PSYCHOPATHOLOGY AND DYSFUNCTIONAL BELIEFS IN BATTERED WOMEN

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DECLARATION

I, the undersigned hereby declare that the work contained in this thesis is my own original work and has not previously in its entirety or in part been submitted at any other university for a degree.

OPSOMMING

Hierdie studie het die insidensie van depressie, post-traumatiese stressimptome, woede en skuldgevoelens in 'n groep van 40 vroulike slagoffers van gesinsgeweld, wat die huweliksverhouding verlaat het en in 'n skuiling vir mishandelde vroue opgeneem is, ondersoek. Die disfunksionele, evaluerende kognisies, soos deur die Rasioneel–emotiewe gedragsterapie gepostuleer, asook die korrelasie tussen hierdie kognisies en die simptome van psigopatologie, is ook ondersoek. Deelnemers het die Beck Depression Inventory, Post–traumatic Stress Diagnostic Scale, Anger Diagnostic Scale, Trauma-Related Guilt Inventory en Survey of Personal Beliefs voltooi.

Die resultate het aangedui dat 63% van die deelnemers matige tot ernstige vlakke van depressie getoon het, terwyl hoë post–traumatiese stressimptomatologie by 59% voorgekom het. Tussen 38% en 50% het probleme met woede getoon, terwyl matige skuldgevoelens by 48.5% voorgekom het. Oor die algemeen het hierdie simptome nie verband getoon met die ouderdom van deelnemers of met die duur of frekwensie van die mishandeling nie, behalwe die vlak van woede wat 'n verband getoon het met 'n geskiedenis van kindermolestering.

Tellings op die Survey of Personal Beliefs het aangedui dat die groep die disfunksionele, evaluerende kognisies van Self– en Ander-gerigte Eise, Katastrofering, Lae Frustrasie – toleransie en Negatiewe Selfwaarde getoon het. Slegs Lae Frustrasie–toleransie (onderskatting van hanteringsvaardighede) het beduidend met vlak van depressie, woede en skuldgevoelens gekorreleer.

ABSTRACT

This study investigated the incidence of depression, post-traumatic stress symptomatology, anger and guilt in a shelter sample of 40 battered women. In addition, the presence of dysfunctional, evaluative beliefs, as viewed from a Rational–emotive perspective, was investigated, as well as the relationship between dysfunctional beliefs and symptoms of psychopathology.

Participants completed the Beck Depression Inventory, Post-traumatic Stress Diagnostic Scale, Anger Diagnostic Scale, Trauma Related Guilt Inventory and Survey of Personal Beliefs.

It was found that 63% of the participants showed moderate to severe levels of depression, while 59% manifested high post-traumatic stress symptomatology. Between 38% and 50% experienced problems with anger whilst 48.5% showed moderate guilt. In general, these symptoms did not correlate with the age of participants or with the duration or frequency of abuse, except for anger which was related to a history of childhood sexual and/or physical abuse.

The results of the Survey of Personal Beliefs indicated that the group displayed Other- and Self–directed Demands, Awfulizing, Low Frustration-tolerance and Negative Self–worth. Only Low Frustration–tolerance (underestimation of coping skills) correlated significantly with levels of depression, anger and guilt.

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1. INTRODUCTION

Domestic violence, and more specifically, spouse abuse, is an internationally recognized problem. Women may be abused on several levels: physically, sexually, emotionally, verbally or economically. The term 'battered women' does however carry a physical connotation and for the purposes of this study a battered women is considered to be any woman who has been subjected to serious and/or repeated physical injury as a result of deliberate assaults by her spouse (Hilberman 1980). Gelles (quoted in Welch, 1987) conducted a survey of 2000 American subjects and found that violence between family members occurs in 50% of American families. Antonopoulou (1999) conducted a survey amongst 676 Greek social psychology students. She reported that 230 (34%) of the women had been exposed to or had been victims of domestic violence. Of the women who had experienced violence themselves, two thirds had been battered by their spouse and one third by their father. According to the Russian Federation's 1994 report, (in Horne, 1999) the official 1993 figures for domestic violence were as follows: out of a total of 331 815 women, 14 500 (4,3%) were killed by their male partners and another 56 400 (17%) were injured. By the end of 1995 a further report stated that the number of women killed by their partners had surpassed 16 000. In South Africa, Marais, de Villiers, Möller and Stein (1999) found that 21,5% of a group of 1050 women visiting their general practitioner reported a history of domestic violence whilst Jacobs (in Blaser, 1998) found that 50% of women attending the Mitchell's Plain Day Hospital reported having been abused at some stage by their partners. A similar figure was reported by Abrahams (in Blaser, 1998) who interviewed a random group of male municipal workers in Cape Town and found that 46% admitted to using force / violence against their partners at some stage. A further South African study by Jewkes, Penn-Kekana, Levin, Ratsaka and Schreiber (1999) showed that in a sample of 2232 randomly selected women from households across three provinces the prevalence rate of having been physically abused by a current or ex-partner was 26,8% (Eastern Cape), 28,4% (Mpumulanga) and 19,1% (Northern Province). Welch (1987), however, cautions that there are two major points to be kept in mind when viewing statistics concerning spouse abuse. Firstly, that spouse abuse is generally more under reported than rape and secondly that statistics from police departments may be inaccurate due to domestic violence sometimes being categorized as assault, harassment or disturbing the peace.

Partner abuse is generally a recurrent event with the result that, in addition to physical trauma, the victims suffer from ongoing psychological degradation. This degradation may lead to various clinical syndromes. Those syndromes most frequently associated with battering are

post-traumatic stress disorder (PTSD), depression, anxiety disorders, and substance abuse (Hall Smith & Gittelman, 1994). Apart from these clinical syndromes, survivors of battering are also at risk for developing a range of negative after-effects of varying degrees, including passivity, fatigue, low self worth, a sense of hopelessness and despair, agitation, sleep disturbances, various somatic complaints as well as both anger and guilt (Hilberman, 1980).

A survey of the literature revealed only two studies which have examined the psychological and emotional effects of battering on South African women (Marais et al, 1999 and Jewkes et al, 1999). A need exists for further research on the psychological sequelae of battering.
The primary objective of the study was therefore to investigate the incidence of PTSD and depression as well as the levels of anger and guilt in a South African sample of physically abused women, and to determine whether these psychological reactions are associated with specific dysfunctional beliefs as postulated by the theory of Rational-Emotive Behaviour Therapy (REBT). The extent to which demographic variables such as age, duration of abuse, and childhood sexual or physical abuse are associated with the existing psychological reactions was also investigated.

