Impact of Cognitive Behavioral Therapy on Women Exposed to Domestic Violence in Kibra Sub-County, Nairobi City County-Kenya

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DECLARATION

This PhD thesis is my original work and has not been presented to any other college, institution or university for examination.

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To my late parents, Perminus and Alice Njogu Chacha, who encouraged and supported their children to attain the highest level of education. May God rest and keep your souls in eternal peace.

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ABSTRACT

The study was to determine the impact of Cognitive Behavioral Therapy (CBT) among women exposed to domestic violence within Kibra Sub-County, Nairobi City County. The problem of domestic violence is on the increase with cases of assaults being reported on daily basis. This study embarked on finding out how this menace can be mitigated using CBT. In order to achieve the goal of the research, it was important to establish the various forms of domestic violence among the study participants; assess the influence of demographic variables on domestic violence; determine the association of domestic violence with anxiety and depression; establish efficacy of CBT in reducing the levels of anxiety and depression among the intervention group; explore factors associated with the level of effectiveness of CBT, and lastly, establish the impact of CBT on domestic violence among the study population. The study was a mixed method research of both quantitative and qualitative approaches. The target population was women aged 18 years and above living within Kibra Sub-County who had been exposed to domestic violence. A representative survey was done in selected health facilities within Kibra Sub-County leading to a sample size of 166 participants. The study achieved 155 participants, 45 for intervention and non-intervention groups, and 110 participants for Focus Group discussions (FGDs) since eleven participants failed to turn up. Quantitative data was collected using different questionnaires. The data was analyzed applying three approaches: Univariate; Bivariate; and Multivariate Analysis (MANCOVA). The qualitative approach was done using In-depth Interviews with eight key informants and FGDs. Qualitative data was transcribed and analyzed using thematic and content analysis. Cronbach Alpha was used to test for reliability of the study tools. Research findings show people mostly affected by domestic violence are women and children. Domestic violence occurs mostly when there is a misunderstanding between partners. The findings show that perpetrators of domestic violence are controlling, on the other hand victims are people who feel worthless and inferior. Eight in ten women (80%) suffer emotional and psychological abuse, economic coercion, physical violence and sexual assault. Only 62% women experience the use of children to control them. Various factors trigger domestic violence especially previous relationships and cultural expectations. The study shows social demographics influence the occurrence of different forms of domestic violence. Sexual assault is highly influenced by household income, while economic coercion is influenced by number of children. Use of children to control the partner is highly influenced by age and marital status. There is a significant association of domestic violence with anxiety and depression because domestic violence leaves victims with negative effects especially depression and anxiety. Findings show that women cope with domestic violence mostly by persevering and few others opt for counseling. The effectiveness of CBT depends on various factors especially the number of sessions attended. Research findings show that African cultural tailored CBT has both short-term and long-term impact on the lives of women exposed to domestic violence and psychological disorders. As part of recommendations for effectiveness of CBT, clients need to attend a minimum of 14 to 16 sessions. In addition, support systems available need to restructure the strategies of alleviating the negative impacts of domestic violence.

DEFINITION OF TERMS

Cognition: The mental process of acquiring and using knowledge that includes awareness and thinking.

Cognitive Behavior Therapy (CBT): Cognitive Behaviour Therapy is based on assumption that a systematic change of one's self-statements results into a corresponding reorganization of one's feelings, thoughts and behavior (Arnkoff & Glass, 1992; Weishaar, 1993).

Cognitive Restructuring: This is a psychotherapeutic technique that gets the client to think about their problems in constructive and rational way leading to personality restructuring.

Domestic Violence (DV): This is also referred to as domestic abuse, family violence, dating abuse, spousal abuse, battering, and intimate partner violence (IPV). It is a pattern of behavior involving abuse of one partner against the other in an intimate relationship such as marriage, dating, cohabitation, or within the family (Dutton, 1996).

Abuse/Assault: This terms are commonly used interchangeably referring to unacceptable behaviour towards another person which infringes on their rights.

Physical abuse: actions which cause body physical injuries such as hitting, biting, among others.

Sexual abuse: This occurs when one of the partners is forced into sexual activity when they are not ready or they are prevented from using birth control measures. Sexual assault also includes fondling and exposure to indecent acts to family members who are not of age or willing.

Psychological and Emotional abuse: any type of abuse that makes an individual to have mental anguish, low self-esteem and confidence, which is experienced when one is humiliated, isolated, followed, stalked, not allowed to be independent among others.

Financial coercion: leaving one partner out of decision making on money expenditure or an attempts to use money and other extravagances to control the other partner.

Verbal assault: This occurs when one a person uses derogatory language against another. Sometimes it involves non-verbal communication.

Neglect: This is when the perpetrator does not play the expected roles of providing for the basic need. It often involves failure to provide the family basic commodities.

Mental Disorder: This is a state of having severely disturbed behavioral patterns, thoughts, or feelings, that are usually taken to exclude cases disordera that arise from low intelligence, strokes or other direct brain injuries. (DSM-5, 2013).

Mixed methods research: Mixed methods research is an approach or methodology focusing on both quantitative and qualitative approaches (Creswell, Johnson et al 2007).

Psychotherapy: An art that encompasses any and all professional techniques and activities that are undertaken to resolve human psychological challenges or problems.

Counseling: This a process or a situation where two or more people with different ways of perceiving their social, emotional or psychological environment, come together in a helping relationship, where one is a client and the other a counselor.

Counseling and Psychotherapy: The two terms are used interchangeably for the purpose of this study. The difference between counseling and psychotherapy is not distinct. In Counseling, the counselor's goal is to empower the client change a specific behavior whereas the psychotherapist's goal is to restructure the client's personality, and reorganization of a client's adaptive resources, and to live more authentically, acceptably and making the right decisions (McLeod, 2003). In both cases, healing is achievable.

Variable: This are characteristics or attributes that can be measured, observed and vary among the people or organizations being studied (Creswell, 2007). There are different types of variables such as independent variables, dependent variables, moderating variables and intervening variables.

Independent variables: These are variable that the researcher has control over for example the application of CBT to treat anxiety and depression.

Dependent variables: These are variables which are affected by the introduction of the independent variable for example reduction of anxiety and depression after CBT.

Intervening Variables: These are variables functioning in a theoretical model which mediates the effects of the independent variables to the dependent variables. Sometimes there could be several intervening variables interacting with each other (Creswell, 2007).

Intervention Research: It is designed to measure the impact of a deliberate change to a functioning system. For instance this research aims at reducing levels of anxiety and depression among the participants.

Psychosomatic Disorders: These are any physical disorders whose cause is either partial or whollypsychological (Kendal & Hammen, 1995).

Population: Generally population is a total set of researcheable values from which the research sample is obtained.

Sample size: This is a part of the whole population selected randomly to represent the entire population on which data has been gathered.

Systematic Sampling: It is the method of selecting the 10^{th} person, as a participant in the study. This is also done when selecting a sample of 200 from a population of 200,000 names, then every thousandth name would be selected until the sample of 200 names would be completed (Creswell, 2007).

ABBREVIATIONS

A-B-C-:	A-actual events, B-belief system, C-consequences
CBT:	Cognitive Behavior Therapy
C&P:	Counseling and Psychotherapy
CTG:	Childhood Traumatic Grief
DSM:	Diagnostic Statistical Manual
DV:	Domestic Violence
FGIG:	Focus Group Interview Guide
FGDs:	Focused Group Discussions
GBV:	Gender Based Violence
HADS:	Hospital Anxiety Depression Scale
ICD:	International Classification of Diseases
IPV:	Intimate Partners Violence
KDHS:	Kenya Demographic and Health Survey
KNBS:	Kenya National Bureau of Statistics
KNH:	Kenyatta National Hospital
PD:	Psychological Disorders (Anxiety and Depression)
PH:	Psychological Health
SRS:	Systematic Random Sampling
TFT:	Trauma Focused Therapy

CHAPTER ONE
INTRODUCTION

1.0 Introduction

This study's main objective was to examine the effectiveness of Cognitive Behavioral Therapy (CBT) among women exposed to domestic violence (DV). The study focused on how CBT can be of use in mitigating the side effects of domestic violence within Kibra Sub-County of Nairobi City, Kenya. This chapter provides the background to the study, statement of the problem, objectives of the study, research questions, justification of the study, significance of the study, scope of the study, assumptions, and limitations of the study.

1.1 Background to the Study

Violence is generally known to be within human domains of interactions (Claassen, 2014). It is known to be common in human interactions, and it affects people directly when they are the victims, and indirectly when they witness the event. According to Claassen (2014), violence exists against other social, national, ethnic, racial and religious groups, affecting human lives negatively. In many African states and other parts of the world, there are many victims of political and ethnic cleansing and nepotism, who are suffering due to exposure to violence. Such violence is referred to as communal violence and it causes trauma that subsequently may lead to psychological disorders such as anxiety and depression. There are several forms violence, but this research is concerned with domestic violence, which is seen to be on the rise, as reported in the media (Moses et al., 2010).

A study by Kendall and Hammen (2011) posits that domestic violence is common within societies that are mainly patriarchal. It is a violence that occurs in a home setting, that is, between intimates partners, family members and close allies. This problem alters individual's lifestyle, as it also causes posttraumatic stress disorders (PTSD). The most affected people world-wide by domestic violence are women and girls (Kendall & Hammen, 2011). Women and girls are also commonly victimized in other social places such as schools and workplace. Generally, they suffer outright discrimination in public sectors and economic endeavors. According to Kendall and Hammen (1995), domestic violence is the leading cause of fatalies in families and globally. On a daily basis women and children live in perpetual fear of not knowing what will happen next. The most common forms of domestic

violence are physical violence (slaps, pushing, banging, and whipping, among others), spousal abuse, and sexual assault (Kendall & Hammen, 2011). Evidence based research reports show that cases of domestic violence are rarely reported as a result of challenges to obtaine accurate information. For example, unless specifically asked, women do not volunteer information about their physical and sexual abuse ordeals, perhaps due to fear of contempt and suspicion that the cause of the violence was their fault (Kendall & Hammen, 2011). Domestic violence can also be an economic form of abuse when one intimate partner (IP) makes attempt to control the other partner's access to economic resources. This reduces the victim's capacity to support him/herself forcing him or her to depend on the perpetrator financially (Adams et al., 2008).

Attitude towards domestic violence involves perception, cognizance, description and documentation which varies from one country another and from generation to another hence the need for intervention. For example, the laws for preventing domestic violence vary by country. While domestic violence has been illegal in the Western world, for years but it has not been the case in developing nations (Ivana & Oleg, 2005). For example, in 2010, the United Arab Emirates Supreme Court passed a ruling that a man has the right to physically discipline his wife and children as long as there are no physical injuries left on their bodies, regardless of the psychological pain that goes with physical injuries.

According to Ivana and Oleg (2005*)* and the United Nations International Education Children's Fund (UNICEF), 90% of women between the age of 15 to 49 years in Afghanistan and Jordan thought that a husband was justified to hit or beat the wife under certain circumstances. In Africa, some countries such as Mali report 87%, Guinea (86%), Lagos (81%) and Central African Republic (80%) of physical assault directed at women and girls. Declining to submit to a husband's requirements is a reason given to validate domestic violence in developing nations. For instance, 62.4% of women in Tajikistan excuse wife beating if the wife goes out without the partner. When a wife argues with her husband, there is a 68% chance of being beaten and when she declines to have sex with him a chance of 47.9%.

In most African cultures, men had a legal right to use violence to punish their wives and children. Compared to many European countries, this legal right was removed in the late 19th and early 20th centuries. In the 1970s, arrests on criminal offences for domestic violence were very rare, and it only occurred in cases of extreme violence. It was only in the 1990s that vigorous enforcement of laws against domestic violence became a standard policy, but only in the Western countries (Clarke &

Kris, 2013). Due to violence in families, women, children and other family members are affected emotionally and psychological (Kendall & Hamman, 2011). This attests to the existence of trauma and depressive disorders among the otherwise healthy society, especially women. According to Briere and Scott (2006), child abuse and neglect have often been observed in women with conversion and somatization disorders. These studies show that there is a close link between severe traumatic experiences and somatization.

Domestic violence has been associated with the commonly known psychological disorders such as anxiety, depression, hysteria, eating disorders, suicidal tendencies, and schizophrenia, among others (Briere, 1996; Ogbuji, 2015). While some perpetrators are known to be psychologically disturbed, any form of violence causes psychological trauma to the victim and in many cases of violence, women and children are the most affected (Ogbuji, 2015). The main common factors that trigger domestic violence are control and power by the heads of households, egoism, financial status, loss of trust, and jealousy. People who have been exposed to domestic violence struggle in their lives, display post-syndrome effects, both personally and professionally (Briere, 1996).

Lack of skills in emotional self-management, interpersonal skills, and social-problem-solving skills are imminent in those exposed to domestic violence. Victims and perpetrators of domestic violence are found to benefit from allied training approaches that show positive effects when addressed, with a reasonably high degree of reliability. Most communities are confused about whether to consider domestic violence a legal or a social problem, while institutions and agencies are known to respond to the needs of women and children who fear for their lives by providing temporary shelter and secret accommodations (Briere, 1996). Many communities are also still experimenting with legal reforms in dealing with issues such as whether to arrest the violent spouses or parents even if the victim does not prefer charges against them. However, psychological services to such women and children are limited and rarely evaluated systematically for their effectiveness. Hence, Cognitive Behavioral Therapy (CBT) has shown a remarkable impact on recovery from domestic violence (Kazdin, 2001).

Domestic violence is another form of Gender-Based Violence (GBV) and is a global problem. Reports from Kenya Demographic and Health Survey (KDHS, 2008-9) revealed that 39% of married, separated or divorced women who are aged between 15 to 49 years reported to have suffered violence during their life time. In Kenya Gender-based violence is frequently caused by unequal power relations between men and women, socio-cultural norms which normalize GBV, discriminatory

practices and changing gender roles (National Policy for Prevention and Response to GBV, 2014). Factors associated with the problem are inclusive poverty, illiteracy, alcohol and substance abuse, insecurity, as well as uncensored media content. Political conflicts and instability as well as poor law enforcement and policies contribute to violence (National Policy for Prevention and Response to GBV, 2014).

It is a fact that anybody exposed to violence needs a therapeutic environment for calming, support of emotions and fostering of expression. This enables one to cope with feelings and crisis situations, reducing intense depression incidents, emotions such as anxiety, fear, and tension. Furthermore, there are concerns regarding safety planning, need for housing and other family changes that might result. Therefore, cognitive behavioral therapy would be the appropriate intervention for this research as also supported by Creswell and Clark (2011), to alleviate the problems resulting from domestic violence. One cannot overemphasis that domestic violence has serious consequences on the lives of women, families and countries. The experience is that the abused become abusers at a later stage in life (Black et al., 2011; Dutton, 1994).

Despite its popularity, cognitive behavioral therapy has not yet been highlighted to show its effectiveness in clinical practice, particularly in Kenya. According to Craighead (1994), learning experiences, or failure to receive or profit from various learning experiences, accounts for the behavioral patterns of an individual. Therefore, a good behavioral modification model is one that provides learning experiences that promote adaptive and pro-social behavioral patterns. Hence, cognitive behavioral therapy involves training clients to engage in certain behaviors in order for them to learn new modes of behavior.

This research was crucial to confirm the current state of affairs in the treatment of cases of domestic violence using CBT. This research, therefore, focused on the efficacy of CBT on women exposed to domestic violence and who have developed psychological disorders, mainly anxiety and depression that may result from it. The researcher identified Kibra Sub-County in Nairobi City because the phenomenon of domestic violence is a common occurrence among residents of Kibra and other parts of Kenya (Kimuna & Djamba, 2008; Swart, 2008).

