe depressive related problems due to IPV, had either no education or only primary education. This therefore indicated that lower education attainment could be the likely cause of respondent being abused by her intimate partner thereby developing symptoms of depression, as compared to those with higher education. It can be concluded that those with poorer social support system developed depression emanating from the IPV. The poorer the support system the severer the IPV, and greater possibility of depression. This assertion is affirmed by Grav, Hellzen, Romild and Stordal (2012) who
investigated the association between social support and depression of a general population in Norway and affirmed that there is higher probability of experiencing depression where there is lack of social support. As affirmed by Paykel (1994) absence of social support appears to be associated with onset and relapse of depression. This affirms the assertion that poorer support system, has high possibility of depression.

5.4 Conclusions and Clinical Implications

The study findings indicate that social demographic responses in relation to IPV revealed that older age categories had more respondents meeting the IPV criterion as compared to the younger age categories. A postulation that can be made is that older clients have experienced IPV for a longer period without intervention. Therefore, awareness creation on the effects of IPV and earlier intervention may be helpful in minimizing prolonged effects of IPV.

Divorced/Separated respondents had a higher prevalence of meeting IPV criterion. This indicated IPV could be the likely cause of divorce or separation. Psychologists and clinicians working with this group must probe into the cause of the divorce or separation. Serious consideration be given to psychological education to help make her aware of the total dependence on the man and a possibly attachment negotiated wrongly from infancy and to help correct such tendencies.

Education attained plays an important role since respondents with no education or primary education had a higher prevalence of meeting IPV criterion. This indicated lower education attainment could lead to no work opportunities and so tend to rely solely on the partner for daily living, causing the respondent to be abused by the intimate partner as compared to those with higher education attainment leading to work opportunities. Clients need to be encouraged to
be self-sufficient; thus girl child need to be encouraged to avoid early intimate relationships but in turn complete at least secondary school education first.

Some of those who have attained higher education are also stuck in the abusive relations due to attachment issue. Women with attachment issues are prone to IPV and eventually end up with psychological issues such as PTSD or depression. The clinical and psycho-trauma issues would then need to be addressed prior to the IPV problem to be able to help the client effectively. The other area that the therapists need to assess is the attachment style of the client.

BDI, PCL-5 and HITS scores in the current study are positively correlated indicating that increase in HITS (IPV) scores were significantly related to increase in both PTSD and depressive symptoms. Therefore, high scores in HITS indicates severe IPV incidences which cause the development of both PTSD and depressive disorders, which are presented as comorbid disorders.

Those with higher scores in BDI, PCL-5 and HITS have poorer social support system. It can be concluded therefore that in order to improve the depressive and traumatic state, one must improve the social support system. This study also indicated that there is a significant strong positive association among the different forms of social support. Treatment consideration should therefore, be given to the different forms of social support system of the client as indicated in this study. The current study adds to social evidence within Kenya that social support contributes effectively in improving the mental as well as the physical effect of IPV. Poor social support implies high scores in IPV, BDI and PTSD. Therefore, social support must highly be explored in the treatment of IPV.

5.5 Recommendations from the Research

This research at large has presented IPV from four different perspectives namely the individual perspective, the relationship perspective, the community perspective and the societal
perspective. In order to offer comprehensive recommendations, all these four perspectives would have to be addressed. The findings of this study would therefore benefit the government together with the civil society, the individual and also institutions dealing with mental health issues at large.

Considering the study outcome, the recommendations put forward will be categorized into four parts 1. Government law enforcement and education 2. Mental Health workers 3. Pastoral workers 4. NGOs and community empowerment.

5.5.1 Government law enforcement and education

The government, especially the Police Force, which enforces the laws, could be trained and protocols developed, to guide them on how to handle survivors who report on IPV. The training could emphasize on the psychological outcomes and the effectiveness of social support of the IPV. They could also be guided to the fact that no one has the right to violate another, even if they are in intimate relationship. The Police implementation of the law will be the government’s role in reducing IPV and reaching out to the survivors.