1.1 Post-traumatic stress disorder (PTSD) in battered women

Battered women have been identified as being at risk for the development of post-traumatic stress disorder (PTSD) (Kemp, Green, Hovanitz, & Rawlings, 1995). In order to diagnose PTSD according to the DSM IV (APA, 1994) six criteria need to be satisfied:

A: Exposure to (an) identifiable, life threatening, traumatic event(s)

B: Recurrent re-experiencing of the event in the form of distressing recollections, dreams or a sense of reliving of the event(s)

C: A tendency to avoid any stimuli associated with the event(s)

D: Increased arousal symptoms such as sleep disturbances, irritability, decreased concentration and hypervigilence

E: The symptoms must be present for more than one month. (A shorter duration of symptoms allows a diagnosis of Acute Stress Disorder).

F: The symptoms of PTSD must create significant impairment in daily functioning.

Houskamp and Foy (1991) assessed a sample of 26 battered women by means of a structured clinical interview and found that 45% of the women met the requirements for PTSD according to the DSM III-R criteria (APA, 1987). Astin, Lawrence and Foy (1993) assessed 53 battered women for PTSD using two standardized self-report questionnaires: the PTSD Symptom Checklist and the Impact of Events Scale (IES). The results of the PTSD Symptom Checklist yielded a positive PTSD rate of 55%, whilst the IES yielded a positive PTSD rate of 58%

However, Astin et al. (1993) only assigned a positive PTSD diagnosis to those women who met the diagnostic criteria on both measures. This conservative criterion resulted in 33% of the women being diagnosed as PTSD positive. Kemp, Rawlings and Green (1991) reported a positive PTSD rate of 84% in their shelter sample of 77 battered women. However, a non-standardized clinical interview was used and it was administered within the first three days after arriving at the shelter, which may have inflated the figure of 84% (Astin et al., 1993). Each of these studies reported a positive correlation between PTSD symptomatology and severity of violence. In a South African sample of 226 battered women, research using a self-report questionnaire, found the incidence of PTSD to be 35,3% (Marais et al., 1994). A survey of the literature revealed no South African figures for PTSD symptomatology in a shelter sample.

Studies correlating the frequency, severity and chronicity of battering with PTSD symptoms have yielded conflicting results. Hall Smith and Gittelman (1994) found that the severity of PTSD symptoms correlated positively with the severity and chronicity of the battering, whereas Kemp et al. (1991) found that PTSD symptoms were positively correlated to frequency and severity, but that chronicity of the battering relationship did not correlate with PTSD symptomatology.

Previous research examining the association between PTSD and a history of childhood physical or sexual abuse in battered women has shown that there is no significant relationship between these variables (Stoebner, Johnson, Combs, & Nash, 1999). However, Kemp et al. (1991) and Kubany, Abueg, Owens, Brennan, Kaplan and Watson (1995) reported that PTSD and depression are closely associated in battered women.

1.2 Depression in battered women

According to Orava, McLeod and Sharpe (in Kubany, 2000) battered women are at increased risk for developing depression. Cascardi and O'Leary (1992) found that 52% of a sample of battered women seeking counselling scored above 20 on the Beck Depression Inventory (i.e. moderate to severe depression), and that as the number, form and consequences of the battering increased so did the women's depressive symptomatology. Campbell, Kub, Belknap and Templin (1997) reported that 28% of their sample of battered women presented with moderate to severe depression (as measured by scores of above 20 on the BDI), and that 11% presented with severe depression as measured by scores of above 30 on the BDI. They also found that physical abuse is an important part of the etiology of depression in battered women and that the abuse, in combination with daily hassles, supports a stress explanation of

depression with the women's ability to take care of herself as a protective factor. In addition childhood physical abuse was shown to be a significant predictor of depression.

Kubany et al. (1995) found that 50% of a shelter sample of battered women presented with at least moderate to severe depression (scores above 19 on the BDI). In a recent South African study, Marais et al. (1999) found that major depression, as defined by the DSM IV, (APA, 1994) was found in 48,2% of women who had a history of domestic violence. This, however, was not a shelter sample. A literature review revealed no South African figures on the incidence of depression in a shelter sample of battered women.

1.3 Anger in battered women

A survey of the literature revealed that very little research has been done on the incidence of anger in battered women. Hilberman (1980) maintains that battered women rarely experience their anger directly although their experiences elicit anguish and outrage in the listener. She further maintains that it is probable that the constellation of passivity, guilt, intense fear of the unexpected and violent nightmares reflected not only fear of another assault but a constant struggle with the self to contain and control aggressive impulses. The violent encounter with another person's loss of control of aggression precipitates great anxiety about one's own controls. Hilberman (1980) claims that fear of loss of control is a universal concern amongst battered women. A minority of women have lost control of their aggressive impulses and become homicidal whilst other women fantasized detailed plans for murdering their husbands. However she reported that battered women's aggression was most consistently directed against themselves in the form of suicidal behaviour, depression, alcoholism or self-mutilation. She further asserts that the passivity and the denial of anger do not imply that the battered women has adjusted to or likes her situation but that these are the last desperate defences against homicidal rage.

1.4 Guilt in battered women

Guilt is a common emotional response to battering and has been identified as such by several authors. Klass (1988) claims that the aftermath of physical assault on women, such as battering, rape and incest, frequently includes intense guilt. Resick (quoted in Klass, 1988) reported that battered women often feel guilty about their inability to help their assailants refrain from battering. Self-blame and causality (or responsibility) are closely related constructs to guilt. Self-blame carries a moral evaluation that, if judged negatively, can result in feelings of guilt. Self-blame can therefore be seen as a precursor to guilt, and self- blame may lead abused women to feel worthless and to experience depression and learned helplessness. Self-blame has been cited as a cause as well as a maintenance factor in

depression (Abramson, Seligman, & Teasdale, 1978). In contrast, causality may or may not result in guilt feelings. Responsibility (or causality) for the event may allow the woman to feel that she has some kind of control over her situation and she may, in fact, cope better (Holtzworth-Munroe 1988). This line of thinking was expanded on by Janoff- Bulman (1979) with respect to rape victims: if the rape could be attributed to one's own behaviour, then the locus of control is internal and a further rape could be avoided by behaving in a different manner. However, Dutton, Burghardt, Perrin, Chestman and Halle (1994) as well as Cascardi and O'Leary (1992) found that this 'adaptive mechanism' was not evident in battered women.

2. DOMESTIC VIOLENCE FROM A COGNITIVE PERSPECTIVE

2.1 Attributions of blame in domestic violence

A survey of the literature produced a considerable number of articles that deal with the attribution of blame in domestic violence. It was found that factors such as the duration, frequency, and severity of abuse, as well as whether or not the woman was still in the relationship, influenced the attribution of blame.