1.2 Statement of the Problem

The research gap is that the use of CBT as a therapy has not been tested as an effective therapy in treating cases of women exposed to domestic violence despite CBT having been in use in Africa for several decades. For example, in Kibra and other parts of Kenya, there has not been such a study in the recent times to test the effectiveness of CBT. The cases of domestic violence have frequently been reported in local dailies and on radio and television. This shows there is a rise of domestic violence in not only Kibra but Kenya in general, a menace which has to be addressed. Some of the victims choose to go for therapy in secrecy while others, out of ignorance, do not seek therapy at all, even as their situation deteriorates to the extent of being psychologically classified as sufferers of anxiety and depression.

The research aimed at examining the effectiveness of CBT in overcoming the negative effects of various forms of domestic violence, which is reported to be on the rise. This is because the therapeutic techniques and theories available have not sufficiently addressed the menace of domestic violence in Kenya, particularly in Kibra. The researcher sought to investigate how CBT can help to alleviate suffering among Kibra women exposed to domestic violence, and to generalize the success rate to the rest of the regions of Kenya and Africa. Hence, this research aimed at examining the effectiveness of cognitive behavioral therapy (CBT) in reducing or alleviating anxiety and depression in women exposed to domestic violence.

Of interest to note, CBT techniques have been in use for several decades in other parts of Africa and the world, hence one would expect to find reports showing its success or failure rate, which is not the case. Currently, there is scarcity of research work on the use of CBT to treat cases of domestic violence in Kibra other regions of Kenya, despite the frequent occurrences of domestic violence. Seemingly, there is an academic gap between theory and practice in counselling and psychotherapy. Therefore, this study focused on engaging a CBT which is culturally tailored in line with different forms of domestic violence experienced in Kibra, and Kenya in general, in order to solve the psychological disorders manifest among the study participants.

It is largely known that domestic violence is on the rise in Kibra and many other parts of Kenya and the world in general (Moses et al., 2010). People experience violence which leaves them traumatized and injured. Others lose lives. The laws in place help to somewhat curb the situation, but the real

causes and negative effects of domestic violence, in particular anxiety and depression, remain unattended to in most cases. The study investigated how CBT can help women facing domestic violence to avoid psychological disturbances. Furthermore, it was necessary to establish whether there are factors that influence the occurrence of domestic violence among the study participants. Whenever the psychological problems caused by domestic violence are not addressed in good time, they transform from acute to chronic conditions in which the affected individual loses the capacity to perform ordinary duties and becomes a burden to the immediate family members and the society. Therefore, there was need to examine the intervention to apply after an experience of domestic violence, because women are also exposed to many other forms of challenges in life, including their responsibilities in the society.

Domestic violence occurs in trusting environments, especially among family members, close friends and between neighbors. When this problem occurs, it is poorly reported or kept secret by the victims for various reasons such as stigma, fear of the perpetrator, among others. Consequently, the victims are affected psychologically; they develop psychological disorders such as anxiety and depression. Their families are equally affected and destroyed by the developing disturbances, and they are never the same again. Furthermore, the maltreatment of women, who are the "backbone of the society", by the perpetrators, is a risk factor for diverse psychopathology and other deleterious outcomes for a healthy nation and families, hampering the expectations of the Kenya Vision 2030. Hence, the researcher accentuated the effects of domestic violence and the significance of CBT after a traumatizing experience. This means that therapy to reduce levels of anxiety and depression is crucial. Therefore, due to rampancy of domestic violence, the researcher had to investigate and apply therapy to the victims using CBT.

Dimensions of social conditions thought to be risk factors such as women's social status, gender norms, socioeconomic development roles, among others, pose difficulties especially across cultures, and hence understanding domestic violence, requires research in many social contexts. Similarly, despite the recent scale-up of mental health care and treatment programs in Kenya, mental health research shows there is need to develop new and more effective methods of treatment. Therefore, this could be one of the reasons why uptake of psychotherapy and counseling services in various facilities has been low, which warranted further investigations, and hence the need for this research.

Research reports show that there is a clear urgency to identify, disseminate, and implement effective psychosocial treatments for maltreated women, in a timely manner. This is because early life maltreatment in an individual is associated with abnormality in brain development and physical illnesses, which is why domestic violence needs deeper investigation and treatment. One bad experience or learning leads to another, for instance the perpetrator of domestic violence may have been abused in childhood (Black et al., 2011).

In addition, counseling centers do not seem to be quite effective in addressing the psychological disorders emanating from domestic violence. The reason identified to account for this problem is that victims of domestic violence opt to go to health facilities for medical assistance for issues such as headaches and blood pressure, to mention a few. In some health facilities, victims of domestic violence are given medical treatment but no psychotherapy for the underlying problem is given to them (McLean, 2003).

Forms of therapy such as trauma focused-cognitive behavior therapy (TF-CBT) have been observed to be superior in improving depressive symptoms in many comparative trials in America and other parts of the world. This does not mean that it is applicable to all forms of trauma and cultural setting such as is found on the African continent. Furthermore, some of the treatments theoretically described in publications are not fully efficacious, which means there is need for evidence-based treatments (McLean, 2003). In this light, the Western concept of CBT may be alien to African community therapists dealing with women who have been maltreated or exposed to violence. Therefore, the need to device an African-tailored CBT to treat the trauma symptoms of domestic violence is crucial. However, there is need for African communities and individuals to adopt and adapt the current structure of CBT as used in Western countries. The researcher cannot overemphasize the need to attempt to explore what is considered as the current 'state-of-the-art' treatment for the traumatized female adults in Kibra Sub-County.

This study improves the professionalism engaged in counseling and psychotherapy practices. Of importance, the focus was on the effectiveness of CBT on dimensions of both psychological trauma and cultural systems that govern patterns of daily living, how the cultures create psycho-special ways to assist the members who have suffered significant traumatic events, and how cultures provide the different pathways to healing and integration of extreme stressful experiences. In some societies mental healthcare is delivered by medicine men and women, witchdoctors, traditional healers,

conventional medical practices, culture-specific rituals, and community-based practices that offer forms of social and emotional support for the persons suffering adverse, maladaptive aspects of trauma (Moodley & West, 2005). The researcher sought to interrogate what would impede healing in people exposed to domestic violence and who have developed anxiety and depression. The study aimed at investigating the role played by psycho-socio-cultural factors acting as positive effect modifiers to psychotherapy and counselling, leading to improved efficacy in the whole scenario. (See Appendices C and D)

This being a research on psychological matters, it aimed at providing a clear description of human behavioral patterns and their underlying psychological processes, as well as providing explanations for the behavior. It goes beyond explanations of the problem to providing answers as to how and why the behavioral patterns, such as domestic violence, come about. The use of experiments, such as having both intervention and non-intervention groups using CBT, made it possible to answer questions about causes of a given behavior. Effectiveness of CBT was achieved by way of helping the participants to rethink the forms of interventions to embrace and move on with their lives. Through experiments, the researcher tested theories and the unobservable mental processes which other researchers may have found difficult to deal with, especially the ones addressing domestic violence and other African women's issues. In order to test the effectiveness of CBT in dealing with the problem of domestic violence in Kibra, it was necessary for the researcher to determine the various forms of abuse which women experience, establish how the social demographic variables influence domestic violence, determine the association of domestic violence with anxiety and depression, establish the efficacy of CBT in reducing the levels of anxiety and depression, explore the factors associated with effectiveness of CBT, and establish the impact of CBT in reducing the burden of domestic violence.

1.3 Objective of the Study

The broad objective of the study was to examine the effectiveness of cognitive behavioral therapy among women exposed to domestic violence to mitigate the negative effects of domestic violence in Kibra.

1.3.1 Specific objectives

The following were the specific objectives of the research:

1. To examine the forms of domestic violence and how demographic variables influence the occurrence of domestic violence among the study sample;
2. To examine the association of domestic violence with anxiety and depression among the study sample;
3. To establish the efficacy of cognitive behavioral therapy in reducing levels of anxiety and depression among the intervention study sample;
4. To explore the factors associated with the level of effectiveness of cognitive behavioral therapy between the intervention and non-intervention study samples; and
5. To establish the impact of cognitive behavioral therapy on domestic violence among the study sample.

1.4 Research Questions

The study will seek to answer the following questions:

1. What are the forms of domestic violence experienced by women and how do social demographic variables influence these forms of domestic violence?
2. How is domestic violence associated with anxiety and depression among the study sample?
3. What is the efficacy of cognitive behavioral therapy in reducing levels of anxiety and depression among the intervention study sample?
4. What factors are associated with the level of effectiveness of cognitive behavioral therapy between the intervention and non-intervention study sample?
5. What is the impact of cognitive behavioral therapy on domestic violence among the study sample?

1.5 Study Justification

Domestic violence is the most pervasive, socially-tolerated human rights violation in the world today. It affects both genders of male and female directly and indirectly. It is fatalistic, defaces, and harms more people, especially women and girls, than cancer, malaria, road traffic accidents' injuries and

other calamities (Kirsten, 2015). The are many forms of domestic violence such as physical, sexual, psychological, and economic abuse. A recent study by Kirsten (2015) established that between 20-66% of women never tell anyone about what happened to them, whereas 55-80% never pursue services from anyone at any time. Women are more vulnerable than men due to the major roles they play in families as mothers. Therefore, the purpose of this study was to try to reduce, if not solve, the problem of domestic violence and its consequences, by testing the effectiveness of cognitive behavioral therapy among women participants, exposed to domestic violence and have developed anxiety and depression, as a result of domestic violence. Women are most likely to react in a more unique way to a traumatizing experience as they easily develop psychological disturbances due to pressure of the several roles they play in their daily lives.

Apart from physical, sexual and psychological abuse and financial coercion, women also experience the use of children to control them, discrimination in job opportunities and remunerations. In addition, some cultural practices that demean women may include wife inheritance, early marriages, failure to honor bride price commitments after marriage, among others. Women and girls are abused by the very people they trust in relationships, especially their spouses and family members. In addition, they may also have been victims of abuse as they grew up during their childhood. Therefore, the purpose of treating them using CBT is to empower them to take care of their families better, enhance their performance at work and improve their way of life in general.

Evidence-based research on domestic violence reveal that there is a high rate of violence in families and the victims of violence have been identified to become abusers at a later stage in their lives. That may mean that the perpetrators may have suffered similar fate at some stage in their life (Black et al., 2011). This creates a need to conduct research to explore the existence of domestic violence, reduce the sufferings being experienced within families using a culturally tailored CBT approach. The achievement of the study impacts on scientific explanations and improvements of problem-solving skills, simply because many facets of human affairs involve psychological tasks. This, in other words, is to say that science progresses when new facts lead to new knowledge, as new theories and techniques are developed or emerge. The researcher also took this opportunity to express the basic fact that scientific progress, among other factors, is motivated by the need to solve practical problems observable in the society, such as domestic violence and psychological disorders. This fact is informed from clinical observations done during this research, and experiences from experts in the

field of counselling psychology and African Women's research. As mothers of any given society, women have concerns that demand active listening; when that fails, issues emerge affecting families and the entire society.

Through use of content and conceptual analysis as well as inference from results of previous empirical studies in Kenya, this study shows that the current description of domestic violence model is inadequate for the understanding of trauma and recovery of the affected populations. Therefore the study aimed at coming up with a broader and more holistic approach for diagnosis of domestic violence through the intricate meanings that survivors attach to their suffering. This leads to improved psychotherapy and counselling interventions for domestic violence and its long-term effects. This research demonstrates the effect of one variable on another. In its simplest form, two groups of participants were involved: intervention and non-intervention groups. Any observed difference between the two groups was attributed to the different forms of treatment. People in the non-intervention group were treated after the intervention group, for comparison.

The study was based on a conceptual framework that focused on five dimensions related to domestic violence: social demographic, socioeconomic status, mental health, cultural and spiritual beliefs or religion that shape victims' experiences of suffering and recovery after traumatic experiences. Inclusion of a framework that includes the spiritual dimension offers a coherent understanding of human beings and acts as a supportive factor in the process of recovery. Moreover, such a conceptual framework enabled support of the development of a more resilient behavior attributable to the development of less severe psychological disorder symptoms in reduction of anxiety and depression levels. The challenges and barriers encountered in realizing the concept and importance of counseling and psychotherapy uptake among the clients diagnosed with anxiety and depression out-weighs the expected benefits.

Therefore, the relationship between domestic violence and psychological disorders was an important aspect to examine because traumatic experiences are part of the life cycle. Similarly, the universality in manifestation and occurrence of domestic violence demands a response from a cultural practice in family support, counselling, medical care and other interventions. In addition, describing the association between domestic violence and psychological disorders required a bigger-picture overview of both the problem and the consequences (Marsella & White, 1999). These, put together, may affect the effectiveness of psychotherapy and counselling efficacy due to attitudinal aspect

towards the practice of psychotherapy and counselling in Kenya today, hence the need for this research to examin the efficacy of CBT in relation to factors attributed to domestic violence.

1.6 Significance of the Study

This section demonstrates the importance of the study to the academia and the society in general. The beneficiaries of this study include victims of domestic violence, service providers, counsellors and social workers, practitioners in mental health facilities, government and private institutions, policy makers, trainers of counsellors, counseling supervisors, clinical and counselling psychology lecturers. The results generated by this study are useful in influencing policy. It is important to note that injuries generated by trauma as a result of domestic violence include the full range of physical, psychological and emotional injuries. Mental health interventions include a wide array of posttraumatic adaptations that are inclusive of symptoms such as mood disorders: major depression, anxiety disorders, dissociative phenomena and substance use or abuse disorders (Spiegel, 1994).

This study adds value to the scholarship around psychology of various schools of thought from both developing and developed countries. It will be helpful in evaluating and discussing the effectiveness of CBT in treating cases of domestic violence and other psychological challenges. It is a multidisciplinary research that cuts across psychology practices and women issues within our societies. Scholars of social sciences develop awareness of different epistemological backgrounds of studies in the social sciences and, in particular, counseling and psychotherapy. It will also provide an opportunity to compare the varied civilization perspectives involved in the research. This research stands to benefit government policy developers, ministries of education and health, and national security, to mention but a few.

Kenyan scholars stand to benefit in their academic achievements and inputs. This study will also enable scholars to assess and develop social science studies in general at both international and regional levels. This is the desired understanding and acquaintance, which could help in moving beyond historical experiences and misunderstandings of the downtrodden man or woman or, better still, a traumatized person in both the developing and the developed world. All of the above feed into the foundation for good and fruitful communication between the African and Western beliefs, values and practices. It was also important for therapists and their clients in understanding their rights, cultural and spiritual values, as well as in dealing with domestic violence in their communities. In

other words, all parties stand a chance to realize what, when, who, how, where and whether they benefit from counseling and psychotherapy, and the potential of restoring the mind to its original state.

1.7 Assumptions

The study was guided by the following assumptions, some of which greatly influenced the research findings. The researcher adopted the assumption that the participants would make themselves available and participate fully in giving information, and in return benefit from the counseling services provided by the Principal Investigator (PI) and the other specialized counselors involved in the study. It so happened that most women came to the health facilities expecting to receive medical intervention alone but to their surprise, the counsellors were readily available to counsel them without charging any extra fees. The participants or the target population, of women aged 18 years and above, were assumed to be the most vulnerable and more likely to have been exposed to domestic violence. It turned out that domestic violence cuts across all age bracket.

The other assumption was that the assisting professionals are highly trained on African values and are competent enough in cognitive behavioral therapy techniques. This assumption was buttressed by the fact that the right people came on board to join the researcher. It was something good to reckon with. Given a working and well enabled support system, occurrences of domestic violence and psychological disorders in traumatized clients can be reduced. This fact was proven and very encouraging to the researchers as they waited for the final analysis and results. Understanding of the emotions and behaviors that no longer function for the client provides the counselor with a basis for assessing the underlying belief systems, schemas and assumptions. Bearing this approach in mind, emotional health can be reestablished through altering maladaptive thinking, removing negative biases and distortions in thoughts, and enabling the clients' progress towards greater balance in their personality and functioning. Most clients attested to this fact towards the end of their CBT sessions. For instance, some of them confessed: "I have even forgotten I ever felt hurt." This means gradual healing was being achieved in the life of the client as the therapy sessions progressed.