The Police could network with other mental health practitioners in order to prepare safe havens for survivors and places of safety for proper psychological treatment. This will imply building coalitions between the government and civil society institutions.

It would be appropriate for the government to create awareness of IPV within different media and communities. This awareness would be an eye-opener to many who never thought of IPV as a factor leading to mental health issues. It may also empower the many women who are survivors of IPV to be able to share with others what has been going on in their relationships and also to help others identify signs of the advent of the violence within their relations.
5.5.2 Mental Health workers

It is a call to psychiatrists, psychotherapists and other mental health workers treating women clients to consider looking at IPV as a prerequisite to the clinical session and treatment plan to include ways of preventing IPV. Health care providers are reminded to make questions on IPV part of the routine questions especially in older women since abuse disclosure is rare among the older age.

The psychologists and mental health providers in their treatment plan to highlight the role of social support in minimizing the effect of IPV and also to guide the client in identifying the support system available to her. For the safety of the survivor, the therapist must be encouraged to suggest or recommend separation as a treatment modality.

5.5.3 Pastoral workers

Since the church is usually one of the first places survivors seek reprieve, pastoral agents working within the community could be equipped with relevant skills in handling issues of IPV using behavior change communication to achieve social change and also making their Christians aware of the society role in the reduction of such menace. The pastoral agents could also be encouraged to collaborate with mental health workers in dealing with this menace.

5.5.4 NGOs and Community empowerment

NGOs working in areas such as reduction of IPV in communities and empowerment of a girl child be encouraged to continue such advocacy. These campaigns must also be informative and educative to the girl child to educate herself against such social malice.

The survivors could be equipped with the knowledge of the consequences of IPV and encouraged to consult mental health personnel when one is going through IPV. At the same time, knowledge gathered from this research can strengthen women’s civil rights to reform civil and
criminal legal frameworks bothering on IPV, raising awareness so as to intensify media and advocacy campaigns about IPV and existing legislation so that such legislation can be implemented.

5.6 Limitations of the study
This research focused on the women survivors and not on the perpetrators. One would therefore not be able to deduce what triggers the perpetrators into violence against their victims. The research also limited itself to the lower class, middle class and lower up class of the society but did not cover the upper class of the society. Another area not covered in the research were people below the age of 18 who may have been victims of domestic violence putting into consideration effects of IPV on children growing up in the environments.

The researcher being a priest within the Kayole community, by the virtue of his status may have influenced the respondents’ participation and responses. There are other mental health effects of IPV but the research only limited itself to PTSD and depression.

5.7 Areas of Further Research
Areas that can be explored in future researches on this topic of IPV may include: The Church ministers’ role and contribution in perpetuating IPV within the Kenyan society. Interventions for Female survivors of IPV in Kayole. Other areas to tackle could be “the male survivors of IPV in the masculine dominated Kenyan society.” Finally, another study could be “an exploratory study on children growing in an IPV environment in Kayole.”

5.8 Summary of the Chapter
Gathering from the social demographic information of the respondents revealed a number of key findings and factors compelling the survivor to continue to stay in the relationship. It was revealed that the survivors stay in the relationship even though the violent relationship leads to adverse mental effect. Some of the mental effects discussed in the current study were PTSD and
depression which are very prevalent in the Kayole society. The reality of violence meted on the female respondents within Kayole calls for creating community settings for IPV screening and intervention particularly for females who are vulnerable.

The study also revealed that those with severe mental health issues had lower education and lower social support. One significant way of minimizing the effect of the mental health outcomes is social support. Other recommendations suggested in the study will go a long way to minimize such violence in relationships.
References


Committee on Divisions/APA Relations (CODAPAR). 2012. Intimate Partner Abuse and Relationship Violence.


National Center for PTSD (2013) U.S. Department of Veterans Affairs


Tie S., Poulsen S., (2013). Emotionally Focused Couple Therapy with Couples Facing Terminal Illness. *Contemporary Family Therapy*


Appendix I

Informed Consent Form

Dear Madam,

I am a doctorate Student in Clinical Psychology at the United States International University, Africa (USIU- A). I am currently doing my research entitled “relationship between levels of Social Support and symptoms of PTSD and Depression among female survivors of intimate partner violence (IPV) in Kayole, Nairobi, Kenya”.