2.1.1 Duration, frequency and severity of abuse

Miller and Porter (1983) argued that self-blame shifted to partner-blame with increasing severity, frequency and duration of abuse. This view was supported by Frieze (quoted in Cascardi & O'Leary, 1992), who showed that 19% of women blamed themselves for the first episodes of violence, whilst only 9% blamed themselves for the violence in general. The higher incidence of self-blame in the early stages may represent an attempt to save the marital relationship, whereas the shift to partner-blame may be due to an emotional break in the relationship. Cascardi and O'Leary (1992) found that, in their sample of 33 battered women, only 12% blamed themselves for causing their partner's violence and that neither self-blame nor partner-blame was associated with the length of abuse or the frequency and severity of physical aggression. However, self-blame was marginally associated with depression.

2.1.2 Cohabitation

Andrews and Brewin (1990) found that the attributions for blame changed with marital circumstances. They found that women currently living with violent partners reported the highest rate of self-blame and women no longer living with such a partner reported a significant shift from self-blame to partner-blame. Several authors (Frieze, 1987; O' Leary, Curley, Rosenbaum & Clarke, 1985; Shields & Hanneke, 1983; Walker, 1984 [quoted in

Holtzworth-Munroe, 1988]) questioned women who were still in the relationship and women who had actually left the relationship. A striking similarity in results across the two sets of women where achieved, suggesting that being in the relationship or having left the relationship did not alter the attributions of blame.

2.1.3 Other factors

O'Leary et al (1985) showed that 33% of their sample of battered women blamed themselves for their partners' behaviour and this was attributed to their own assertiveness or disagreement with their partner.

Holtzwoth-Munroe (1988) found that women generally do not blame themselves for their husband's violence. She found that the causes were more complex, with women citing more than one cause for the violence, for example, women often blame themselves, their partners, situational factors or certain aspects of the interaction within the relationship.

2.2 REBT perspective on domestic violence

REBT holds that dysfunctional, evaluative beliefs are at the root of psychological problems. These dysfunctional beliefs can be divided into four categories: Demandingness (which is the inflexible, dogmatic, unrealistic demands of self and others), Awfulizing (the overestimation of the seriousness of an event or stressor), Negative ratings of human worth and Low Frustration-tolerance (an underestimation of one's coping skills) (Walen, DiGiuseppe, & Dryden, 1992). However, Ellis's most recent writings (quoted in Walen et al., 1992) proposed that all emotional disturbances share the single root of demandingness. The consequence of unfulfilled demands is emotional discomfort.

2.2.1 Cognitions and post-traumatic stress disorder

REBT stresses that PTSD is created by the patient's dysfunctional or dysfunctional, evaluative beliefs and by their frequently avoiding and numbing themselves to the severe pain of their traumatic experience (Ellis, 1994). Such individuals may have beliefs such as the following: " I should be invulnerable to and not overreact to traumatic events", "I should have behaved better during the events", "The world should be just", or "I should act well in practically all situations in order to accept myself as a 'good' person" (Ellis, 1994).

To relate this general theory of PTSD to domestic violence one might also expect dysfunctional, evaluative beliefs similar to those described by Ellis (1994) in relation to rape victims: "This thoroughly unfair act absolutely should not have occurred (Demandingness)", "I should have somehow prevented it from happening (Demandingness) and therefore the world is a horrible place (Awfulizing)", and " I, as one who did not do as I supposedly should have

done, is an inadequate person (Negative human rating)". These dysfunctional thoughts, in addition to the physical trauma, may make the woman feel appropriately concerned and fearful as well as inappropriately devastated and self-downing. In the present study the dysfunctional evaluative beliefs postulated by REBT were investigated by means of the Survey of Personal Beliefs (see section 4.2.5). It was expected that physically abused women with high levels of PTSD symptomatology would show lower scores on the Survey of Personal Beliefs (denoting more dysfunctional beliefs) for Self-worth, Self-directed Shoulds, Other-directed Shoulds and Awfulizing, compared to battered women with low PTSD symptomatology.

2.2.2 Cognitions and depression

Ellis (in Walen et al., 1992) suggests three cognitions associated with depression. Firstly, a firm belief in one's personal inadequacy (Negative self-rating), secondly, the 'horror' of not having what one 'needs' (Demandingness) and thirdly, the 'awfulness' of the way things are (Awfulizing).

Beck (1963) found that depressed patients differed from non-depressed patients in the prominence of certain themes; viz. low self -regard, ideas of deprivation, overwhelming problems and duties, self criticisms and self-blame, self commands and injunctions and wishes to escape or die. Hauck (1971), following the REBT theory of depression, attributes all psychological depression to three factors: self-blame, self-pity and other-pity.

It was expected that, in the present study, battered women with higher levels of depression would show lower scores on the Survey of Personal Beliefs for Negative self-worth, Self-directed Shoulds and Awfulizing compared to battered women with low levels of depression.

2.2.3 Cognitions and anger

According to REBT theory, anger occurs as a result of unfulfilled demands aimed at other people or objects. Walen et al. (1992) differentiated between anger as a healthy and appropriate reaction to various life circumstances and clinical anger, which is based on dysfunctional beliefs that interfere with goal-directed behaviour. Ellis (in Walen et al.,1992) describes clinical anger as a series of demands: firstly a judgment of right and wrong which reflects an absolutist kind of moral indignation and secondly, a demanding, absolutist 'should' directed outwards towards others. DiGiuseppe, Tarfrate and Echardt (1994) proposed that beliefs that interfere in resolving clinical anger include:

- Lack of emotional responsibility and blame: This refers to the failure to take responsibility for one's own emotions and the tendency to assign responsibility for emotions to outside events, for example "He made me angry".

- Condemnation of others: This refers to the idea that the target of one's anger is a totally worthless human being and is deserving of the anger.
- Self–righteousness: The transgressor is portrayed as morally wrong while the patient sees him or herself as the aggrieved party.
- Cathartic expression: Many clients believe that great anger outbursts are healthy and necessary. However Tavris (in DiGiuseppe, et al., 1994) concluded that this theory has failed to gain empirical support.
- Anger expression as an effective way to control others: Anger outbursts are reinforced by significant others as there is a tendency to comply with the angry demands, However, this is a short term gain, as the significant others remain resentful, bitter and distant.

In the present study it was expected that battered women with high levels of anger would endorse Other-directed Shoulds and Negative rating on the Survey of Personal Beliefs to larger extent than would battered women with low levels of anger.

2.2.4 Cognitions and guilt

REBT theory holds that guilt arises from dysfunctional beliefs of Demandingness directed at oneself, for example " I should have been able to keep the family together" or "I should have known better than to argue with him". Ellis (in Klass, 1998) maintains that REBT considers guilt feelings as the result of the dysfunctional beliefs that personal worth is contingent on correct behaviour and that people who violate standards are bad and should be punished. According to this view, guilt feelings express not only recognition of personal wrongdoing but unwarranted self-evaluation. Ellis considers guilt to be a poor regulator of behaviour in that it leads to self-punitive rumination and defensive denial instead of actions that remedy or prevent transgressions. He speculated that humans tend to equate negative evaluation of behaviour with negative evaluation of self. Such negative evaluations of the self would easily lead onto dysfunctional beliefs of poor self-worth that would facilitate the onset of depression. It was expected that battered women with high levels of guilt would, to a significantly larger extent, endorse Self-directed Shoulds and Negative rating than would battered women with low levels of guilt.