1.8 Scope of the Study

The study was carried out in five health facilities within Kibra Sub-County that were conveniently selected due to limitations of time and other resources. Eligible participants were women previously exposed to domestic violence. The study limited itself to women who are above 18 years because these were assumed to be of childbearing age. They are adults according to the Constitution of Kenya; therefore, they could participate in the study with their consent. Lastly, this is the age bracket when a majority of women are involved in family life and relationships. Women from different professions, occupations, races, ethnicities or other statuses were welcomed to participate in the study. The exposure to domestic violence was assessed through the use of domestic violence assessment scale (see Appendix D). In order to participate in the study, women exposed to domestic violence should have developed elevated levels of anxiety and depression, of 11 scores and above, which was determined through the use of Hospital Anxiety and Depression Scale (HADS), (see Appendix E). They were randomly distributed into two groups: intervention and non-intervention.

CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

This chapter focuses attempts a conceptualization of the definition of domestic violence and an understanding of its prevalence. The chapter progresses to evaluate the various forms of domestic violence experienced by survivors as well as factors contributing to occurrence of domestic violence. In addition, the chapter explains the psychological effects of domestic violence and how they affect women. Gaps in this literature review show how practice and theory are delinked. The literature meta-analysis by Stefan, Anu, Imke, Alice and Angela (2012) states that cognitive behavior therapy is effective in reducing the impact of domestic violence among the affected population, yet according to their findings, the problem is on the rise. The theoretical framework section examines the psychological theories in reference to cognitive behavioral therapy. The interventions for psychological disorders, in particular anxiety and depression, can be reduced using CBT. A conceptual framework has been put forward to demonstrate the interrelationship of the variables at play in an attempt to mitigate psychological disorders and eventual reduction of domestic violence.

2.1 Domestic Violence

Domestic violence, is also known as domestic abuse, wife beating, dating abuse, spousal abuse, family violence, and intimate partner violence (IPV). It is a pattern of behavior which involves the abuse by one partner against another in an intimate relationship such as cohabitation, marriage, dating or within the family sub-systems. Domestic violence includes physical hostility or assault which may involve one partner throwing objects, hitting, slapping, biting, shoving, restraining, battering or threating the other. Domestic violence also takes the forms of sexual abuse, controlling or domineering, stalking, intimidation, neglecting and economic deprivation (Dutton, 1994). It involves incidents of frightening behavior, violence or abuse be it sexual, psychological, physical, financial or emotional between adults who are or have been intimate partners or family members regardless of gender or sexuality. Studies have acknowledged violence as a result of interpersonal interactions of individual relationships and environmental factors (Heru, 2007). According to Heru (2007), many community and clinical studies have found that intimate partner violence is often two-sided or bidirectional, where each partner is both an aggressor (perpetrator) and a victim.

According to Ogbuji (2015), domestic abuse is any hurtful word or behavior from a spouse against his/her partner or children that is intentionally threatening and or inflicting pain. Domestic violence involves various aspects of human living such as physical, emotional, psychological, social, economic/financial, verbal, or spiritual. Feminist understandings shaped by the lived experiences of abused women and supported by research evidence have aided to develop conceptualization of domestic violence as physical force, physically injurious assault, coercive and controlling behaviors that cause psychological, interrelated range of abusive treatment, sexual or physical harm to the victim (Barnish, 2004). This definition concentrates largely on both genders, consistent with the evidence concerning main abuse trends.

The main research findings are to the extent dynamic in relation to domestic violence. They expound the theories, factors associated with vulnerability to victimization, perpetrator types, risk markers for perpetration, the harm done to women, and women's reactions to domestic violence. However, some issues of terminology remain disputed if domestic violence should be a gender-specific or neutral referent encompassing all forms and incidents of abuse in all types of intimate relationships. The fact remains that abuse and violence have affected an individual in a trusting environment and relationship.

According to the United Kingdom criminal justice system, domestic violence is any assult between current and former partners in an intimate relationship. This kind of violence includes sexual, physical, emotional and financial abuse, and use of children (Barnish, 2004). Some organizations, including some police services and national probation services, incorporate abuse in other close relationships into their definitions. Police definitions generally limit their additional scope to violence towards adult family members, whereas definitions by probation and child protection services (CPS) includes child abuse, though the CPS limits its sphere of activity to criminal offences (Criminal Justice Trials Commission, 2015; Population Council, 2008).

The United States government has defined domestic violence as abusive behavioral patterns in a given relationship, deemed by one partner as a mileage to acquire or maintain power (social or political) and control over another intimate partner (Dutton, 1996). Anyone can experience domestic violence regardless of age, race, religion, sexual orientation, or gender and can take many forms, including

physical abuse, sexual abuse, emotional abuse, economic, and psychological abuse (*Violence Against Women*, 2011).

According to Adams and Bybee (2008), there is also economic abuse, which happens when one intimate partner has control over the other partner's right to use economic resources. This diminishes the victims' capacity to support oneself and forces him or her to depend on the perpetrator financially. Domestic violence cannot be narrowed to the obvious physical violence but also it involves all forms of endangerment, kidnapping, criminal coercion, harassment, unlawful imprisonment, trespassing, or stalking (National Network to End Violence, 2008/DC 2011).

Individual variables include personality traits and illnesses, which means some of the perpetrators could be psychologically unwell while the victims could be physically unfit. Environmental variables on the other hand include the environment that one lives in or has grown in, which may promote or dissuade/discourage violence. Other situations which one would be suffering from are acute or chronic stress due to financial challenges (poverty), intoxication (with drugs such as alcohol and cannabis sativa), narcissistic (selflessness) injuries, acute or chronic illness, as well as losses in life factors. Alcohol drinking and mental illness can be co-morbid with abuse and present additional challenges in eradicating domestic violence (Dutton, 1996). Contemporary agreement has been reached that a common explanation of domestic violence should refer to assults directed to family members and intimates in adult relationships (National Network to End Violence, 2008/DC 2011). Agencies' intensifications of these essential definitions generally contextualize domestic violence and focus on main concerns.

Domestic violence is common among spouses. It is mostly characterized as involving a pattern of forcible abuse of power, controlling behavior aimed at forming or maintaining authority, particularly in patriarchal societies. The perpetrators abuse the victims through criminal or sub-criminal actions, some of which may cumulatively amount to an offence of harassment. In some instances, women have been perpetrators of domestic violence in heterosexual relationships (Barnish, 2004). Furthermore, domestic violence in western countries is seen to occur in lesbian or gay partnerships where the perpetrator exercises power over the other partner.

2.2 Prevalence of Domestic Violence

Prevalence is about some of the occurrences and frequencies of domestic violence. Domestic violence happens all over the world in various cultures and it affects people from all societies irrespective of economic status. According to the Bureau of Justice Statistics of United States in 1995, women reported a six times greater rate of IPV than men. Nevertheless, studies have found that men are much less likely to report assault when it occurs (Flury & Riecher-Rossler, 2010). According to Demographic Briefs on Domestic Violence (DBDV), reports show that minor force such as a slap is 49% among women compared to 36% men who sustain physical injury. Severe force such as choke, strangling, use of weapons has 77% women and 56% men who sustain physical injury (Flisher, Myer, Merais, Lombard, & Reddy, 2007).

A summary of Archer's meta-analysis of domestic violence prevalence demonstrates that women experience 65% of domestic violence injuries (Langhinrichsen-Rohling, 2005). The World Conference on Human Rights held in Vienna the year 1993, as well as the Declaration on the Elimination of Violence against Women concluded that civil society and governments agreed that violence against women is a public health and human rights alarm. According to police records, 95% of child abuse victims in Nicaragua were girls, while according to anonymous population-based surveys, 70% of child abuse victims were girls and 30% boys (Flury & Riecher-Rossler, 2010). One can only be interested in following up and observing the future lives of such children to see how they progress in their lives. They may be living in fear, anxiety or depression, having been exposed to domestic violence at a vulnerable age. Some of them could be “skilled” perpetrators, repeating on others what was done to them. The thinking would be so distorted that they see no harm in abusing their relationship partners (Black, 2011).

Cases of domestic violence are under-reported. Therefore, the degree of seriousness and nature of offence are compromised due to stigma especially as regards sexual violence. Usually, these incidents go unreported but are treated in health facilities (Henrica & Jansen, 2009; Kantor, Jasinski, Williams, 2007). This means a lot of violence takes place in families but is kept secret for reasons best known to the victims. Over the centuries, many women have often been treated with cruelty in patriarchal societies (Ogbuji, 2015). Patriarchal society is a social setting where men are the heads of the families and thus women and children are under the authority of men. This kind of social setting is practiced

but it is sometimes abused and becomes oppressive when the power invested in men is misused. In patriarchal society settings, many women suffer exploitation in forms of denial of inheritance, economic marginalization, lack of formal education, wife battering, wife inheritance, sexual abuse including incest and rape (Ellsberg, 2006).

A cross-sectional research was carried out in Kisumu District Hospital, Kenya, amongst randomly selected pregnant women. The aim of the study was to find out the prevalence and factors associated with intimate partner violence among expectant women. A structured questionnaire was used to gather data. The participants gave self-reports of their own IPV experiences and the associated risk factors. Thirty seven percent (37%) of the 110 sample population reported or experienced IPV during prenatal period. Psychological assault was the leading form of abuse with (29%), followed by sexual assault (12%) and physical violence at (10%) (Kamweya et al., 2013). According to International Federation of Women Lawyers-Kenya, 5,200 Kenyan women experience domestic violence every year. Also, many cases of homicides reported in Kenyan dailies are usually related to domestic violence (Ogbuji, 2015).

Various studies show that researchers do not state how to support women exposed to trauma (Ogbuji, 2015). The figures showing prevalence of domestic violence indicate that the problem is disturbingly high and afflicts all levels of society. These behavioral patterns trouble the lives of too many women and children in the societies. Both victims and perpetrators live in fear of disclosing the abuse because of so many threats in their lives (Ogbuji, 2015).

2.3 Forms of Domestic Violence Experienced by Survivors

Domestic violence is characterized by all sorts of maltreatment. Maltreatment is a behavior towards another person which is outside the norms of conduct, and entails a substantial risk of causing physical, psychological and emotional harm. These maltreatment patterns are also referred to as assaults. The commonly known assaults globally include sexual assault, physical assault, financial coercion, psychological and emotional abuse, verbal assault and neglect. These are briefly discussed below.

Physical abuse: Physical acts by a partner, spouse, parent, guardian or caretaker that cause physical injury to the victim. The perpetrator slaps, hits with a fist, kicks, hits against the wall, shoves, strangles, burns, stabs or uses other crude objects to inflict pain on the victim's body.

Sexual abuse: This occurs when one of the partners is forced into sexual activity when they are not ready or they are prevented from using birth control measures. Sexual abuse as well occurs when adults who are step-parents, older siblings or other relatives molest underage children by luring them to some favors or threatening to withdraw privileges for the exchange of sexual activities. Sexual assault also includes fondling and exposure to indecent acts to family members who are not of age or willing.

Psychological and emotional abuse: This type of abuse is experienced when a partner demeans the other, tries to isolate the other partner for example by taking sides, leaving the victim alone without informing him or her the whereabouts. It occurs also when the victim is followed, stalked and not allowed to be independent. Victims can be traumatized when the perpetrator involves children in their abuse, use children to spy on them or obstructs the victim from visiting their children in school.

Financial coercion: This especially involves decision making on financial expenditure. In this case, one of the partners decides, without involving the other partner, on how finances are to be managed in a household. In addition, financial coercion occurs when one partner mishandles family finances or leaves little amount of money for family expenditure. Lastly, financial coercion is experienced when one of the partners attempts to use money and other goodies to control the other partner.

Verbal assault: This occurs when one of the partners uses insults, put-downs and name calling among others, which are inappropriate and intimidating to the other partner. Sometimes verbal assault can include the tone, pitch, and other non-verbal gestures, and body language.

Neglect: This is when the perpetrator does not play the expected roles of providing for the needs of the family such as food, clothing, medical care and education, among others. Furthermore, neglect can manifest itself when the vulnerable, especially a disabled or marginalized member of the family, is not attended to in the right manner. In addition, when the perpetrator abandons the family or tries to sabotage the parenting skills of the other partner, this harms the family wellbeing.

2.4 Factors Contributing to Domestic Violence

There are several factors related to likelihood of domestic violence occurrence, that is, victimization or perpetration between the partners. Risk factors for victimization and perpetration include childhood physical or sexual victimization, social and economic factors, alcohol and drug abuse, among others. These factors can be seen from a dimension of individual, relational, community and societal factors, that contribute to the risk of one becoming a victim or perpetrator of domestic violence. The awareness of these multilevel factors can aid in identifying various opportunities for prevention.

To start with, a number of studies have reported populations most at risk for domestic violence are those that have tendencies to have imbalance of power and control (Heise & Garcia-Moreno, 2002). Some people with very strong traditional beliefs, especially in patriarchal societies, believe that they are justified by their culture to control their partners. In addition, both men and women think that they are not equal. This brings about gender inequality and discrimination that cuts across public and private spheres of life, across cultural, political, social and economic rights (UN General Assembly, 2006). Coming from such a background, men are seen to be the most perpetrators of domestic violence while women and girls are victimized and marginalized in many aspects of life. Some cultural practices reinforce women and girls subordination while tolerating male violence, consequently encouraging male dominance. For example, some practices such as paying bride price are used by some men as a justification of dominating their spouses (Mbiti, 1999).

Secondly, Social economic factors contribute to occurrences of domestic violence. Studies show that domestic violence cuts across household income brackets. However, domestic violence is most frequent among the poor people who earn little household income or are completely unemployed. Limited economic opportunities aggravated by underemployment of men put their women at a higher risk of domestic violence. In addition, women and girls facing financial constraints are forced into child marriages, sexual exploitation by perpetrators and in some instances trafficking to other countries as slaves and for labor (Jenna, 2003).

Inter-ethnic relationships, religion and race (mixed marriages) are other factors which contribute to domestic violence. For example, in some African communities inter-ethnic relationships are discouraged. When some females get married in other ethnic communities, they experience

victimization from the local communities partly because they are seen as outsiders and different. Furthermore, marriages between inter-denominations are seen to experience higher rates of domestic violence. Lastly, in Western countries, black females experience higher rates of victimization when they get married to white males as compared to white females getting married to white males (Tjaden and Thoennes, 2000).

According to Heru (2007), domestic violence can be repeated from person to person or generation to generation if the correct interventions are not put in place in good time. This is because an abused individual can be an abuser in due time. Reccurrence of abuse is also attributed to children growing up and witnessing violence in their families or to children who experience bullying while growing up in their families or in school. Furthermore, when perpetrators convicted of domestic violence offences are released from prison, a good number of them often take revenge against their partners who had sent them to jail (Capaldi, et al, 2012).

Some studies have shown that women experience domestic violence from their partners when they are pregnant (Kamweya et al., 2013). This is because these women are in vulnerable conditions where they are not able to support themselves or meet the gendered roles. The perpetrators abuse them which consequently can affect the unborn baby in various ways such as miscarriage, low birth weight, premature births, fetal death and birth defects, (Heise & Garcia-Moreno, 2002).

People who abuse alcohol and other drugs are at a higher risk of causing domestic violence. This is because these people have little control of their behaviour due to the fact that they have no inhibitions. In addition, these people have difficulties in regulating their emotions such as anger and other strong emotions when they are intoxicated. Furthermore, they misuse household income, especially in sub-Saharan Africa where some perpetrators spend a lot of time in alcohol dens and ignore their responsibilities in family life (Khasakhala, 2013).