The study seeks to understand the relationship between mental health and social support in the life of a survivor in an intimate relationship. From this study we can put forward strategies to minimize Intimate Partner Violence (IPV) and at the same time highlight the role of society in relation to IPV.

I will kindly request of you to answer all questions pertaining to this research. However, you can personally withdraw from this exercise at any time that you feel uncomfortable to pursue with it. I will also like to assure you that your responses will be kept confidentially, since you will not be identified by name in my final report meant solely for academic research. Do not write your name on the questionnaire for confidentiality purposes. I wish now to seek your consent to proceed with the questions.

Thanks in advance,

Anthony Amissah

PsyD Candidate
Appendix II

**Socio-demographic Questionnaire (SDQ)**

This SDQ has 4 main questions. Kindly answer all questions, ticking the answer that appropriately fits you.

1. Age (years):
   - 18-27,
   - 28-37,
   - 38-47,
   - 48-60,

2. Highest Education levels:
   - No education;
   - Primary education;
   - Secondary education;
   - College education;
   - University education.

3. Marital status:
   - Married
   - Single,
   - Divorced/Separated,
   - Widowed/widower.

4. Type of employment:
   - Permanent
   - Casual
   - No work
Appendix III

The HITS screen

Date…………………………………..

Age…………………………………….

Kindly fill the form below using the 5 point scale. Each question is answered on a 5-point scale: 1 = never, 2 = rarely, 3 = sometimes, 4 = fairly often, 5 = frequently.

<table>
<thead>
<tr>
<th></th>
<th>How often does your partner physically hurt you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hurt</td>
<td>How often does your partner insult or talk down to you?</td>
</tr>
<tr>
<td>Insult</td>
<td>How often does your partner threaten you with physical harm?</td>
</tr>
<tr>
<td>Threaten</td>
<td>How often does your partner scream or curse at you?</td>
</tr>
<tr>
<td>Scream</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
</tr>
</tbody>
</table>

Each item is scored from 1-5. Thus, scores for this inventory range from 4-20. A score greater than 10 signify the participant is at risk of domestic violence abuse, and should seek counseling.

Clinical Research and Methods (Family Med 1998;30(7):508-12.)
Appendix IV

PTSD Check List-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month. In the past month, how much were you bothered by: Not at all (0); A little bit (1); Moderately (2); Quite a bit (3); Extremely (4).

1. Repeated, disturbing, and unwanted memories of the stressful experience? 0 1 2 3 4

2. Repeated, disturbing dreams of the stressful experience? 0 1 2 3 4

3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)? 0 1 2 3 4

4. Feeling very upset when something reminded you of the stressful experience? 0 1 2 3 4

5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)? 0 1 2 3 4

6. Avoiding memories, thoughts, or feelings related to the stressful experience? 0 1 2 3 4

7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)? 0 1 2 3 4

8. Trouble remembering important parts of the stressful experience? 0 1 2 3 4

9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)? 0 1 2 3 4

10. Blaming yourself or someone else for the stressful experience or what happened after it? 0 1 2 3 4

11. Having strong negative feelings such as fear, horror, anger, guilt, or shame? 0 1 2 3 4

12. Loss of interest in activities that you used to enjoy? 0 1 2 3 4

13. Feeling distant or cut off from other people? 0 1 2 3 4

14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)? 0 1 2 3 4
15. Irritable behavior, angry outbursts, or acting aggressively? 0 1 2 3 4
16. Taking too many risks or doing things that could cause you harm? 0 1 2 3 4
17. Being “super alert” or watchful or on guard? 0 1 2 3 4
18. Feeling jumpy or easily startled? 0 1 2 3 4
19. Having difficulty concentrating? 0 1 2 3 4
20. Trouble falling or staying asleep? 0 1 2 3 4

PCL-5 (14 August 2013) National Center for PTSD
Appendix V

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is placed at the end of the questionnaire. Read each of group statement and pick the one which best fits the way you have been feeling for the past two weeks including today. Tick the number beside the statement that best fits your feeling. In areas where several statements fits equally well in a group, you may tick the highest number in the group. Do not choose more than one statement in a group, including item 16 and 18.