3. OBJECTIVES AND HYPOTHESIS

As indicated, a review of the research literature indicated that only a few South African studies have investigated the prevalence of physical abuse against women and it's psychological sequelae. In addition, very little research has been done from a cognitive perspective on the understanding of the psychological consequences of battering, particularly from a Rational-emotive perspective. Consequently, the primary objective of this study was to investigate the incidence of PTSD and depression, as well as the levels of anger and guilt, in a South African sample of physically abused women, and to determine whether these psychological reactions are associated with specific dysfunctional, evaluative beliefs as postulated by REBT. It was hypothesized that battered women:

- with high PTSD symptomatology would endorse significantly more Negative self-worth, Self-directed Shoulds, Other-directed Shoulds and Awfulizing than battered women with low PTSD symptomatology;
- with higher levels of depression would show more Negative self-worth, Self-directed Shoulds and Awfulizing, compared to battered women with low levels of depression;
- with higher levels of anger would, to a larger extent, endorse Other-directed Shoulds and Negative rating than battered women with low levels of anger, and
- with high levels of guilt would, to a significantly larger extent, endorse Self-directed Shoulds and Negative rating than battered women with low levels of guilt.

4. METHOD

4.1 Participants

The sample consisted of 40 women who had been in a physically abusive, heterosexual relationship and had subsequently left that relationship. At the time of the study they were all residing in protective shelters. These included: The Arc Place of Refuge, Sisters Incorporated, Carehaven Shelter, Saartjie Baartman Center for Battered Women and the Beitun-Ragma Shelter for Muslim Women, all of which are in Cape Town or the surrounding areas.
In order to be included in the study, the women had to have been in a physically abusive relationship, which they had subsequently left, and also to be able to read and write either English or Afrikaans.
Biographical data (age, marital status, highest grade passed, duration of the abusive relationship, duration and frequency of abuse, and whether or not the respondent was physically or sexually abused as a child) was obtained by means of a biographical questionnaire and is presented in Table 1.

Table 1 indicates that the respondent's ages ranged between 18 and 53 years (mean age = 35 years). A large proportion of the sample (33%) left school after completing grade 10, while 15.4% completed only a primary school education (grade 7), and 15,4% obtained a grade 12 education. The language distribution between English and Afrikaans was approximately equal, while only 3 participants were Xhosa speaking. Fifty percent of the women were married at the time of the study, whilst in 33% of the cases the abuse took place outside of a marital relationship. The duration of abuse ranged from less than 4 years to above 11 years, with 25.7% of the women reporting having been abused for 11 years or more. The frequency of the abuse varied, with the largest proportion of participants reporting weekly abuse (47.4%). The category "other" received replies such as "When he felt like it" or "It varied from daily to monthly".

Table 1

Biographical Data of the Sample

	n	%	Cumulative %
Age			
51 – 60	2	5.0	100.0
41 – 50	10	25.0	95.0
31 – 40	15	37.5	70.0
18 – 30	13	32.5	32.5
Highest Educational Grade passed			
Tertiary education	2	5.1	100.0
Grade 12	6	15.4	94.9
Grade 11	1	2.6	79.5
Grade 10	13	33.3	76.9
Grade 9	7	17.9	43.6
Grade 8	4	10.3	25.6
Grade 7	2	5.1	15.4
Grade 6	3	7.7	10.3
Grade 5	1	2.6	2.6
Home Language			
Afrikaans	20	50.0	
English	17	42.5	
Xhosa	3	7.5	
Duration of the relationship			
11 years or more	13	32.5	100.0
5 to 10 years	14	35.0	67.5

4 years or less	13	32.5	32.5
Duration of abuse within the relationship			
11 years or more	9	25.7	100.0
5 to 10 years	12	34.3	74.3
4 years or less	14	40.0	40.0
Frequency of abuse			
Daily	9	23.7	
Weekly	18	47.4	
Monthly	7	18.4	
Other (mostly weekends only)	4	10.5	
Childhood physical abuse			
No	21	56.8	
Yes	16	43.2	
Childhood sexual abuse			
No	18	48.6	
Yes	19	51.4	

Note: frequencies not adding up to a total of 40 are due to 'non-respondents' for that particular item.

Apart from the biographical questionnaire, participants completed the following instruments (in the order in which they are presented here).

4.2 Measuring Instruments

4.2.1 Beck Depression Inventory (BDI; Beck,Ward, Mendelson, Mock, & Erbaugh, 1961)

The BDI is a 21 item self-report questionnaire that measures the cognitive and behavioural symptomatology of depression experienced over the preceding week. Each question has four possible answers that are measured on a Likert-type scale ranging from 0 to 3. A guideline for the interpretation of the total test score, which serves as an indication of the severity of depression, is as follows:

0-9: normal score

10-15: mild depression

15-19: mild-moderate depression

20-29: moderate-severe depression

30-63 severe depression

The psychometric properties of the BDI have been examined extensively in clinical and non-clinical populations. The accumulated evidence strongly supports the BDI as a reliable and valid indicator of the severity of current depression (Beck, Steer, & Garbin, 1988). Mean

coefficients alpha of 0.86 and 0.81 were reported for psychiatric and non-psychiatric patients respectively. The validity of the BDI was tested against clinical ratings as well as scores on the Hamilton Rating Scale for Depression (HRSD). Mean correlation of BDI scores with clinical ratings and HRSD scores were 0.72 and 0.73 respectively for psychiatric patients. For non-psychiatric samples corresponding correlations of 0.60 and 0.74 respectively were reported.

4.2.2 Post Traumatic Stress Diagnostic Scale (PDS; Foa, 1995)

The PDS is a 49 item self-report instrument designed to aid in the detection and diagnosis of PTSD. The first section determines the nature of traumatic event that the participant has experienced but for the purposes of this study the women were briefed that the trauma referred to in the questionnaire was specifically the trauma of domestic violence. The second section determines the presence and severity of the DSM-IV diagnostic criteria for PTSD (APA, 1994). The PDS divides the DSM-IV criteria into six categories: exposure to the traumatic event, re-experiencing symptoms, avoidance symptoms, arousal symptoms, duration and onset of symptoms and impairment in daily functioning. This second section was scored on the PDS hand-scoring worksheet (Foa, 1995).