Some psychologists believe that biological or genetic factors predispose perpetrators to cause domestic violence. This is attributed partly to the hormone testosterone which is quite high in men making them to be over controlling and domineering against opposite gender. In addition, neuroanatomical variances and other biological factors in men and women lead to men's tendency to be violent against women (Kantor & Jasinski, 1998).

Another factor which leads to domestic violence or put women and girls at a greater risk of violence is age. Females aged of 16 to 24 are at a higher risk of domestic violence. Mostly, these are females who are in high school, colleges, or are just settling down in relationships. The last factor is when some people have victim-blaming ideas which predispose them to become victims of domestic violence. For example, some victims believe that they are the ones to blame for the abuse. They see themselves as the cause of domestic violence because of their behaviour, mode of dressing, physical appearance, sexual orientation, among other irrational beliefs and personal judgements. In other cases, when the victim feels the need to terminate a relationship for practical reasons, there are some perpetrators who, out of anger, inflict pain onto the victims for lack of better ways to deal with the loss (Stith et al., 2004).

2.5 Psychological Effects of Domestic Violence

Negative effects of domestic violence are experienced differently by different individuals who have suffered or witnessed violence (Friedman, Loue & Goldman, 2011). Intimate Partner Violence (IPV) leads to youthful drugs and alcohol abuse, low income, low academic achievement, low self-esteem, as well as aggressive or delinquent behavior. Other symptoms of domestic violence are prior history of being physically abusive, antisocial personality traits, depression, borderline personality behaviors, anger, hostility, having few friends and being isolated from other people (Flury, Nyberg & Riecher-Rossler, 2010).

According to Lloyd, Taluc, Max, Rice, Finkelste and Bardwell (1999), there are several negative effects of domestic violence which include belief in strict gender roles (like male dominance and aggression in relationships), having a history of poor parenting experiences as a child, lack of employment, desire for power and control in a relationship, emotional dependence and insecurity, perpetrating psychological aggression, being a victim of physical or psychological assault, experiencing physical violent discipline as a child, among others, predisposes one to manifesting negative effects of domestic violence (Lloyd, et al., 1999; Leadbetter, 2004). According to Black et al., (2011), victims of frequent violence experience more severe consequences than victims of one-time incidents.

Besides deaths and injuries, physical assault by an intimate partner is also related to a number of adverse health outcomes (Black, 2011; Breiding, Black & Ryan, 2008). These conditions include

cardiovascular, gastrointestinal, endocrine and immune systems, which are due to chronic stress and other metabolic conditions (Black, 2011; Crofford, 2007; Leserman & Drossman, 2007). Other health disorders associated with IPV include bladder and kidney infections, fibromyalgia, asthma, gastrointestinal disorders, circulatory ailment, cardiovascular disease, joints disease, irritable bowel syndrome, chronic pain syndromes, central nervous system disorders, migraines and headaches, among others (Black, 2011).

Tjaden and Thoennes (2000) posit that domestic violence, whether physical, sexual, or psychological, can cause various psychological consequences to victims. These include antisocial behavior, anxiety, depression, and PTSD, suicidal behavior in females, low self-esteem and failure to trust others, especially in intimate relationships. More negative consequences are emotional detachment, fear of intimacy, flashbacks, sleep disturbances, and replaying assault in the mind. Such conditions are very common and sometimes not easily noticed. Victims of IPV sometimes face certain social consequences such as limited access to services, stressed relationships with health service providers and employers, seclusion from social networks, as well as homelessness, among others (Black, 2011; Coker et al. 2002; Heise & Garcia-Moreno 2002; Roberts, Klein, & Fisher 2003; Plichta 2004; Warshaw et al., 2009).

Women with a history of domestic violence are likely to show behaviors that present further health risks such as alcoholism, substance abuse, and suicide attempts, among others, as compared to women without a history of domestic violence (Heise & Garcia-Moreno, 2002; Plichta, 2004; Roberts, Auinger, & Klein 2005; Silverman et al., 2001). The relationship between domestic violence and psychological disorders is described in a systematic review and meta analysis study by Kylee and Trevillion (2012). The study shows that there is a higher risk of experiencing adult lifetime partner violence among women with depressive and anxiety disorders compared to women without mental health challenges (Kylee & Trevillion, et al., 2012). The reports show that the more severe the violence, the stronger its relationship to negative health behaviors by victims, (Khasakhala-Mwenesi, Buluma, Kongáni & Nyarunda, 2004).

People who suffer domestic violence, struggle in their lives both personally and professionally due to post syndrome effects of what they have experienced. They present concerns of interpersonal skills, emotional self-management, and social problem-solving skills (Dyer; Dorahy; Hamilton; Corry;

Shannon & MacSherry, 2009). Child maltreatment has a large overlap with domestic violence because children become wounded during IPV incidents between their parents. Therefore, physical violence is usually accompanied by emotional or psychological abuse in both women and children (Appel, & Holden, 1998).

The researcher's expectation was that the study population would be found within and around Kibra Constituency. Similarly, there was need to study the current situation concerning effects of domestic and psychological disorder in Kenya and other parts of the world. However, minimal is known about the magnitude to which being a victim of domestic violence is related with different mental disorders in women, which is one of the objectives of this research.

2.6 Gaps in Literature

From the literature review, it is clearer that a majority of victims of domestic violence are women and children (Lloyd, Taluc 1999; Max, Rice, Finkelstein, Bardwell & Leadbetter, 2004). There is high prevalence and increased likelihood of being a victim of domestic violence in men and women across all diagnostic categories (with disorders) compared to people without disorders. Converging evidence suggests an association between violence and trauma particularly in cases of childhood maltreatment and adulthood somatization. Individuals with a history of childhood abuse have been found to show more somatization symptoms as well as more medically-unexplained symptoms than non-traumatized persons (Briere, 1992).

There is a close link between severe traumatic experiences and somatization (Briere & Scott, 2006). Extensive periods of extreme stress, intense family conflicts, involvements that pose threats of personal harm such as suicide, homicide, witnessing and experiencing injuries, inclusive death among others, have an impact on the mental health and emotional well-being of an individual. Research shows that exposure to domestic violence and the stress associated with spousal conflicts increase the risks of developing mental health difficulties, among them depression, anxiety and substance abuse. Substantial psychological impairment has been concomitant with domestic violence.

This study aimed at exposing the success of cognitive behavioral therapy techniques among victims of domestic violence and its negative effects. Both anxiety and depression, as psychological disorders, have cognitive and behavioral components, and for the person to recover, both the thinking and the

behavior elements must change. Cognitive behavioral therapy alters maladaptive behavioral patterns by the use of extinction and inhibitory processes as well as by use of positive or negative reinforcers. Both maladaptive ways of thinking and behavior are on focus to alleviate the occurrence of anxiety and depression. The gap is in the effectiveness of the procedures followed as well as the different categories of people. Studies done in this area of domestic violence and CBT have been carried out in separate studies and only few of them have linked both areas, especially in helping people who have suffered domestic violence.

The literature available, however, does not provide a clear procedure as to how these behavioral changes occur. Theory and practice are crucial for the completion of the process. Both anxiety and depression disorders are as common as domestic violence yet easily ignored or misdiagnosed or unrecognized and hence no treatment is given. The situation gets worse to a point where the abused becomes an abuser at a later stage in life. Lack of awareness becomes the order of the day, while people get busy blaming it on the government, the leaders and others.

The literature available does not emphasise the capacity of the therapist or training background. This could be one of the factors affecting the presupposed effectiveness of counselling and psychotherapy. Counselling research in Kenya was not clearly defined in the literature. For instance, CBT has not been researched enough in African settings, although a lot of other researches are ongoing in Kenya and elsewhere; a case in point is in the medical field. There would be several reasons why this would be the case. For example, challenge of resources such as time, finances, as well as the personnel to do research. Knowledge generation requires sacrifice of time and other resources. According to the available literature, CBT has been used but it was not clear whether it was an effective way of handling domestic violence. The researcher sought to establish the effectiveness of CBT on domestic violence among African women in the context of African cultural expectations and experiences, hence the need to fill the knowledge gap.

2.7 Theoretical Framework

According to Craighead (1994), learning experiences or failure to receive or profit from various learning experiences accounts for the behavioral patterns of an individual. Therefore, a good behavioral modification model is one that provides learning experiences that promote adaptive and pro-social behavioral patterns of an individual. Following this trend of thought, cognitive behavioral

therapy involves training clients to engage in certain behaviors in order to demonstrate a learning experience in their new modes of behavior. This helped the researcher as the basis of choosing CBT as the key therapeutic approach for domestic violence intervention.

The theoretical framework of the study is based on the psychological theories of self-appraisal, learned helplessness, and identified behavioral patterns, which form the pillars supporting this research work as they explain the existence of the problem under study: domestic violence and the intervention using CBT. Self-appraisal refers to the way a people view themselves. This is also the continuous process of determining individual growth and progress, which can be raised or lowered by the treaments of a close significant other such as an abusive spouse or other family members. Individuals are more threatened by friends than strangers. Abraham Tesser, a social psychologist professor emeritus in the University of Georgia, developed the self-appraisal maintenance theory in 1988. The self-appraisal maintenance model has two assumptions: one, a person should try to maintain or increase their own self-appraisal, and two, self-appraisal is more often than not influenced by relationships with others (Tesser, 1988). This tells a lot about the women clients requiring CBT for them to start operating differently for better living.

Learned helplessness is a situation that occurs when a person is repeatedly subjected to an aversive impetus that he/she cannot escape. Ultimately, the person will stop trying to avoid the impetus and behave as if this is utterly difficult to change. Even when opportunities to escape are presented, learned helplessness prevents any thought for action to change the particular condition. When a person feels they have no control over their condition, they begin to behave in a stranded manner. This self procrastination leads someone to overlooking opportunities for self relief or change. Generally, women who have suffererd exposure to domestic violence have inclinations of helplessness, a manifestation that requires therapy, such as CBT, in order to change themselves. This concept of learned helplessness was discovered by two psychologists, Martin Seligman and Steven F. Maier, in 1967. Learned helplessness has also been linked with several different psychological disorders such as depression and anxiety, among others, which can be exacerbated by the same learned helplessness. On the other hand, CBT helps to overcome the thinking and behavioral patterns which cause learned helplessness leading to the indicators of psychological disorders, anxiety and depression in some cases.

For the purposes of this study, it is crucial to note that identifying behavioural patterns that cause the problems, is vital for psychological and emotional healing. For example, if a client decides to separate from their partner, she will miss the opportunity of learning what the particular experience was meant to imply from the other person. This kind of scenario exposes her to the danger of continuing to meet more of the same picture patterns in the next relationships that she tries to develop. This pattern of things keeps around until she resolves the emotional source of the previous experiences. A woman would therefore need to understand that change can happen if she focused honestly on what is going on in her live and her reactions as well as behavioural patterns, instead of projecting the blame onto her partner. Taking personal responsibility would help the woman alter the direction of her life and erect it firmly at a better position, which means self-empowerment. Self-empowerment simply means she is confidently taking charge of all aspects of her life. Hence, self-empowered characters do not allow their power to others to abuse, rather they use it suitably. Something of great importance to note is that individuals have the inborn ability to empower themselves but others have to relearn it. The dissimilarity between those who possess and know their power and those who do not, is simply an inside belief system, a *self-defeatist talk,* meaning one is incapable of self-empowerment, something that may have been instilled or conditioned since childhood. Cognitive behavioral therapy is known to be the best approach to these theoretical frameworks of the human mind.

The origin of cognitive behavior therapy is known from the stoic philosophy of Epictetus, who was in the first century known to report that people are more troubled by the interpretations they take of happenings than the events themselves. In principle, people are capable of choosing their orientation, and a person's psychological standing is influenced by his or her views about the self in relation to the world (Woolfe, & Dryden, 1996) as observed above. Cognitions, verbalizations and feelings are recognized as inner events which function as stimuli in controlling the behavior of an individual (Weiss, 1978; Jacobson, 1981), and cognitive events play major roles in the theory of personality and behavior.

Cognitive Tehavioral Therapy is one of the various applicable approaches for creating new beliefs and behavioral variations (Craighead, 1994). This approach, being a psychological treatment, is intended alter maladaptive behaviors of thinking, leading to improvement on reduction of psychological disorders among people (Colledge, 2002). It is therefore highly diverse and concerned with the development, maintenance and alterations of behavior. Craighead (1994) posits that CBT's

main purpose is to help people bring out the intended behaviors, without influencing intentions. In addition, CBT is more useful in face-to-face interactions than in group or community-level interventions. The CBT intervention is a amalgamation of many methods, strategies and techniques that can work in helping people overcome their particular emotional problems successfully without negative side effects (Briere & Scott, 2006 & 1996).

The cognitive part of the therapy refers to a thinking style or learning which is part of the therapy which can be imparted to the person (Kendal & Kriss, 1983). The individual then needs to put what has been taught into practice at home and on daily basis. Through repetition, the client feeds the new knowledge into her brain such that it becomes an automatic behavior or a habit. This is basically the same procedure as that of school teaching or learning. The client is taught new information and skills, absorbs them and uses them in her daily life. Of importance is that, when the client learns them well enough through repetition, it affects the retention processes and allows her brain to think, act, and feel differently. This exercise needs insistence, repetition, and endurance. When a client sticks with this therapy, without giving up, visible progress begins to happen (Beck, 1967). The cognitive approach claims that abnormality stems from defective cognitions about others, the world and oneself. This damaged thinking may come about due to cognitive shortages or cognitive distortions, resulting to processing things inaccurately. These thoughts cause distortions in the way the person sees things and the behavioural patterns that follow.

Albert Ellis (1957; 1962) suggested that distortions are through irrational thinking. He proposed that each individual has a sole set of assumptions about themselves and the world that serves as a guide through life. In addition, this also helps to determine the persons reactions to the various situations encountered. Regrettably, some individuals assumptions are profoundly irrational, which leads them to acting and reacting into inappropriate ways. This prejudices the person's chances of happiness and success in life. In addition, Albert Ellis stated that these are some of the basic irrational assumptions in which some people assume irrationally that they are failures. They endlessly seek approval and persistently feel rejected. All their relations are affected by the elementary irrational assumptions when they do not get enough compliments. Beck (1967) proposes this to be a form of cognitive triad.

Albert Ellis (1957) developed an approach known as the ABC Technique of Irrational Beliefs. According to him, there are three steps of the process by which a person can develop irrational beliefs.

One is activating event or objective situation: This is an event that ultimately leads to some type of high emotional response or negative dysfunctional thinking of the victim; beliefs, in this step the client recognizes and writes down the negative thoughts that occurred to her; and consequence, this is the negative or distressing feelings and dysfunctional behaviors that follow. The negative thoughts of the second step are seen as the connecting bridge between the situation and the distressing feelings. The third level is explained by describing emotions or negative thoughts that the person thinks are caused by the first level. This could be anger, sorrow, anxiety, and so on. Ellis believes that it is not the activating event (A) that causes negative emotional and behavioral consequences (C), but rather that a person interprets these events unrealistically and therefore has an irrational belief system (B) that helps cause the consequences (C) (see Figure 1).

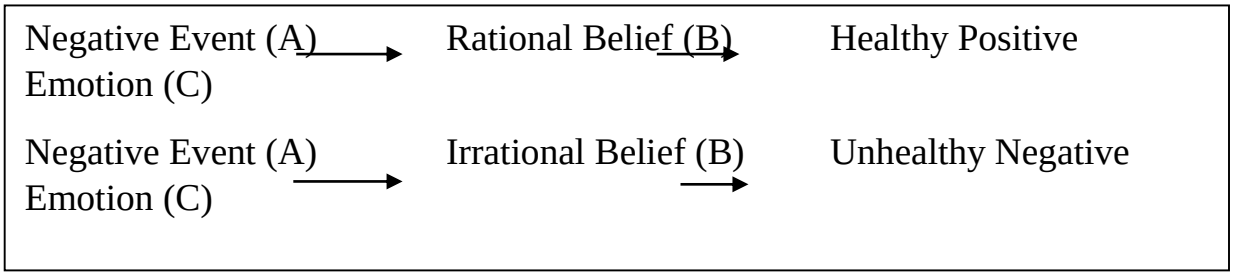

Figure 1: ABC Model (Retrieved from Beck Judy, 2011)

During therapy, after irrational beliefs have been identified, the therapist works with the client, challenging the negative thoughts on the basis of evidence from the client's experience, by reframing it, meaning reinterpreting it in a more realistic fashion or manner. This helps the client to develop more rational beliefs and healthy coping strategies. Ellis's Rational Emotive Behavior Therapy (REBT) has been cited in many studies in support of this approach. Most early studies were conducted on people with experimentally induced anxieties or non-clinical problems such as mild fear of snakes (Kendall & Kriss, 1983), but a number of recent studies have been done on actual clinical participants and have also found that REBT is often helpful (Beck, 2011; Lyons & Woods, 1991).