1.
0 I do not feel sad.
1 I feel sad
2 I am sad all the time and I can't snap out of it.
3 I am so sad and unhappy that I can't stand it.

2.
0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel the future is hopeless and that things cannot improve.

3.
0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4.
0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5.
0 I don't feel particularly guilty
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6.
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7.
0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8.
0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9.
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10.
0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11.
0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.
0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.
0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.
0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.
0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.
0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.
0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.
0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3. I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

The scoring is done by adding up the number ticked for each of the twenty-one questions. The highest possible total for the whole test would be sixty-three. The lowest possible score will be zero. Depression can be evaluated according to the Table below.

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Levels of Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-13</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>14-19</td>
<td>Mild disturbance</td>
</tr>
<tr>
<td>20-28</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>29-63</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>
Appendix VI

Social Support Questionnaire (SSQ).

INSTRUCTIONS:
The following questions ask about people in your environment who provide you with help or support. Each question has two parts. For the first part, list all the people you know, excluding yourself, whom you can count on for help or support in the manner described. Give the person’s initials and their relationship to you (see example). Do not list more than one person next to each of the letters beneath the question.

For the second part, circle how satisfies you are with the overall support you have.

If you have no support for a question, check the words ‘No one,’ but still rate your level of satisfaction. Do not list more than nine persons per question. Please answer all the questions as best you can. All your responses will be kept confidential.

EXAMPLE:
Who do you know whom you can trust with information that could get you in trouble?

No one 1) T.N. (brother) 4) T.N (father) 7)
2) L.M (friend) 5) L.M (employer) 8)
3) R.S. (friend) 6) 9)

How satisfied?
6-very satisfied 5- fairly satisfied 4- a little satisfied 3- a little satisfied 2- fairly satisfied 1-very satisfied

dissatisfied dissatisfied dissatisfied

1. Whom can you really count on to listen to you when you need to talk?

No one 1) 4) 7)
2) 5) 8)
3) 6) 9)

How satisfied?
6-very satisfied 5- fairly satisfied 4- a little satisfied 3- a little satisfied 2- fairly satisfied 1-very satisfied

dissatisfied dissatisfied dissatisfied

2. Whom could you really count on to help you if a person whom you thought was a good friend insulted you and told you that he/she didn’t want to see you again?

No one 1) 4) 7)
2) 5) 8)
3) 6) 9)

How satisfied?
6-very satisfied 5- fairly satisfied 4- a little satisfied 3- a little satisfied 2- fairly satisfied 1-very satisfied

dissatisfied dissatisfied dissatisfied

3. Whose lives do you feel that you are an important part of?

No one 1) 4) 7)
2) 5) 8)
3) 6) 9)

How satisfied?
6-very satisfied 5- fairly satisfied 4- a little satisfied 3- a little satisfied 2- fairly satisfied 1-very satisfied

dissatisfied dissatisfied dissatisfied
4. Whom do you feel would help you if you were married and had just separated from your spouse?

   No one  1)   4)   7)
   2)   5)   8)
   3)   6)   9)

   How satisfied?
   6-very satisfied  5- fairly satisfied  4- a little satisfied  3- a little dissatisfied  2- fairly dissatisfied  1-very dissatisfied

5. Whom could you really count on to help you out in a crisis situation, even though they would have to go out of their way to do so?