The PDS has demonstrated satisfactory reliability and validity on victims (N=248) of a wide range of traumatic incidents (Foa, Casman, Jaycox & Perry, 1995). The internal consistency, as measured by coefficients alpha, was 0.92 for the total PTSD score, 0.78 for the re-experiencing symptom cluster, 0.84 for the avoidance symptom cluster and 0.84 for the arousal symptom cluster. The intercorrelations among the three symptom clusters and the total PTSD score ranged between 0.72 and 0.94. The test-retest reliability (mean interval of 16 days) of the PTSD diagnosis was assessed using kappa as a chance-corrected measure of agreement. A kappa of 0.74 was obtained and the percentage agreement was found to be 87%. The convergent validity of the PTSD diagnoses, obtained from the PDS, was assessed by comparing them to the diagnoses obtained from the Structured Clinical Interview for the DSM-III-R (SCID). A kappa of .65 between the PDS and SCID was obtained, with 82% agreement between the two measures.

4.2.3 Anger Disorder Scale (ADS; DiGuiseppe & Tafrate, 2001)

The ADS assesses clinical populations for anger problems. It gives a general measurement of anger and is not specifically related to anger in battered women or to specific incidents. Thus, in the present study, the women were asked to respond to the questions in a manner that reflects how they usually feel or act when they are angry. It is a 74 question self-report inventory. Each question has five possible answers that are graded on a Likert-type scale between 1 and 5. The 74 questions can be divided into 2 higher order factors: anger-in and

anger-out, plus 5 subscales: relational aggression, selfish motives, revenge motives, passive aggression and indirect aggression. Only the total anger score was used in the present study. The total anger score can be translated into a percentile score for qualitative assessment (DiGiuseppe & Tafrate, 2001). There are three qualitative categories of clinical significance. Firstly, a score that falls within the top three percentile represents strong dysfunctional anger and this is equivalent to a total ADS score of 247 and above. Secondly, a score that falls into the top ten percentile represents clinically interpretable anger and this is equivalent to a total ADS score of 209 and above. Thirdly, Deffenbacher (in DiGiuseppe & Tafrate, 2001) suggests a more lenient cut-off for identifying people with high anger. Following his research using the STAXI (Spielberger, 1988), Deffenbacher and other researchers have found that people in the top quartile differ from low anger people on certain variables. Thus the top quartile may also be used to separate high anger from low anger respondents.

The internal consistency of the total scale is reflected by a Cronbach's alpha of 0.95. Test-retest reliability coefficients over a one month period were shown to be in the range of 0.82 to 0.91(DiGiuseppe & Tafrate, 2001).

4.2.4 Trauma Related Guilt Inventory (TRGI; Kubany, Haynes, Abueg, Manke, Brennan & Stahura, 1996).

The TRGI is a 32-item self-report questionnaire with three scales and three subscales. The scales include a 4-item global guilt scale, a 6-item distress scale and a 22-item guilt cognitions scale. The subscales, which correspond to cognitive factors, include a 7- item hindsight bias/ responsibility subscale, a 5-item wrongdoing scale and a 4-item lack of justification scale. Only the total score was used in this study. Each question has a choice of 5 answers that are graded on a Likert-type scale between 0 and 4. An answer of 0 indicates no guilt feelings and an answer of 5 indicates high guilt feelings. The total score thus ranges between 0 and 160. In order to qualitatively assess the degree of guilt the total score is divided by the total number of questions, i.e. 32. This results in an average individual question score. An average individual question score above 1,75 is considered to be 'moderate to greater guilt' and a score above 2,75 is considered to be 'considerable guilt'. The questionnaire's instructions state that the respondent should think of a single, typical traumatic (i.e. abusive) incident and should respond to the questions in a manner reflecting how she felt in connection with that one incident. In the present study therefore, scores reflect the degree of guilt experienced by the women specifically related to an abusive incident.

The TRGI was tested for internal consistency with a sample of battered women (Kubany et al., 1996). The coefficients alpha computed for the global guilt, guilt cognitions and the distress scales were: 0.90, 0.86 and 0.86 respectively. Coefficients alpha for the hindsight bias/

responsibility, wrongdoing and lack of justification subscales were: 0.82, 0.75 and 0.67 respectively. In validity studies involving battered women the TRGI scales and subscales were significantly correlated with other measures of guilt, PTSD, depression and other indexes of adjustment. The TRGI was also found to be valid across ethnic groups (Kubany et al., 1996).

4.2.5 Survey of Personal Beliefs (SPB; Kassinove, 1986)

This questionnaire measures the incidence and intensity of the dysfunctional, evaluative beliefs as postulated by REBT. It assesses the presence of these beliefs in general and not specifically in relation to physical abuse. The SPB is composed of 50 questions and is divided into five categories with 10 questions in each category. The five subscales represent the five categories of dysfunctional beliefs, namely: Awfulizing (AWF), Self-directed Shoulds (SDS), Other-directed Shoulds (ODS), Low Frustration-tolerance (LFT) and Self-worth (SW). Each question is graded on a Likert-type scale from 1 to 6. The scores vary from 10 to 60 per subscale and from 50 to 300 for the total questionnaire. A low score is indicative of dysfunctional thinking. The reliability of the SBP total and subscale scores was measured by means of Cronbach's coefficient alpha on a sample of 280 non-clinical adult subjects (Demaria, Kassinove, & Dill, 1989). The following alpha values were found: Awfulizing: 0.67; Self-directed Shoulds: 0.63; Other-directed Shoulds: 0.57; Low Frustration-tolerance: 0.72; Self-worth: 0.66 and the total SPB score: 0.89. Factor analysis by Demaria et al. (1989) confirmed the validity of the five first order factors and the higher order total SPB score. The construct validity of the SPB has been established by Nottingham (1992). His study showed that the total SPB score demonstrated moderate correlations with other well-established measures of depression (the BDI and the Automatic Thoughts Questionnaire), of hopelessness (Beck Hopelessness Scale) and of anxiety (Beck Anxiety Inventory). The AWF, SDS, LFT and SW subscales also demonstrated moderate correlations with measures of dysphoria, although the ODS subscale did not. Although there are no standardized norms for this questionnaire, Muran, Kassinove, Ross and Muran (1989) collected the following data (from a college sample of 60 students and a sample of 45 adult mental health patients) that will be used as a comparative base for the present study. The mean scores of these sample groups for each of the subscales of the SPB are given in brackets, with the college sample score first followed by the mental health patient score. Awf. (24.5; 24); SDS (26; 24.5); ODS (31.3; 29.2); LFT (31.2; 27.8); SW (29.4; 27.5) and total mean score (142.3; 133).