The Beck's cognitive triad is in three forms of negatives: helplessness, hopelessness and critical thinking which are typical of individuals with anxiety and depression, mainly due to negative thoughts about the self, the world and the future (Colledge, 2002 & Beck, 2011). These thoughts tend to be automatic in the affected persons as they occur spontaneously (see Figure 2).

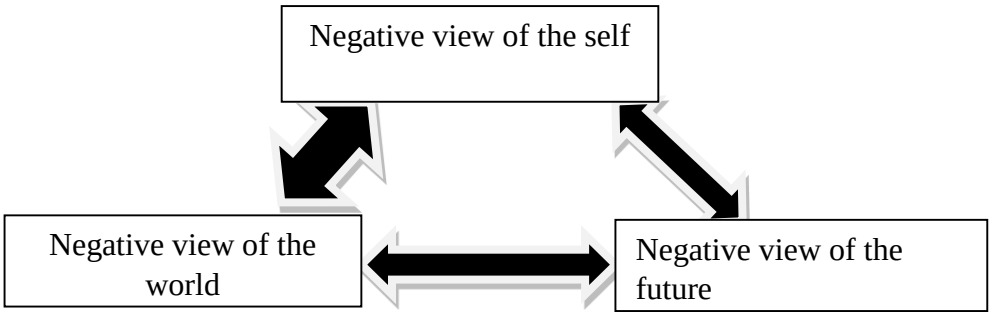

Figure 2: The Cognitive Triad (retrieved from Colledge, 2002; Beck, 2011)

As these three components interrelate, they interfere with the usual cognitive processing, leading to damages in perception, memory and problem-solving skills, which results to the person becoming obsessed with negative thoughts (Colledge, 2002; Beck, 2011). As is the norm, people interact with the world through mental pictures, and if our mental representations are wrong or our ways of reasoning are insufficient, our emotions and behavior may convert similarly disordered. Once people are impacted by a traumatizing event such as domestic violence, their behaviors and life styles are affected, and so is their way of processing issues. The therapist trains the victim how to identify distorted perceptions through a process of appraisal. The victim learns to differentiate between their own views and reality, having learnt to identify their feelings and monitor own thoughts (Butler & Beck, 2000).

Victims of violence need a therapeutic environment for steadying, validation of emotions, accepting of self-expressions, surviving with feelings and crisis conditions, which reduces strong emotions such as anxiety, fear, and tension (Hoagwood, 2006). Cognitive behavioral therapy has been found to be helpful in reduction of levels of anxiety and depression among people who have been exposed to domestic violence; witnessing parent fatalities or those whose loved ones die from traumatic experiences (Herman, 1992).

Clients with social anxiety condition learn to capture their automatic negative thoughts and convert them into rationally neutral thoughts. This deliberately turns their negative thoughts into rational and neutral thinking. The neutral thinking is then gradually moved up in step-by-step to a more realistic level, into which time and repetition enables the client's thinking is moved slowly upwards and becomes more realistic. In the beginning, this process is a conscious procedure, but the further it is practiced and repeated, the more it becomes an automatic progression (Colledge, 2002 & Beck, 2011).

That in itself justifies the number of the recommended sessions stated in the methodology section of this research.

Butler and Beck (2000) reviewed 14 meta-analyses investigating the success of Beck's cognitive therapy and determined that about 80% of adults profited from the therapy. It was also found that the treatment was more effective than drug therapy and had a lower reversion rate, supporting the suggestion that depression has a cognitive origin. This was to suggest that knowledge of the cognitive explanation improves the quality of lives. The second part of CBT is that it seeks to alter abnormal or maladaptive behavioral forms by use of extinction and inhibitory procedures and positive and negative rein-forcers during classical and operant conditioning positions (Craighead, 1994). Rather than on some analytical or dynamic analysis of the underlying conflicts, the focus shifts onto the behavior itself. This increases positive relations among individuals, alters the environmental conditions, and teaches people to uphold their newly learned positive behavioral changes.

This therapeutic approach has had a remarkable impact on clinical psychology (Reber, 1985). During these procedures, clients are helped to identify the negative thoughts and errors in logic that cause them anxiety and depression. The therapist leads clients to question and test their dysfunctional thoughts, trying out new interpretations, and eventually apply alternative ways of thinking within their lives. As such, CBT treatments seem to work pretty well across a range of different types of traumas (Hoagwood, 2006). Therefore, the researcher found out that effectiveness of CBT was key to the study, and hence the choice of the experimentation.

Furthermore, the actual events, belief system, consequences (ABC) theory shows that people's problems do not stem from activating events but rather from their beliefs about such events. For example, anxiety and depression result from the emotional problems originating from one's beliefs, which need to be challenged. The way a person interprets own experiences will determine how they feel and behave (Colledge, 2002). All persons impacted by violence need a therapeutic environment for stabilization, validation of emotions, fostering of expressions, coping with feelings and dealing with the crisis to normalize the situations and reduce intense emotions such as anxiety, fear, and tension (Hoagwood, 2006). The participants taken through CBT were to be relieved from emotional disturbances, helping them change their maladaptive beliefs and behaviors.

All psychological disorders have both cognitive and behavioral components and for anyone to heal from the trauma, both elements of thinking and behavior must change. Cognitive behavioral therapy is based on the postulation that a reorganization of one's self-statements results into an equivalent reorganization of the thoughts and behavior which brings out the fact that for recovery to take place there must be a secondary change in thoughts (Gelder, 1989). Hence, it was noble to establish the levels of efficacy of CBT in alleviating pain and suffering experienced by victims of domestic violence, even after many years since the traumatizing event.

The following are some of the substantive propositions based on appropriate discipline and research-based literature concerning CBT. Cognitive behavioral therapy approach has the following attributes: a supportive relationship between the client and the therapist, the premise that psychological suffering is largely a function of disorders in cognitive processes, a focus on altering cognitions to produce the desired change in feelings and behavior, and a largely time-limited and educational treatment focusing on specific and organized targeted problems (Arnkoff & Glass, 1992; Weishaar, 1993). This makes it necessary to spend more time with victims and perpetrators of domestic violence, for any healing to be achieved. Cognitive behavioral therapy lays emphasis on the thoughts and urges, rather than on supposed sources of those covert events. It is concerned with the development, maintenance and alterations of behavior. Learning experiences or failure to receive or profit from various learning experiences accounts for the behavior in an individual (Craighead, 1994).

During therapy, the individual is not essentially helped to gain awareness into the origin of current problems but to instead, stress is laid on the environmental, situational, and social factors that influence domestic violence (Kazdin, 2001). This fact is supported by the type of questionnaire assessing exposure to domestic violence (see Appendix C). All these variables are called to play in the application and effectiveness of cognitive behavioral therapy. Effective therapy should therefore aim at alteration of the behavior the client presently expresses. This approach is highly scientific as it is methodological in terms of assessment of behavior, evaluation of intervention and minimization of inferred variables. It also has enabled identification of gaps, as well as ways and means of addressing them. Both the theoretical framework and conceptual framework in this research are supported through a review of the available literature.

2.8. Conceptual Framework

The Conceptual framework demonstrates interrelationships of the predictor variables of domestic violence. It forms a symbolic representation of the abstract ideas and the complex mental formulation of experiences by individuals. It also forms the operationalization of variables, showing how the variables in the study interact. This is the researcher's supposition originating from the literature review. The conceptual framework shows domestic violence as the heart of the study and the center of the problem. The model seeks to illustrate the possible factors associated with the disease of domestic violence and impact of CBT. The conceptual framework integrates the issues that have been observed from the available information, adopting best practice as well as building on the success of other interventions carried out by other therapists and researchers. Studies show high rates of violence in families, consequently attributable to psychological disorders such as anxiety, depression, hysteria, eating disorders, suicidal tendencies, and schizophrenia, among others, as classified in diagnostic statistical manual (DSM V 2013; DSM IV 2004), which are important in this research.

According to Creswell (2011), an independent variable is thought to be a cause or an effect of an outcome variable such as domestic violence (dependent variable). It can also be called a predictor variable or antecedent variable. A dependent variable is affected by changes caused by an independent variable. It can also be called outcome variable or consequent variable (Elms, Kantowitz & Roediger III, 2003).

The conceptual framework provided has three types of variables: demographic variables such as age, marital status, gender, religion, culture and so on (see Appendix C). They were measured using single-item questions and closed-ended questions. Demographic variables are linked with the moderating variables such as economic status (household income), family conflicts, un-employment, among others. Thirdly, there are dependent variables which are experienced by the victims of domestic violence, such as physical assault, sexual abuse, psychological assault, economic coercion, and use of children by a partner; as well as data collected through in-depth interviewing method. These were measured by use of single-item questions and open-ended questions (see Appendix D). In addition, anxiety and depression are dependent variables which arise as a result of victims being exposed to domestic violence. Lastly, independent variable, which is the intervening variable by using CBT, was measured using multiple items as seen in the hospital anxiety and depression scale (see Appendix E).

Enabling environment of domestic violence occurrence is motivated by a perpetrator with propensity to cause harm to the other party and the availability of the other person who is helpless in avoiding the situation, and hence overpowered by the perpetrator. In the occurrence of the above, there are inhibitory and facilitatory factors. The inhibitory factors (reducing domestic violence) include less use of alcohol, less use of drugs, above average social economic status, high level of self-esteem, supportive social cultural orientation, and high education status, among others. There are also facilitatory factors (increasing the problem) such as alcohol, drugs, poverty, lack of employment, low education level, low social cultural orientation, among others. Application of CBT enabled minimization of the facilitatory factors of domestic violence while at the same time strengthening the inhibitory factors leading to reduction and control of domestic violence. Application of CBT on anxiety and depression lead to reduction of the effects of domestic violence and consequently the victims of domestic violence have a normal life. This thought is also supported by the works of various psychologists such as Aaron Beck (1957) and Albert Ellis (1962) (see Figure 3).

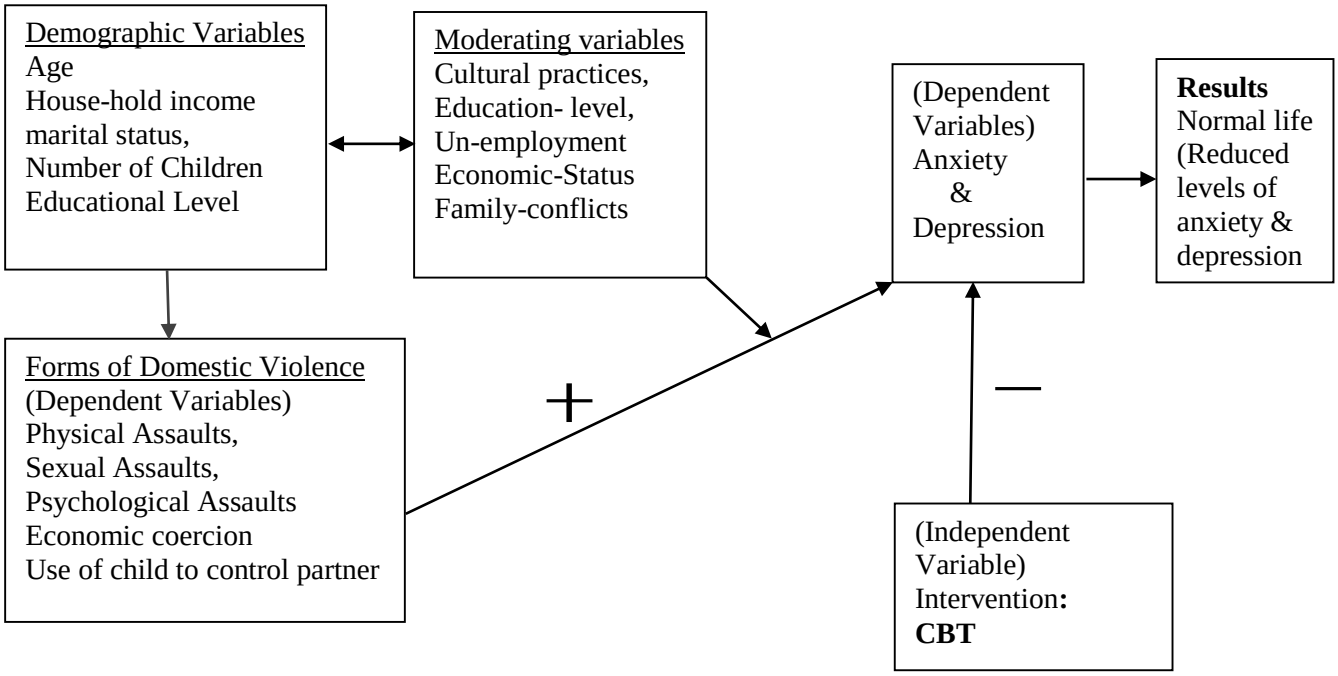

Figure 3: Conceptual framework flow chart showing psychosocial factors interactions

Key: The + sign indicates increase

The - sign indicates reduction

CHAPTER THREE
METHODOLOGY

3.1 Introduction

The success of this study was achieved through engagement of an essential methodology of a well-designed intervention and comparative study which strives to answer the question: Did the intervention method work compared with some other treatment? Comparison of this nature is a fundamental part of a scientific method. Therefore, effectiveness of CBT in this study was achieved following the design principles, alongside usage of statistical analysis and modeling. This study engaged snowballing, random assignment, experimental control, pretesting and retesting, which were the major influences of validity and reliability of the study. The pretest-retest design for this study is an example of repeated measures, where there is the baseline, mid and end of study measurements. The change equals the results of baseline, minus the end of study measures that evolve over a time, even when there is no intervention, hence use of time-line series in the final analysis of the quantitative data. This maturation or statistician's characterization is key to a scientific research (Fisher & Garson, 2010). This approach ensured reliability and validity of the study.

In light of this, this chapter is subdivided into the following sections: research design, study setting and participants, target population: inclusion and exclusion criteria, sampling procedure, sample size estimation, research instruments: demographic, domestic violence assessment, hospital anxiety depression scale (HADS), interviewing guide for key informants and focus group discussions guide, intervention criteria, data collection, data management and analysis, the ethical considerations and lastly, the limitations of the study.

3.2 Site Description

Kibra Constituency is located in southwest of Nairobi City, and includes Kibera slum and adjoining areas such as Lang'ata, Karen, Dagoretti and Kilimani areas. Kibra is a Nubian word meaning 'forest' or 'jungle'. Kibra Constituency is within Nairobi County, and has an area of 12.1km^2 (IEBC, 2015) and a population of 201,365 people (KNBS, 2016). It is a cosmopolitan constituency with people from different parts of Kenya and East Africa. As a result of the social and economic changes, some women and girls living within this constituency have experienced domestic violence. In most cases,

they visit nearby health facilities for treatment and to receive counseling services. This was the reason why the researcher identified Kibra for the study because it represents the larger part of Kibera slum and other slums within Nairobi County (see the map of Kibra Sub-County below).