   No one  1)   4)   7)
   2)   5)   8)
   3)   6)   9)

   How satisfied?
   6-very satisfied  5- fairly satisfied  4- a little satisfied  3- a little dissatisfied  2- fairly dissatisfied  1-very dissatisfied

6. Whom can you talk with frankly, without having to watch what to say?

   No one  1)   4)   7)
   2)   5)   8)
   3)   6)   9)

   How satisfied?
   6-very satisfied  5- fairly satisfied  4- a little satisfied  3- a little dissatisfied  2- fairly dissatisfied  1-very dissatisfied

7. Who helps you feel that you truly have something positive to contribute to others?

   No one  1)   4)   7)
   2)   5)   8)
   3)   6)   9)

   How satisfied?
   6-very satisfied  5- fairly satisfied  4- a little satisfied  3- a little dissatisfied  2- fairly dissatisfied  1-very dissatisfied

8. Whom can you really count on to distract you from your worries when you feel under stress?

   No one  1)   4)   7)
   2)   5)   8)
   3)   6)   9)

   How satisfied?
   6-very satisfied  5- fairly satisfied  4- a little satisfied  3- a little dissatisfied  2- fairly dissatisfied  1-very dissatisfied

9. Whom can you really count on to be dependable when you need help?

   No one  1)   4)   7)
   2)   5)   8)
<table>
<thead>
<tr>
<th>3)</th>
<th>6)</th>
<th>9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How satisfied?</td>
<td>How satisfied?</td>
<td>How satisfied?</td>
</tr>
<tr>
<td>6-very satisfied</td>
<td>5- fairly satisfied</td>
<td>4- a little satisfied</td>
</tr>
<tr>
<td>3- a little dissatisfied</td>
<td>2- fairly dissatisfied</td>
<td>1-very dissatisfied</td>
</tr>
</tbody>
</table>

10. Whom could you really count on to help you out if you had just been fired from your job or expelled from school?

<table>
<thead>
<tr>
<th>How satisfied?</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-very satisfied</td>
</tr>
<tr>
<td>3- a little dissatisfied</td>
</tr>
</tbody>
</table>

11. With whom can you totally be yourself?

<table>
<thead>
<tr>
<th>How satisfied?</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-very satisfied</td>
</tr>
<tr>
<td>3- a little dissatisfied</td>
</tr>
</tbody>
</table>

12. Whom do you feel really appreciates you as a person?

<table>
<thead>
<tr>
<th>How satisfied?</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-very satisfied</td>
</tr>
<tr>
<td>3- a little dissatisfied</td>
</tr>
</tbody>
</table>

13. Whom can you really count on to give you useful suggestions that help you to avoid making mistakes?

<table>
<thead>
<tr>
<th>How satisfied?</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-very satisfied</td>
</tr>
<tr>
<td>3- a little dissatisfied</td>
</tr>
</tbody>
</table>

14. Whom can you count on to listen openly and uncritically to your innermost feelings?

<table>
<thead>
<tr>
<th>How satisfied?</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-very satisfied</td>
</tr>
<tr>
<td>3- a little dissatisfied</td>
</tr>
</tbody>
</table>
15. Who will comfort you when you need it by holding you in their arms?

<table>
<thead>
<tr>
<th>No one</th>
<th>1)</th>
<th>2)</th>
<th>3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4)</td>
<td>5)</td>
<td>6)</td>
<td>7)</td>
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<tr>
<td>8)</td>
<td>9)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How satisfied?

| 6-very satisfied | 5- fairly satisfied | 4- a little satisfied | 3- a little dissatisfied | 2- fairly dissatisfied | 1- very dissatisfied |

16. Whom do you feel would help if a good friend of yours had been in a car accident and was hospitalized in serious condition?

<table>
<thead>
<tr>
<th>No one</th>
<th>1)</th>
<th>2)</th>
<th>3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4)</td>
<td>5)</td>
<td>6)</td>
<td>7)</td>
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<tr>
<td>8)</td>
<td>9)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How satisfied?

| 6-very satisfied | 5- fairly satisfied | 4- a little satisfied | 3- a little dissatisfied | 2- fairly dissatisfied | 1- very dissatisfied |

17. Whom can you really count on to help you feel more relaxed when you are under pressure or tense?

<table>
<thead>
<tr>
<th>No one</th>
<th>1)</th>
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<th>3)</th>
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</thead>
<tbody>
<tr>
<td>4)</td>
<td>5)</td>
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<td>8)</td>
<td>9)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How satisfied?