4.3 Procedure

At each of the shelters involved in the study, the social worker was approached and the nature and objectives of the study were explained. The social workers then approached the women to ask for volunteers for the study. After the women had been recruited by the social workers, they completed the questionnaires under the supervision of the researcher, either individually or in small groups of approximately 5 women. The sessions were conducted in either English and/or Afrikaans as indicated by the preference of the participants. At the beginning of each session the objectives of the study were again briefly explained and consent for participation was confirmed. The individual questionnaires were then explained to the women and it was determined whether they preferred to work through the questionnaires by themselves or if they wished the questions to be read out to them. Most preferred to work by themselves and to ask for assistance if necessary. Assistance was given in such a manner as to offer no new information. Each session took approximately 2 to 3 hours. Although most of the women became visibly tired, no respondent gave up before completing the questionnaires.

5. RESULTS

The results of this study are presented in two sections. In the first section the incidence of psychopathology (i.e. level of depression, PTSD symptomatology, clinical anger and guilt), as well as the association between these symptoms and the participants' age, duration and frequency of abuse and childhood physical and sexual abuse is presented. In the second section the relationship between the measures of psychopathology and dysfunctional, evaluative beliefs is presented.

5.1 Psychopathology

5.1.1 Depression

Internal reliability for the BDI was found to be within acceptable limits (alpha = 0 .92). Level of depression, in terms of BDI scores, is shown in Table 2.

Table 2

Level of Depression (N = 35)

BDI	n	%
0-9 (normal)	3	8.50
10-15 (mild depression)	5	14.20
16-19 (mild-moderate)	5	14.20
20-29 (moderate-severe)	6	17.10
30-63 (severe depression)	16	46.00

Table 2 indicates that of the 35 women who completed the BDI only 8.50% experienced a level of depression within normal limits, while the majority (63%) experienced moderate to severe or severe depression.

The association of level of depression with age and duration and frequency of abuse was investigated by means of F-tests, while the association of level of depression with childhood physical and sexual abuse was investigated by means of t-tests. The results are shown in Tables 3 and 4 respectively.

Table 3

Association of Level of Depression (BDI) with Age and Frequency and Duration of Abuse

	n	Mean BDI score	F	df	p
Age (N = 35)					
41-53	9	25.78	.07	2, 34	.94
31-40	15	27.33			
18-30	11	28.18			
Duration of abuse (N=32)					
4 years or less	11	31.73	2.68	2, 31	.09
5 to 10 years	12	28.75			
11 years or more	9	18.56			
Frequency of abuse (N=31)					
Daily	9	29.33	1.44	2, 30	.26
Weekly	15	31.87			
Monthly	7	20.71			

Table 3 indicates no significant differences between the different age groups in terms of level of depression. Duration and frequency of abuse were also not significantly related to level of depression. Table 4 indicated that participants with a history of childhood physical and sexual abuse obtained mean BDI scores of 31.79 and 30.18 respectively, indicating severe depression, while those without a history of childhood abuse showed mean BDI scores of 23.83 and 22.50 for physical and sexual abuse, indicating moderate to severe depression. This difference, however, was not significant.

Table 4

Association of Level of Depression (BDI) with Childhood Physical and Sexual Abuse

	Mean BDI score	SD	t	df	p
Physical abuse (n=14)	31.79	13.61	1.55	30	.13
No physical abuse (n=18)	28.83	14.88			
Sexual abuse (n=17)	30.18	14.77	1.55	31	.13
No sexual abuse (n=16)	22.50	13.64			

5.1.2 Post-traumatic stress symptomatology

Participants were divided into a high and a low post-traumatic stress symptomatology group according to their responses on the PDS, as shown in Table 5.

Table 5

Incidence of High and Low Post-traumatic Stress Symptomatology (N=39)

PTSD symptoms	n	%
Low	16	41.00
High	23	59.00

Table 5 indicates that of the 39 women who completed the PDS, 59% showed a high level of post-traumatic stress symptoms.

The association of post-traumatic stress symptomatology with age and duration and frequency of abuse as well as it's association with childhood physical and sexual abuse was investigated by means of χ^2. The results are shown in Table 6.

Table 6 indicates that post-traumatic stress symptomatology was not associated with age, duration and frequency of abuse or childhood physical or sexual abuse.

Table 6

Association of Post-traumatic Stress Symptomatology with Age, Frequency and Duration of Abuse and Childhood Abuse

	High PTSD symptomatology n	Low PTSD symptomatology n	χ^2	df	p
Age					
41-53	8	4	.70	2	.71
31-40	9	6			
18-30	6	6			
Duration of abuse					
4 years or less	10	3	4.17	2	.12
5 to 10 years	7	5			
11 years or more	3	6			
Frequency of abuse					
Daily	5	4	.25	2	.88
Weekly	11	6			
Monthly	4	3			
Child phys. abuse	10	5	.74	1	.39
No child phys. abuse	11	10			
Child sexual abuse	10	9	.27	1	.60
No child sexual abuse	11	7			

5.1.3 Anger

The internal reliability of the total ADS was shown to be 0,978. The mean ADS score for the sample of battered women was 181.5 (SD = 58.09), indicating that the group as a whole fell into the top quartile which, according to the criteria postulated by Deffenbacher (in DiGiuseppe & Tafrate, 2001) indicates that the group experienced problems with anger. According to the cut-off points described by DiGiuseppe and Tafrate (2000) 3 participants (9%) fell into the category of strong dysfunctional anger (97^{th} percentile and above, i.e. total ADS score 247 and above). Ten participants (29.4%) showed clinical anger (90^{th} – 97^{th} percentile, i.e. total ADS score between 209 and 246). This indicates that 38.4% of the participants experience problems with anger. If, however, Deffenbacher's criteria (in DiGiusepe & Tafrate, 2001) are used, then 50% of the women (n=17) fell into the top quartile and would be considered to have problems with anger.

The association of level of anger with age and duration and frequency of abuse was investigated by means of F-tests, while the association of level of anger with childhood physical and sexual abuse was investigated by means of t-tests. The results are shown in Tables 7 and 8 respectively.

Table 7

Association of Level of Anger (ADS) with Age and with Duration and Frequency of Abuse

	n	ADS mean score	F	df	p
Age (N= 34)					
41-53	10	185.20	2.29	2, 33	.12
31-40	13	157.15			
18-30	11	205.82			
Duration of abuse (N=30)					
4 years or less	11	196.00	3.68	2, 29	.04*
5 to 10 years	10	191.40			
11 years or more	9	140.67			
Frequency of abuse (N=29)					
Daily	7	166.71	1.49	2, 28	.25
Weekly	17	203.35			
Monthly	5	163.00			

* p<.05

Table 8

Association of Level of Anger (ADS) with Childhood Physical and Sexual Abuse

Childhood abuse	n	ADS mean score	SD	t	df	p
Physically abuse	15	209.13	63.45	2.98	29	.01*
No physical abuse	16	152.69	40.20			
Sexual abuse	16	201.44	60.47	2.90	29	.01*
No sexual abuse	15	147.60	39.95			

*p< .05

Table 7 indicates that age and frequency of abuse were not related to level of anger. Levels of anger differed significantly in terms of duration of abuse, as a shorter duration was associated with higher anger levels and vice versa. Significant differences in level of anger were also

associated with a history of childhood abuse. Participants who reported childhood physical and/or sexual abuse experienced significantly higher anger levels than participants without a history of childhood abuse.