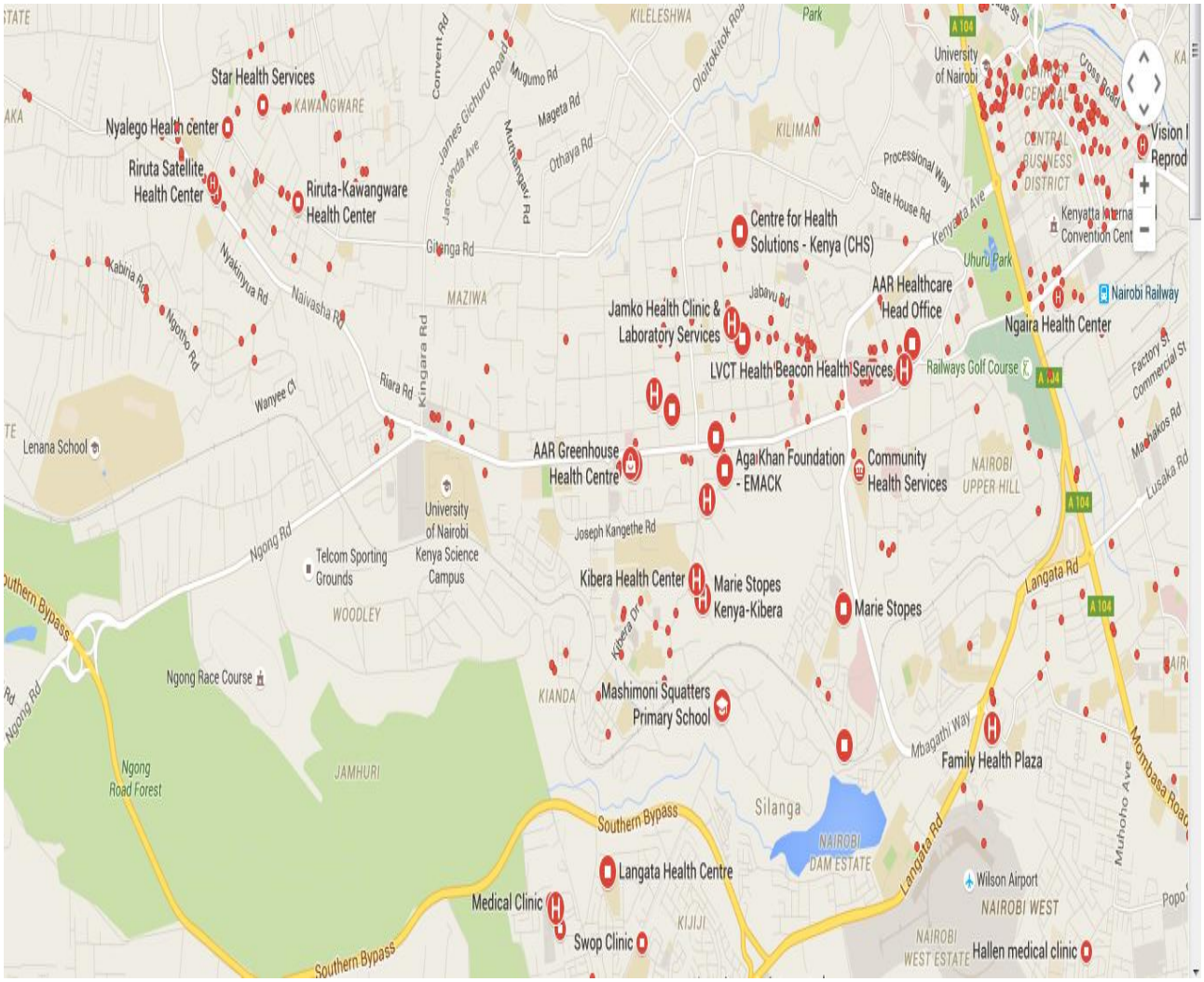

Figure 4: Current map of Kibra Sub-County Nairobi City

3.3 Research Design

The study design that was followed in this research was guided by the work of Fisher and Garson (2010), which states that intervention studies, both experimental and quasi, have been invaluable sources of scientific information and knowledge. The study applied a mixed method approach of both quantitative and qualitative approaches, which complement each other in data collection and analysis as per the proposed objectives and hypotheses. The study used both cross-sectional survey method

and a short-term longitudinal study designs for data collection. Quantitative approach was used to gather data for all the objectives while qualitative approach helped to gather data for objectives one, two and five. Quantitative data was gathered using structured questionnaires, administered self-report inventories, and by applying repeated measurement data collection methods. On the other hand, qualitative data was gathered by use of an interviewing guide for key informants and focus group discussion (see Appendices C to F).

3.4 Unit of Analysis and Unit of Observation

The study targeted women aged 18 years and above attending the selected health facilities for various reasons. The women experiencing domestic violence or had experienced the same were purposively selected from the population. The research participants for both intervention and non-intervention groups were the women who had high scores of anxiety and depression.

3.5 Target Population

The target population constituted of women of child-bearing age, that is, 18 years and above, attending the selected health facilities within reach in Kibra Constituency, Nairobi County. These women were attending the health facilities for various reasons apart from domestic violence experiences.

3.6 Sampling Procedure and Sample Size

3.6.1 Sampling procedure

The research process started with the introduction of an informed consent form, which was presented to the participants and explained by the principal investigator (PI) assisted by the research assistants. The consent form was signed by both the research assistant and the participant as a sign of consent to freely participate in the study. After consent signing, the study took the following steps: the principal investigator or the research assistant first step was to assist the participants fill the social demographic questionnaire followed by assessment of the forms (types) of domestic violence. This was to ascertain those exposed to domestic violence as an inclusion criteria. Those found to have been exposed to domestic violence had to undergo further test to detect anxiety and depression, using HADS. These participants were randomly divided into two groups: intervention and non-intervention groups. An intervention of CBT was given to the intervention group for a period of 10-14 sessions. This was

repeated on a weekly basis while the non-intervention group participants were called back for treatment towards the 10th session during which the intervention group had made good progress.

In order to establish the efficacy of CBT, two groups were compared, that is the intervention group and the non-intervention group. The reduced levels of anxiety and depression scores among the intervention group indicated the effectiveness of CBT. After the efficacy of CBT was realized, the non-intervention group participants were invited, re-tested, treated and measures were repeated for further comparisons. A test-retest was done to determine the recovery rate of the women getting therapy before and after therapy. This is the reason why time series analysis was necessary to determine the effect of CBT treatment (Steele, 2014).

The second step was to investigate the perception of domestic violence among the sample population and to identify the demographic influences associated with domestic violence by using key informants and focus groups discussions (FGDs). Two key informants from each and within the selected facilities were purposively sampled and prepared for in-depth interviewing, which made a total of 10 key informants for the study. However, two key informants from different health facilities were not available for interviews, thus leaving the researcher with only eight to interview; they gave enough information needed for the study. The FGDs were held within the selected health facilities. The target sample was women aged 18 years and above who were known by the key informants to have experienced domestic violence previously and had recovered or were in the process of recovery. An in-depth interview guide was used and recording of data was done using a digital recorder as well as through note taking (see Appendix F). The methods of qualitative analysis applied were thematic and content analysis, closely taking note of the emerging themes and the sub-themes in the information provided by the participants (Gillham, 2004).

The sampling of the five health facilities was done on the basis of their locality for convenience, given the time and scope of the research. The sample population was identified in terms of the number of reported cases of domestic violence on weekly basis according to the records of the facility. The procedure was as follows: identification of the health facilities in regard to the workload of those presenting with domestic violence and sampling participants coming to the health facilities for medical attention and domestic violence. The sample allocation was weighted to the total number of women attending the facility, and therefore a proportionate allocation was applied in allocating the sample size per facility. The third step involved determining those with anxiety and depression, using

hospital anxiety and depression scale (HADS). The fourth step involved randomly allocating the sample of participants exposed to domestic violence and manifesting anxiety and depression into two groups: intervention and non-intervention groups. The fifth step involved giving the CBT treatment and repeating the test before starting the sessions. This was repeated on a weekly basis for 14 weeks.

3.6.2 Sample size

The sample size depended on the population within the catchment area computed in annual, monthly and weekly bases. This demonstrated the occurrence of domestic violence within the area of the health facilities (see Table 1). The sample size was distributed proportionately to the number of patients' population attending the targeted facilities. This is represented as follows: K is Kibra; TP is Total Population; K1 is Mbagathi Hospital; K2 is Nairobi Women's Hospital, Adams Arcade; K3 is Joseph Kang'ethe Health Centre; K4 is St. Mary's Mission Hospital; K5 is Lang'ata Health Centre.

Sample size estimation was based on the anticipated proportion of those who had experienced domestic violence as per health facility in the past six months using formula by Kirkwood and Sterne (2005). Level of significance at 95% corresponds to the value of 1.96. The value corresponding to the power of 80% is 0.8. Anticipated Prevalence of DV π=0.20 and π_{null} =0.5. Therefore the Sample Size formula: $n \geq [\pi * \sqrt{(p*(1-p))} + \sqrt{(Z*\pi_{null})}]^2 / [(\pi - \pi_{null})]^2$ (Kirkwood and Sterne, 2005).

Thus $n \geq [0.8 * \sqrt{(0.20*0.80)} + \sqrt{(1.96*0.5*0.5)}]^2 / [(0.20-0.5)]^2$.

Hence the minimum estimated sample size is:

$n \geq [0.8 * \sqrt{(0.20*0.80)} + \sqrt{(1.96*0.5*0.5)}]^2 / [(0.20-0.5)]^2$ n>= 149.

After adjusting for refusal rate of 10% giving the final sample size as n= (149/ (0.9) =166. Therefore, the final sample size after adjusting for refusals becomes 166 women. Allocation per facility was as follows: Example, Total Population (TP) for the 5 health facilities was therefore Ki= (Ki/TP) *ESS where *i refers to the hospital 1=Mbagathi, 2= Nairobi Women's Hospital-Adams Arcade, 3=Joseph Kang'ethe-Woodley, 4= St. Mary's Mission Hospital, 5= Lang'ata Health Centre-Southland Clinic* (see the table 1).

A sequential random sampling procedure was used in order to identify the study population. According to Roberts (2003), out of 100 people 10% are likely to have experienced domestic violence

(Roberts, Klein, & Fisher 2003; Breakwell, Hammound & Fife-Shaw, 2003; McLeod 2003). Therefore, the sample size was estimated using the Fishers Test (1998) by applying a prevalence of 10% of those likely to have encountered domestic violence and have developed psychological disturbances (anxiety and depression). Furthermore, studies carried out by Kishor and Johnson (2004) reveal that 10% of women seeking health services related to domestic violence are likely to have psychological disturbances, mainly anxiety and depression, which was the reason why the researcher wanted to interrogate whether this is a most likely scenario in a Kenyan population.

Out of the targeted population of 166 participants, the study achieved a population of 155 who were grouped into two categories. The first category was the participants who formed the intervention and non-intervention groups. The second category was the women who formed the focus group discussions. The first category of women were purposively selected from the study population because they had high anxiety and depression levels and were the best for the research study. According to Kirkwood et al. (2005), for every 500 cases of domestic violence, 10% manifest psychological disorders especially anxiety and depression. Based on this analogy, cost, time and other limitations, the minimum sample for CBT was fifty (50) participants who were selected and randomly divided into two equal groups. The intervention group had 25 and the non-intervention had 25 participants proportionately distributed in the five targeted health facilities. The researcher picked only 50 participants for effectiveness in administering CBT for individual counseling. The intervention group had 25 participants who attended an average of 10 to 13 sessions, while the non-intervention group achieved 20 participants because five participants did not turn up when they were invited back during the 10^{th} session to test their anxiety and depression levels for the purpose of comparison with the intervention group. Afterwards, the women from the non-intervention group who had high levels of anxiety and depression were given therapy sessions using CBT.

The remaining population of 116 participants were women who had earlier been exposed to domestic violence, but were not showing signs of anxiety and depression; they were in the process of recovery. This category was also distributed proportionately in the five targeted health facilities to form the focus group discussions (FGDs) for group sharing. However, only 110 women turned up for the FGDs; six women were not available. During the group discussions, the participants had a chance to learn some few CBT coping mechanisms on how to deal with domestic violence in their settings (see Table 1).

Table 1: The health facilities reached sampled

Serial	Health Facility	No. of patients attended within the study period	Study sample for CBT per health facility	Participants in each health facility for FGDs
K1	Mbagathi Hospital	32	8	24
K2	Nairobi Women's Hospital-Adams	60	16	44
K3	Joseph Kang'ethe-Woodley	18	6	12
K4	St Mary Mission Hospital	27	9	18
K5	Lang'ata Health Centre – Southland Clinic	18	6	12
TOTAL		**155**	**45**	**110**

3.7 Data Collection

3.7.1 Sources of data

The researcher used primary and secondary sources to collect data. Primary sources of data collection are firsthand sources of data gathered by the researcher by administering the questionnaires, in-depth interviews for both key informants and FGDs. On the other hand, secondary data were accessed through reading available literature on domestic violence and cognitive behavioral therapy.

3.7.2 Reliability and validity of the data collection instrument

In this study, two different scales were used to collect data: domestic violence assessment scale and hospital anxiety depression. This was intended to facilitate the researcher to examine the effectiveness of cognitive behavioural therapy among women exposed to domestic violence and how to mitigate the side effects of domestic violence, in Kibra. The domestic violence scale had a Cronbach Alpha $\alpha = .926$; while hospital anxiety depression scale had $\alpha = .721$. The results suggested that the two scales had good internal consistency because of the values of $\alpha > .7$ (see Table 2).

Table 2: Cronbach's Alpha checking for reliability (internal consistency) of the scales

Scale	Author	Number of items	Cronbach's Alpha
Domestic Violence Scale	Ganley (1996)	39	0.926
Hospital Anxiety Depression Scale	Zigmond & Snaith (1983)	14	0.721

Note: N=25; Good internal consistency ranges .7 ≤ α < .9 (Karmova & Martin 2003; & Herroro et al., 2003)

3.7.3 Methods of collecting data

The study adapted a mixed method approach of using both quantitative and qualitative approaches. The quantitative provided the numerical statistics while the qualitative allowed for the exploration of experiences and perceptions of women involved in the study on domestic violence and its consequences. Therefore, the two methods complemented each other in drawing a complete picture of women's experiences. Through the intervention group, the study tested the effectiveness of CBT in dealing with the undesired outcomes of domestic violence, mainly anxiety and depression.

The researcher used different instruments to collect data, including social demographic questionnaire for general population, assessing domestic violence for both the victims and perpetrator's pattern of assaultive and coercive behaviors, for identifying domestic violence. This is a validated tool developed by Ganley and his co-workers (Ganley, 1996). hospital anxiety depression scale was also used to identify anxiety and depression. It is a validated tool developed by Zigmond and Snaith (1983). In-depth interviewing guide for key informants and focus group discussions were used to gather data for qualitative research. The data was collected using digital recorder as well as notes writing (see Appendix F). Thematic and content analysis was carried out, closely taking note of the emerging themes and the sub-themes produced by the participants (Gillham, 2004). Cronbach Alpha scale was used to test for validity and reliability of the test instrument used. In general, the Cronbach Alpha reliability and validity test range from 0.71 to 0.90 (Karmova, & Martin 2003; & Herroro et al., 2003). The average Cronbach Alpha is 0.80.

a) Quantitative method

The study started with visits and discussions with hospital management personnel. This was done by the principal investigator, assisted by the research assistants (counsellors), seeking permission to conduct the study in the conveniently identified study institutions. The visits and discussions also helped in establishing the number of participants to include in the study per health facility. The agreement with the hospital personnel was that, once the patient had finished with the medical treatment, she would be asked to visit the counseling department for further treatment if previously she had been exposed to domestic violence. Once the client checked into the counseling department, she was expected to sign the consent form to show that she was willing to participate freely in the study. The principal investigator and the research assistant established if the client had been exposed to domestic violence and the levels of anxiety and depression. Furthermore, the clients' social demographics variables were picked in order to establish how these may influence the occurrence of domestic violence (see Appendix C).