| 6-very satisfied | 5- fairly satisfied | 4- a little satisfied | 3- a little dissatisfied | 2- fairly dissatisfied | 1- very dissatisfied |

18. Whom do you feel would help if a family member very close to you died?

<table>
<thead>
<tr>
<th>No one</th>
<th>1)</th>
<th>2)</th>
<th>3)</th>
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</thead>
<tbody>
<tr>
<td>4)</td>
<td>5)</td>
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<tr>
<td>8)</td>
<td>9)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How satisfied?

| 6-very satisfied | 5- fairly satisfied | 4- a little satisfied | 3- a little dissatisfied | 2- fairly dissatisfied | 1- very dissatisfied |

19. Who accepts you totally, including both your worst and your best points?

<table>
<thead>
<tr>
<th>No one</th>
<th>1)</th>
<th>2)</th>
<th>3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4)</td>
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<tr>
<td>8)</td>
<td>9)</td>
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<td></td>
</tr>
</tbody>
</table>

How satisfied?

| 6-very satisfied | 5- fairly satisfied | 4- a little satisfied | 3- a little dissatisfied | 2- fairly dissatisfied | 1- very dissatisfied |
20. Whom can you really count on to care about you, regardless of what is happening to you?

No one 1) 4) 7) 2) 5) 8) 3) 6) 9)

How satisfied?
6-very satisfied 5-fairly satisfied 4-a little satisfied 3-a little dissatisfied 2-fairly dissatisfied 1-very dissatisfied

21. Whom can you really count on to listen to you when you are very angry at someone else?

No one 1) 4) 7) 2) 5) 8) 3) 6) 9)

How satisfied?
6-very satisfied 5-fairly satisfied 4-a little satisfied 3-a little dissatisfied 2-fairly dissatisfied 1-very dissatisfied

22. Whom can you really count on to tell you, in a thoughtful manner, when you need to improve in some way?

No one 1) 4) 7) 2) 5) 8) 3) 6) 9)

How satisfied?
6-very satisfied 5-fairly satisfied 4-a little satisfied 3-a little dissatisfied 2-fairly dissatisfied 1-very dissatisfied

23. Whom can you really count on to help you feel better when you are feeling generally down-in-the-dumps?

No one 1) 4) 7) 2) 5) 8) 3) 6) 9)

How satisfied?
6-very satisfied 5-fairly satisfied 4-a little satisfied 3-a little dissatisfied 2-fairly dissatisfied 1-very dissatisfied

24. Whom do you feel truly loves you deeply?

No one 1) 4) 7) 2) 5) 8) 3) 6) 9)

How satisfied?
6-very satisfied 5-fairly satisfied 4-a little satisfied 3-a little dissatisfied 2-fairly dissatisfied 1-very dissatisfied

25. Whom can you count on to console you when you are very upset?

No one 1) 4) 7) 2) 5) 8)
3) How satisfied?
6-very satisfied 5- fairly satisfied 4- a little satisfied 3- a little dissatisfaction 2- fairly dissatisfaction 1-very dissatisfaction

6) How satisfied?

9) How satisfied?

26. Whom can you really count on to support you in major decisions you make?

No one 1) 4) 7) 2) 5) 8) 3) 6) 9)

How satisfied?
6-very satisfied 5- fairly satisfied 4- a little satisfied 3- a little dissatisfaction 2- fairly dissatisfaction 1-very dissatisfaction

27. Whom can you really count on to help you feel better when you are very irritable, ready to get angry at almost anything?

No one 1) 4) 7) 2) 5) 8) 3) 6) 9)

How satisfied?
6-very satisfied 5- fairly satisfied 4- a little satisfied 3- a little dissatisfaction 2- fairly dissatisfaction 1-very dissatisfaction

**TO SCORE SSQ:**

1. Add total number of people for all 27 items. (max. is 243)
   Divide by 27 for per item score. This gives you SSQ Number Score, or SSQN

2. Total satisfaction scores for all 27 items. (max. is 162)
   Divide by 27 for per item score. This gives you SSQ Number Score, or SSQS

3. You can also add up total number of people that are family members and that can give the SSQ Family.