5.1.4 Guilt

Results for the TRGI showed an internal reliability of 0.87. The mean TRGI score for the group was 58.42 (SD=20.88), which translates into a mean individual question score of 1.82. As moderate guilt is represented by a mean individual question score of between 1.75 and 2.75, the mean score of 1.82 indicates that the group, as a whole, could be considered to experience moderate guilt. Of the 33 women who completed the TRGI, 15 (45.5%) fell into the category of less than moderate guilt (individual question score below 1.75) and 16 (48.5%) fell into the category of moderate guilt (individual question score between 1.75 and 2.75). Only 2 women (6%) fell into the category of considerable guilt (individual question score above 2.75). The association between level of guilt with age and duration and frequency of abuse was investigated by means of F-tests (Table 9), and the association between guilt and childhood abuse was investigated by means of t-tests (Table 10).

Table 9

Association of Guilt (TRGI) with Age and Duration and Frequency of abuse

	n	Mean TRGI score	F	df	p
Age (N=33)					
41-53	11	67.36	2.43	2, 32	.11
31-40	12	49.08			
18-30	10	59.80			
Duration of abuse (N=30)					
4 years or less	12	59.50	0.13	2, 29	.88
5 to 10 years	10	55.60			
11 years or more	8	55.38			
Frequency of abuse (N=29)					
Daily	7	59.86	1.41	2, 28	.26
Weekly	15	63.53			
Monthly	7	46.86			

Table 10

Association of Guilt (TRGI) with Childhood Physical and Sexual Abuse

Childhood Abuse	n	Mean TRGI score	t	df	p
Physical abuse	12	63.17	1.21	28	.24
No physical abuse	18	53.50			
Sexual abuse	16	60.88	0.82	28	.42
No sexual abuse	14	54.29			

Tables 9 and 10 indicate that the degree of guilt, as measured by the TRGI, was not significantly associated with age, duration and frequency of abuse, or with childhood physical or sexual abuse.

5.2 Symptoms of psychopathology and dysfunctional, evaluative beliefs

The following alpha coefficients for the subscales of the Survey of Personal Beliefs, which measure the dysfunctional, evaluative beliefs postulated by REBT, were calculated for this sample of battered women: Awfulizing: 0.59, Self-directed Shoulds: 0.44, Other-directed Shoulds: 0.25, Low Frustration-tolerance: 0.42 and Self-worth: 0.41. The overall internal reliability of the questionnaire was 0.67. Due to these low figures any correlations between symptoms of psychopathology and SPB scores must be interpreted with caution.

Mean scores and standard deviations for subscale scores on the SPB are shown in Table 11.

Table 11

Mean Scores of the Survey of Personal Beliefs for the Total Sample

SPB	N	M	SD
Awfulizing	40	23.50	6.58
Self-directed Shoulds	38	23.66	6.39
Other-directed Shoulds	36	26.11	5.36
Low Frustration-tolerance	39	26.82	6.19
Self-worth	38	24.95	6.53
Total	33	122.30	18.63

This table indicates that the mean scores for the subscales of the SPB range between 23.50 and 26.82 with the total mean score being 122.30.

In order to investigate the relationship between symptoms of psychopathology and the dysfunctional, evaluative beliefs postulated by REBT, Pearson correlations were computed between the scores on the BDI, ADS, TRGI and scores on the SPB (Table 12), whilst participants with high and low PTSD symptomatology were compared in terms of their SPB scores by means of t-tests (Table 13).

Table 12

Pearson Correlations between SPB Scores and Scores on the BDI, TRGI and ADS

	Awf.	SDS	ODS	LFT	SW	SPB Total
BDI	.28	.16	.13	-.51**	.11	.13
ADS	.18	.23	.06	-.50**	.07	.01
TRGI	.18	-.01	.01	-.40*	.07	-.03

* p>.05

** p>.01

Table 13

Comparison of High and Low PTSD Subgroups on Mean SPB Scores

	PTSD Symptomatology						
	High		Low				
SPB	M	SD	M	SD	t	df	p
Awf	23.91	7.06	22.38	5.75	0.72	37	.48
SDS	24.05	5.63	22.60	7.43	0.67	35	.51
ODS	26.70	4.37	25.67	6.59	0.56	33	.58
LFT	27.09	6.27	27.13	5.80	0.02	36	.98
SW	26.23	6.68	23.07	6.28	1.45	35	.16
Total	124.95	19.35	118.23	18.28	0.99	30	.33

Table 12 indicates that the only SPB subscale showing a significant association with the psychopathology measures was the LFT. This subscale showed a significant negative relationship with level of depression, anger and guilt. This indicates that lower frustration tolerance (underestimation of coping skills) was associated with higher levels of depression, anger and guilt. No significant association between PTSD symptomatology and SPB scores were found (Table 13).

6. DISCUSSION

The results of this study have shown that, in a shelter sample of battered women, only 8.5% (n=3) fell within the normal limits of depression as indicated by a score below 10 on the BDI. A further 63% (n= 22) reported moderate to severe depression (above 19 on the BDI), whilst 46% (n= 16) reported severe depression (above 29 on the BDI).

This figure showing 63% of battered women to be moderately to severely depressed is higher than previously reported American figures. Cascardi and O'Leary (1992) found that 52% of battered women seeking counselling scored above 19 on the BDI, whilst Kubany et al.(1995) reported that 50% of battered women in a shelter sample scored above 19 on the BDI. In South Africa, Marais et al. (1999) found that 48,2% of battered women in a community sample were suffering from major depression as defined by the DSM 1V (APA, 1994). A literature search produced no South African figures for the level of depression in a shelter sample of battered women with which to compare the findings of this study. However, the result of 63% of participants experiencing moderate to severe depression indicates a dire need for psychological support for these women.

High post-traumatic stress symptomatology was found in 59% (n=23) of the women. This is consistent with previous overseas research results. Houskamp and Foy (1991) reported a positive PTSD rate of 45% in a group of women seeking counseling, whilst Kemp et al. (1991) reported a 84% positive PTSD rate in shelter sample. Research of the literature produced no South African figures for PTSD symptomatology in a shelter sample of battered women. However, Marais et al. (1999) found a positive PTSD rate of 35,3% in a community sample of battered women. Once again, the results of this study indicate the need for psychological support for these women.

According to the criteria set by DiGiuseppe and Tafrate (2001), 38.4% (n=13) of the participants experienced problems with anger; 29,4% (n=10) of which may be categorized as having clinical anger and 9% (n=3) of which as having strongly dysfunctional anger. According to Deffenbacher's criteria, 50% (n= 17) of the participants have problems with anger. Thus it seems as if between 38% and 50% of the sample experienced problems with anger. Unfortunately, a survey of the research literature revealed no previous studies with which to compare the incidence and levels of anger in battered women.