The questionnaire captured data on matters related to domestic violence in regard to physical, sexual, psychological assaults, economic coercion, and use of children to control one's partner. In order to obtain a baseline for this study, the participants were further subjected to another screening process seeking to identify those who may have developed psychological disorders, mainly anxiety and depression. This was done using a validated tool developed by Zigmond and Snaith (1983), namely, the hospital anxiety and depression scale (see Appendix E). This formed the baseline testing for identifying those with anxiety and depression using HADS.

Hospital anxiety depression scale is commonly used to determine the levels of anxiety and depression that a patient may be experiencing. It is a fourteen-item scale that generates ordinal data, in which seven items are related to anxiety and the other seven related to depression. The participants diagnosed with anxiety and depression of scores above eleven (11), having been exposed to domestic violence, were given therapy for 10 to 14 sessions strictly using CBT. A retest was done before the beginning of every proceeding session, to determine the changes in relation to anxiety and depression. The participants who scored eleven and below in the HAD scale were deemed to be in normal condition and not suffering anxiety and depression. These were asked to leave their contacts and were called by the principal investigator to come back towards the end of the study for end line retesting, for comparison purpose and also to be part of the FGDs. Diagnostic Statistical Manual (DSM-V,

2013) gives the categories of 0 to 7 as normal, 8 to10 as borderline condition and 11 to 21 as abnormal condition (see Appendix E). This categorization was adopted by the researcher to group the participants for the experimental design (intervention and non-intervention groups) and the focus group discussions (see Figure 4).

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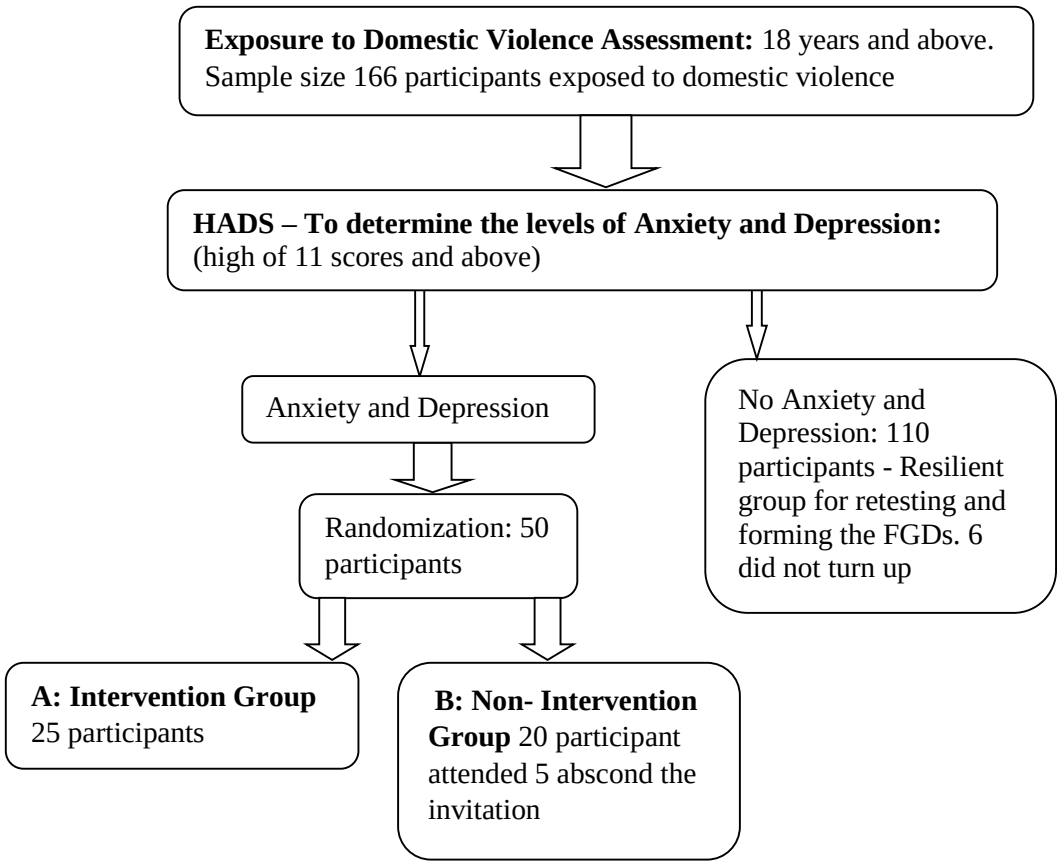


Figure 5: Sampling process into the intervention and non-intervention

After sampling process was done, the study had two groups: the intervention group and the non-intervention group. Test- retest approach was used to determine the recovery rate of the individuals after therapy for both groups. Non-intervention group was treated on the 10^{th} session concurrent with the intervention group session schedule. The non-intervention group was advised to leave their contacts with the researchers so as to be contacted at end of the study for retest and to form part of the FGDs.

In every scientific research, there should always be a scientific method that is followed to arrive at a logical conclusion as Bernard Lonergan puts it in his book 'Method of Theology' (Lonergan, 1990).

In this view, for CBT effectiveness to be tested, the following method was used within a period of 10 to 14 sessions. The summary of the sessions were adapted and modified from Cognitive Behavioral Therapy, Urdu Manual which was developed by Naeem Kingdom in 2010. This was done in order for the main researcher and research assistants to follow the sequence for the purpose of similarity in practice during the research and to draw a similarities and differences between the western countries model of CBT with an African tailored CBT. Naeem Model takes the following sequence: Mood check where the therapist asks about the mood since the previous session. The second step is the Bridge where the focus of the previous session is reviewed to create a bridge to the current session. The next step is Agenda, here the therapist and client identify issues to address in the current session that will act as the agenda. Homework review follows where the homework from the previous session is reviewed to note progress and troubleshoot any difficulties that may have emerged. Afterwards the Agenda items follows where the agenda issues are addressed using cognitive and behavioral strategies. New homework are given which includes giving exercises and tasks for the upcoming week. The last step is Summary and client feedback which is wrap up of the sessions.

A kind of African approach to CBT involved the following sequence: The 1st session was to carry out the intake process by getting the demographic details about the participants, administering HADS and introducing the participant to CBT process for the purpose of making the client comfortable and understood. Furthermore, the therapist helped the participant to identify the agenda of the session before describing the psychological disturbances they were experiencing. Sessions 2 to 4 were providing information on anxiety and depression in understanding the causes, symptoms, consequences and treatment of anxiety and depression of which if severe it would require medical intervention. The therapist evaluated participant's current scores on the HADS scale with the previous scores. The purpose of the score check was to see if the participant's had improved since the previous session.

In Sessions 5 to 8, the previous session was reviewed to bridge it with the current session. Here, the participants were learning to link their daily activities with anxiety and depression. The purpose was to enable them understand how that affected their performance and functionality. They also learnt deep breathing and identifying negative thoughts and feelings. During these sessions, the participants were given homework which was reviewed to note the progress and find out solutions in areas where they had difficulties. The issues emerging were addressed using CBT skills.

Participants attending sessions 9 to 11 were trained on how to take advantage of CBT techniques, to change their thoughts and behavioral patterns. They also learnt problem solving skills and were also assigned exercises and tasks for the following week. During the 12th to 13th sessions, the participants were expected to conceptualize the concepts of their unhealthy attitudes and faulty assumptions. Participants were to meditate on their beliefs and rate themselves on the scale of 1-10. The ending phase was marked on 13th and 14th sessions, where the therapist had discussions with the participants on what they had learnt, finding out if they (participants) were practicing what they had learnt, and how they will use the acquired skills in future life when they face difficulties. (See fig 5 below).

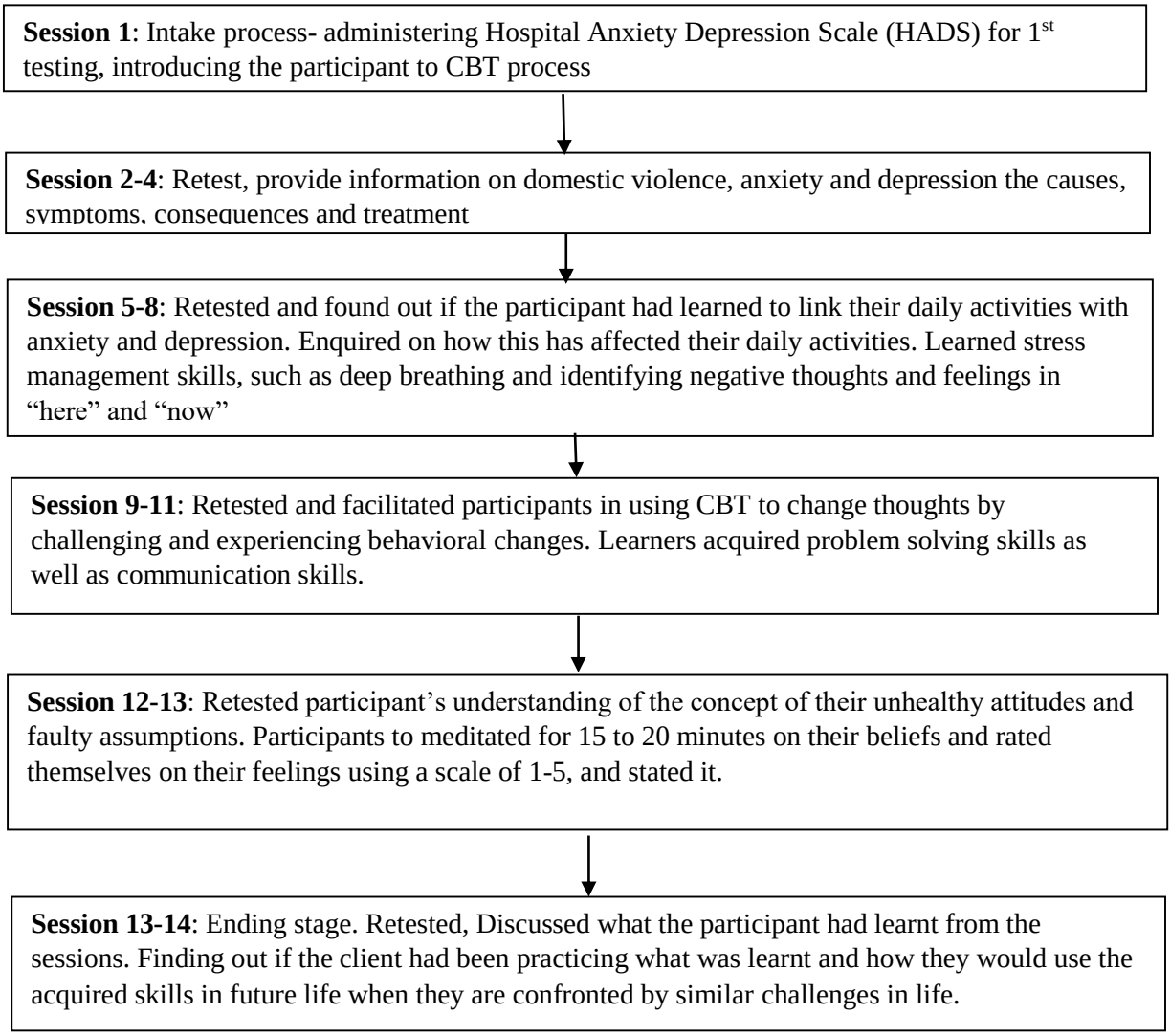


Figure 6: The Muthami Josephine CBT process model (African Women's studies Centre)

b) Qualitative method

This part of the study was meant to complement the quantitative research design where numerical statistical analysis was used. Qualitative data was gathered using a digital recorder, note taking and observation. The data was transcribed and analyzed using both thematic and content approaches, where themes and sub-themes were used. The qualitative study constituted two components: the recruitment of the key informants and the focus group discussions. Eight key informants residing within Kibra were recruited. The key informants were from five health facilities identified for the research making a total of 10 although two key informants were unavailable. The key informants included female nurses, counselors and social workers within the health facilities. They were interviewed on matters concerning their awareness of domestic violence. They also played the role of introducing the researchers to the participants exposed to domestic violence. The researcher was interested to know the following information from the key informants: their perceptions of domestic violence, beliefs, attitudes and behavioral characteristics, manifestations of domestic violence, available intervention strategies and the coping mechanisms (see Appendix F).

On the other hand, the focus group discussion comprised of women aged 18 years and above, who had been exposed to domestic violence but with no psychological disorders. These were women living within and around Kibra. The purpose of FGDs was to elicit information on their perceptions about domestic violence, manifestations of domestic violence, their beliefs, attitudes, behavioral characteristics of both the perpetrator and victim of domestic violence, the challenges and negative impact of domestic violence and the coping mechanisms and available support for victims of domestic violence. These helped to establish the factors associated with domestic violence and psychological disorders. The focus groups constituted 10 to 15 women per group, and were formed on the basis of age categories of 18 to 28, 29 to 39, 40 to 50, 51 to 61, and 62 to 72. The age grouping was to enable women of nearly the same age to participate freely within their age categories without feeling inhibited during the sharing.

3.8 Data Management and Analysis

3.8.1 Intervention

Four research assistants (counselors) were involved in the research. They were qualified professional counselors with a master's degree in counseling psychology, experienced in CBT and had an interest

in working with women exposed to domestic violence. The intervention group constituted of women depicting signs of domestic violence and psychological disorder symptoms (anxiety and depression), with their consent to participate in the study. The intervention entailed individual counseling, using the CBT and debriefing for the counsellors in the groups. The treatment was done once a week for 10 to 14 sessions. Performance was assessed using a pre-post assessment tool, the HADS.

3.8.2 Data management

The data was collected using a semi-structured questionnaire, with some questions having some closed response items. The semi-structured questionnaire was assigned closed items as the research progressed. The values of variables outside the range were checked against the original questionnaire and open-ended questions were re-coded to ensure data completeness. The data was managed in SPSS software for data analysis for initial interpretation. Qualitative data analysis was done using thematic and content approaches. In order to ensure data validity, a double entry procedure was applied for all the data sets to facilitate data validation process. After data entry, the two image files were compared on one-on-one correspondence. Discrepant values were compared with the original data-set and the correct values were included. Data validity was ensured by including valid values in addressing the research questions.

3.8.3 Data analysis

This study involved quantitative and qualitative data analysis approaches. Quantitative analysis required summary statistics such as means, standard deviations, proportions, correlations, and ANOVA for comparison of means by groups and interpretation. On the other hand, qualitative approach required thematic and content analysis. These two approaches complemented each other. The quantitative approach of data analysis has three levels: univariate, which are frequencies for all variables computed, and summary of measures such as minimum, maximum, means and proportions which were also computed. These included descriptive statistics and graphical presentations, constituting exploratory analysis.

The second level of analysis involved computation of bivariate statistical analysis. Bivariate analysis was carried out using the Chi-square test for categorical measurements and t-test for continuous measurements. In bivariate analysis, all the categorical variables were cross tabulated with domestic violence. The Chi-square test was computed and the level of significance was determined at $p< 0.05$.

For continuous measures, analysis of variance was computed and the level of significance was set at the 5%. This is how domestic violence was cross-tabulated with all the other variables: anxiety, depression and other demographic characteristics. The level of significance was pegged at 5% (Viera, July 2008 & LaMorte, May 2013). Those variables observed to be significant at $p<0.15$ were included in the multivariate analysis to determine the factors associated with the domestic violence. In multivariate analysis, variables were observed to be significant if at 15 % ($p<=0.15$).

In order to establish the factors associated with the dependent variables, a step-wise logistic regression analysis using the forward and/or backward selection process was used to establish factors associated with the dependent variables, and logistic regression analysis was applied. A cut-off point of 5% was used to identify the predictors of domestic violence. After applying a multivariate regression analysis, all the variables significant at 5% level constituted the factors associated with the anxiety and depression reduction and CBT efficacy. This enabled the researcher to establish that the factors associated with domestic violence and psychological disorders were identified at p-value less than 0.05. The level of efficacy of CBT among the intervention groups was also established.