In this study the group as a whole experienced moderate guilt. Only 6% (n=2) of the participants reported experiencing considerable guilt, whilst 48.5% (n=16) reported experiencing moderate guilt. The research literature reporting on the incidence of guilt is

complicated by various factors, for example, the severity, frequency and duration of abuse as well as whether the couple are still cohabiting. However, taking these factors into account reports of between 9% (Frieze in Cascardi & O'Leary, 1992) and 33% (O'Leary et al., 1985) of battered women blame themselves for the abuse. It is speculated that the higher figure in this study may be as a result of the women having recently left their homes and thus possibly feeling responsible for splitting up the family.

Regarding the relationship between biographical variables and symptoms of psychopathology, no relationship was found between age and psychopathology. Neither did duration or frequency of abuse correlate with symptoms of psychopathology, except for duration of abuse that correlated with anger: a longer duration of abuse was associated with a lower level of anger. This is an unexpected result and needs further exploration. Similarly, there was a tendency for the level of depression to decrease as the duration of abuse increased but this was not significant. The level of anger was also associated with a history of childhood abuse: a higher level of anger correlated with a history of physical and/or sexual abuse. A tendency was also found for participants with a history of childhood physical or sexual abuse to experience higher levels of depression, but this was not significant. In general, the biographical variables did not correlate with symptoms of psychopathology, except for anger.

The results of this study did not support the hypotheses that specific psychological reactions would be related to specific dysfunctional, evaluative beliefs as postulated by REBT. However, a relationship was found between LFT and scores on the BDI, ADS and TRGI, indicating that LFT (underestimation of coping skills) is related to higher levels of depression, anger and guilt (but not to PTSD symptomatology). It could be speculated that the women who had dysfunctional thoughts of Low Frustration-tolerance i.e. "I cannot stand it when..." would be the women who would be most likely to express discomfort about symptoms of depression or of feeling excessively angry or guilty, whereas other women, with higher tolerance, would not have mentioned the symptoms as they believed that they were able to cope with the discomfort. As a group, the women reported low scores on each of the SPB subscales as well as the SPB total score, indicating the presence of Self-directed demands, Other-directed demands, Awfulizing, Low Frustration-tolerance and Negative rating in this sample of battered women.

During the course of this research project several limitations became evident. Firstly, the study was very broad in nature and the sample size of 40 was relatively small in relation to the number of variables included in the study. It would possibly have been more beneficial if a

simpler design with fewer variables had been used. This would have had the added benefit of decreasing the fatigue experienced by the women during the 2 to 3 hour sessions. Secondly, only the psychological reactions and dysfunctional, evaluative beliefs of women who had already left the abusive relationship were examined, thus generalizability to all battered women is restricted. Thirdly, the only inclusion criteria for this study were that the women had to have been in a physically abusive relationship and that they were able to read and write Afrikaans or English. More accurate results may have been achieved if two further criteria had been added: a time limit for the length of time out of the abusive relationship and a criterion stating a minimum level of education. If the study had been limited to women who had left the relationship within the last three months then the uncertainty, which some women felt in answering the questionnaires, would have been reduced. Several of the women who had been out of the relationship for a longer period of time claimed that they felt very differently at the time of the study compared to how they had felt after they had recently left the relationship. This created a degree of confusion as to how they should answer the questionnaires i.e. as they were feeling in the present time or how they had felt after they had left the relationship. Generally, the directions for the BDI, PTSD, ADS and SPB were to respond as they were feeling at the time of the study, while the guilt inventory was specifically related to how they had felt about a 'battering incident' which in the case of some women might have happened a year or more ago and whilst they might have felt a degree of guilt at that time they did not feel any guilt at the time of the study. Similarly, several of the women claimed to have suffered PTSD symptoms in the past but were presently free of symptoms. The minimum level of education criterion, possibly eight years of formal education, would have eased the process as it was found that certain of the questions were phrased in a complicated manner that required a higher degree of concentration and understanding of the language. The women who, generally speaking, had a lower standard of education took longer (between two and two and a half hours) and needed frequent help with the questions.

The poor reliability of the Survey of Personal Beliefs was a disappointment as it rendered the correlations between the psychopathology questionnaires (BDI, PTSD, ADS and TRGI) and the SPB) unreliable. What this highlighted, however, was that the SPB has limited use in a sample of this nature. Various reasons can be hypothesized in an attempt to explain this fact. Firstly, the questions are presented in words and phrases that are significant to REBT, but these same words and phrases have a different meaning in 'every day', colloquial use of language. For example, 'There are times when awful things happen' (question number 10) or "I just can't take a lot of pressure and stress" (question number 24) are good examples of phrases which are commonly used in day-to-day language Thus an ignorance of the implication of the use of this

type of language in an REBT context may well have contributed to the unreliability of the answers. Secondly, confusion may also have arisen due to the wording of the questions. For example ' Absolutely, my friends and family should treat me better than they sometimes do (question number 48). This is a categorical statement which begs a categorical answer i.e. agree or disagree, yet the questionnaire calls for a graded answer on a scale between 1 and 6 (1 being "totally agree" and 6 being "totally disagree"). Thirdly, the questions are presented in a manner that requires a degree of mental acuity, for example, 'Even if they had promised, and it was important to me, there is no reason why my friends have to do what I want'. It is to be kept in mind that 76.9 percent of these women had 10 years or less of formal education, 63% of the women were depressed and 59% were suffering from PTSD. A fourth factor, which is more a limitation of the procedure followed rather than of the SPB, is that this measure was presented at the end of the questionnaire battery. Although the motivation for this was for the other questionnaires to act as priming agents for the beliefs elicited by the SPB, fatigue may well have played a larger role thereby reducing the reliability of the SPB. The above factors placed great restrictions on the use of this questionnaire. A simpler form of this questionnaire would be an interesting option to pursue in future studies of this nature.

CONCLUSION

In conclusion, the most relevant finding of this study is the high incidence of severe depression and PTSD amongst abused women in the Cape Town shelters. This result, in addition to the fact that many of women joined the study hoping for some kind of psychological help, highlights the desperate need for psychological support in this sector of the community.

It was found that anger was significantly related to several variables: prior childhood abuse, both sexual and physical, and the duration of abuse. This is a finding that deserves further exploration.

Although the original hypotheses of specific psychological reactions being related to specific dysfunctional, evaluative beliefs were not confirmed, the overall low scores on the SPB are indicative of a general tendency towards irrational beliefs in battered women. This study has, however, brought into question the usefulness of the Survey of Professional Beliefs across all population groups. It is suggested that a simpler form of this questionnaire be explored.

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