3.9 Ethical Considerations

The research ethical considerations were guided by the principles of ethics in both research and counseling practice. The researcher had first to be cleared by the ethical review committee of Kenya domiciled at the University of Nairobi and Kenyatta National Hospital (see Appendix H). It is inevitable that research should considerably be guided by ethics. The Ethical Principles of Psychologists provides five principles for psychologists and counselors which guide research and practice in counseling. These principles are non-maleficence, beneficence, autonomy, justice, and fidelity (Heppner, Kivlighan, & Wampold, 1999). The principal investigator together with the research assistants let the participants understand or know the process in which they were to be involved, including why their participation was of great importance. First and foremost, the participants were assured of confidentiality. They were given an explanation about the process of counseling and how they were to benefit from participation. They were informed of how their information was to be used, how and to whom it was to be reported. The information given was treated with high confidentiality during and after the research and the data was not given to unauthorized persons.

The participants were informed that the results of the study would be available for all who participated in the study, if they so desired. Informed consent was sought from the participants who freely participated in the study without coercion. Therefore, CBT was given only after a client's voluntary informed consent was received. They were free to drop out of the study at their own will and no one was forced to stay on. There was no monetary promises or payments involved. Counselors took every necessary step to alleviate or reduce any sense of distress or discomfort experienced by the client to avoid emotional or psychological harm. The counselors were not to have other forms of relationships with clients except that of the counseling environment. This is to safe-guard any dual relationships. There were no incentives to encourage the participants unless it was appropriate, and with good sense and not to have undesirable effects of unprofessional behaviors. The counselors applied only the appropriate method of counseling, CBT, for the purpose of the study. They were trained and provided with the CBT manual for correct practice to determine the effectiveness of the therapy (*Ethical Principles of Psychologists*, 1996). The counsellors received debriefing sessions on a weekly basis as well as supervision from the principal investigator for the purpose of standardization, professionalism and sustainability.

Ethical considerations require reliability and validity as crucial concepts for this kind of research design (Davis, 2003). Reliability for this study refers to the consistency or stability of any experimental effect, such as the use of research tools. The most common technique for establishing reliability is by replication (Davis, 2003). This means that same experimental design results can be obtained in subsequent occasions, even by using different samples. Therefore, reliability is established by other researchers replicating the particular experimental paradigm within their own research. Validity, on the other hand, refers to whether or not the experiment explains what it claims to explain (Davis, 2003). The reliability and validity of the tools in this study are already done as these tools have been used elsewhere by other researchers (Ganley, & Schechter, 1996, Zigmond & Snaith, 1983) (see Appendix E).

Randomization of the study sample was also an ethical concern. This was to ensure that as few differences as possible exist between the different participants in the two groups, by giving every participant an equal chance of being allocated or selected to each of the experimental conditions to be fair to all. Screening for psychological disorders such as anxiety and depression was done after the patient's acceptance to participate in the study and signing of the informed consent form (see

Appendix E). Those participants identified with psychological disorders were randomly assigned to both intervention and non-intervention groups. The intervention group was treated first, using CBT, followed by the non-intervention group while the test retesting was conducted with every individual participant. Treatment was offered in accordance to the usual Ministry of Heath guidelines to ensure that no one was left unattended. The key informants and the FGD participants were equally handled with the utmost ethical considerations like all the other participants in the study.

3.10 Limitations of the Study

The study applied a follow up approach design, where the participants were required to come back for a number of sessions for therapy. There are those who missed the scheduled visits. Others opted to drop out of the study or migrated to other locations. In the sample size estimation, these factors were adjusted and appropriate methods of analysis were applied in order to reduce the biases in the results. Therefore, to access an adequate number of participants and the ability to have follow ups during and after the study were limited to the participant's availability. Research on violence may raise major issues of safety and ethics because some victims may not like sharing their experiences and may fear their perpetrators, who may have threatened them. Usually, treatment of domestic violence may take a long time for the client to recover and hence reduction of effects of domestic violence may require a longer time.

CHAPTER FOUR
DATA PRESENTATION AND RESULTS

4.0 Introduction

This chapter analyses both the quantitative and qualitative data on the effectiveness of cognitive behaviour therapy (CBT) on treating women who have been exposed to domestic violence. The presentation was guided by the study objectives and the findings grouped accordingly. The quantitative data was analysed using descriptive statistics such as the measures of central tendency: means, deviations, variances, and coefficients. Use of percentages, frequencies, and cross tabulation made the presentation clearer and elaborate. The findings have been presented using tables, charts, and graphs. On the other hand, qualitative data was presented thematically, while the verbatim transcription of responses from the key informants and focus groups discussions were included in the research.

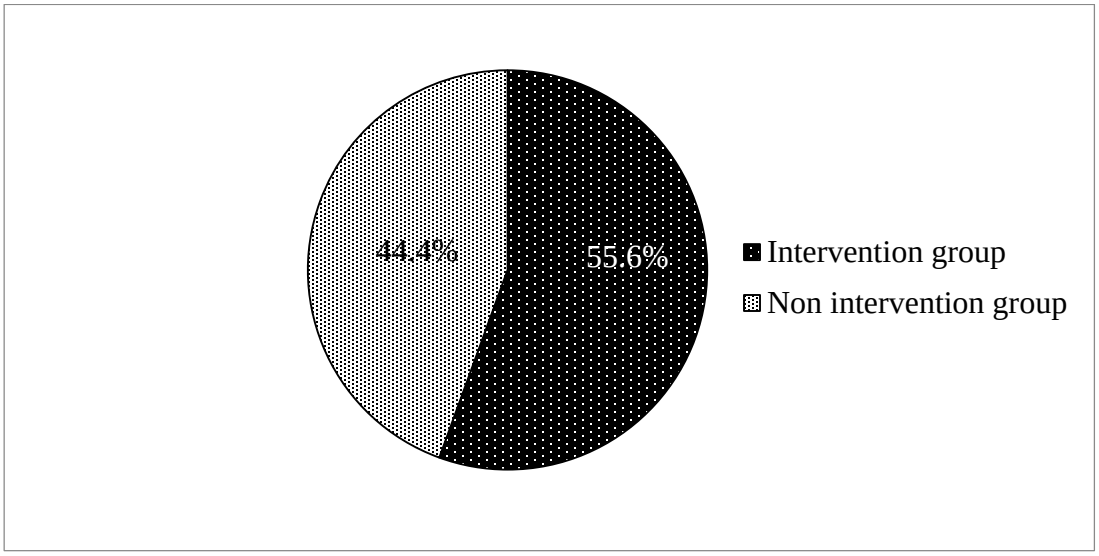
4.1 Analysis of Quantitative Data

4.1.1 Questionnaire return, response rate and missing data analysis

The researcher intended to contact 166 women seeking health services, having been referred by the key informants working within the health facilities. However, the researcher had a sample size of 155: 45 women for intervention and non-intervention (5 did not turn up), and 110 women for FGDs (of these, 6 did not turn up). This translates to a response rate of 93.3% of the sample size. The study sample was meant to be 50 participants who were randomly assigned into two groups: intervention and the non-intervention groups. Details of five (5) participants from the non-intervention group were removed from the dataset because they failed to turn up for the second invitation for retest.

The study sample participants were purposively selected on the grounds that they were seen to have developed anxiety and depression tendencies after experiencing domestic violence. The number of participants (50) was guided by Fishers Test (1998). According to Roberts (2003), out of 500 people, 10% are likely to have experienced domestic violence. Therefore, the study had 25 participants from the intervention group and 20 from the non-intervention group. Five participants from the non-intervention group did not turn up for the second invitation. Their data was consequently removed from the final data used for this analysis. This is because important data was missing and therefore

insightful information would not be obtained from these missing participants. This left the final data in respect of 45 participants. The distribution of the participants from the groups is summarized in the pie chart in Figure 6.



Note: N=45

Figure 7: Proportion of participants in the intervention and non-intervention groups

4.1.2 Forms of domestic violence

From the research, the participants had been exposed to different kinds of domestic violence, which left them with high levels of anxiety and depression. The types of domestic violence which these clients had experienced included: physical assault, sexual assault, psychological assault, economic assault, and use of children to control the other partner (see Table 3). Table 3 demonstrates in a detailed manner each category of domestic violence and the scores. Women who had been exposed to physical violence reported to have been hit by the perpetrator using a fist or other crude weapons. Women who reported to have been exposed to psychological assault said that the perpetrators had humiliated them by calling them names and using such putdown words as dirty woman, lazy woman, stupid woman, prostitute, good for nothing, just to mention a few. Women who had been sexually assaulted reported having been manipulated and coerced by the perpetrators into sexual intercourse when they were not ready, and in the process they were injured. Economic coercion was as a result of women being left out in decision making on matters regarding how to use or spend money. Lastly, the use of children to control the other partner was highly reported when the one partner tried to sabotage the parenting skills of the other partner. Therefore, from the study findings all participants

were exposed to emotional and psychological abuse. Economic coercion was also common among the participants, with 91.1% of them claiming that they were financially controlled and deprived. Witnessing physical violence was also a common occurrence to the study participants, with 88.9% of the participants claiming to be exposed to it. Sexual assault and using children to control spouses were mentioned by 77.8% and 62.2% of the participants, respectively.

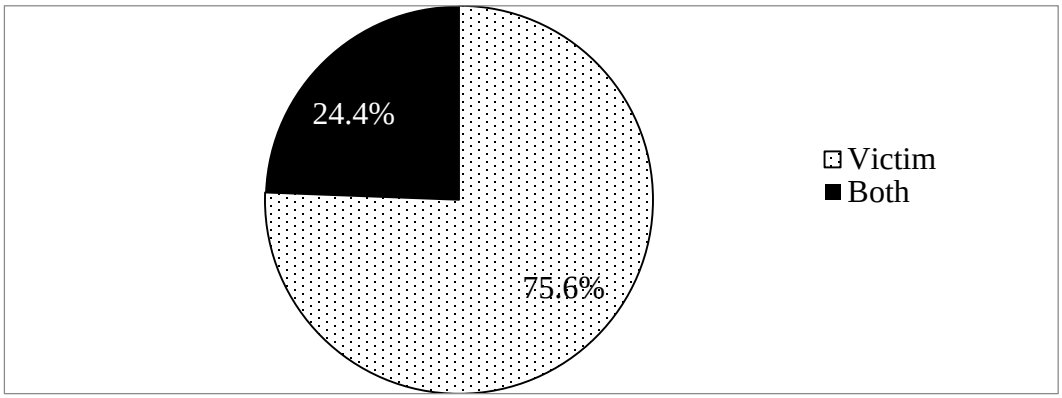
Table 3: Exposure of the participants to domestic violence

Exposure to domestic violence		Frequency	Percentage
Witness of physical violence	No	6	11.1
	Yes	44	88.9
Sexual assault	No	11	22.2
	Yes	39	77.8
Emotional and psychological abuse	Yes	50	100.0
Financially controlled and deprived	No	4	8.9
	Yes	46	91.1
Using children to control you	No	19	37.8
	Yes	31	62.2
Sample size (n)		50	100.0

a) Perpetration due to victimization

The findings of the study reveal that 24.4% of the study participants become perpetrators as a result of victimization. This occurs especially in instances where there is physical assault, psychological and emotional abuse, as the victims make attempts to fight back and eventually turn out to be perpetrators. Furthermore, research had confirmed that, in many instances, some of the children from home settings where they faced or witnessed domestic violence later in life become perpetrators if no therapy is administered to them. Further probe into the study indicated that women become perpetrators of domestic violence due to frustrations as a result of male chauvinism that puts women

far below men in decision making. The remaining 75.6% of the study participants were just victims who were not perpetrators. These were mostly cases of sexual assault as well as the use of children to control the partner. The study found out that it is women and children who mostly fall victims of domestic abuse because of marginalization (see Figure 7).



Note: N=45

Figure 8: Pie chart showing the level of perpetration as a result of victimization due to DV

b) Association between exposure to domestic violence and perpetration/victims

The findings of the study reveal that 24.4% of the study participants who were women facing domestic violence at some point became perpetrators as a result of being victimized emotionally and psychologically, as well as being financially controlled and deprived by the perpetrators. The study also found that 10.7% of women who had been victimized by use of children to control them became perpetrators of domestic violence directed to their partners or children. This was a kind of displaced anger and bitterness directed to children to vent out negative emotions caused by perpetrators. Hence, these women who were initially victims of domestic violence eventually turned into being perpetrators themselves.

Table 4: Exposure of the participants to domestic violence by perpetration

	Perpetrator or victim	
	Victim	Both victims and perpetrators
Witness of physical violence	77.5%	22.5%
Sexual assault	77.1%	22.9%
Emotional and psychological abuse	75.6%	24.4%
Financially controlled and deprived	75.6%	24.4%
Using children to control you	89.3%	10.7%

Note: N=45

4.1.3 Socio-demographic variables influencing domestic violence among participants

Demographic profiles of participants help the reader to create a mental picture of the participants and, by extension, the population which they represent. Even though demographic variables are not manipulated, relationships between them and the dependent variables can be explained, as it is done later in this study. The demographic variables reviewed are age, education level, marital status, children, religion and performance in primary, secondary and tertiary schools. These results are summarized in Table 5.

The information on age among the participants was sought to find out if there is age representation in terms of women undergoing domestic violence. More than 70% of the total participants were aged 50 years and below. Comparing the age distribution of the participants by group, the intervention group seemed to have a young population, whereas in the non-intervention group 50% of the women were more than 50 years of age, although this was a random distribution. The study discovered that these women faced domestic violence from their partners mostly because they were young couples who were trying to settle down and begin a family.

The study also revealed that 48.9% of the participants had tertiary education while 33.3% had O-level as their highest education level. The rest, 17.8 %, of the participants had primary and below levels of education. Sixty percent of participants from the non-intervention group indicated that they had completed tertiary education. Therefore, the study found that domestic violence cuts across education levels. In other words, it affects both the learned and those with little or no education at all. However,

what came out strongly from the research is that women with less education of primary or no education at all did not seek for help from health facilities unless their case was severe such as being severely burnt, being cut with daggers, being sexually assaulted. On the contrary, women who were well informed in terms of education, that is, those with secondary and university education, sought help from health facilities immediately when they sighted signs of domestic violence and when they started experiencing symptoms of depression. These women reported issues such as lack of sleep (insomnia), migraine, and restlessness. The study findings show that these women were aware of what may lead to depression and therefore sought immediate help from health facilities. Lastly, this category of women, who are well informed of their rights, could not be intimidated by customs and traditions which do not empower women to fight for their rights in "the men's' world".

In regard to the participants' distribution by marital status, almost a half of the participants (46.7%) indicated that they were married, with 26.7% stating that they were single. Interestingly, 12% of the participants from the intervention group claimed to be separated, whereas 15% of the participants from the non-intervention group indicated that they were divorced. The findings indicate that married women staying with their husbands are the ones who face domestic violence at high levels of DV as compared to the other marital statuses, which justifies the definition of domestic violence. Women who are single face domestic violence especially from their ex-boyfriends, who still follow, stalk and terrorize them. Separated women face challenges because majority have had children with the perpetrator who keep following them, sabotage their parenting skills; at the same time children keep asking about the absence of their father. Women who are cohabiting face similar assaults like the married ones, although they live in constant fear of what might happen the following day. Majority of them stick in abusive relationship only because of children and being economically disempowered. Divorced women face domestic violence from their partners especially when it came to the family inheritance and the custodian of the children. Women who had been widowed face domestic violence from their in laws where they are married, because these in laws attempt to grab whatever was left behind by their late husband.

The results of Table 5 also indicated that 73.3% of the participants indicated having children. Thirty-six percent of those from the intervention group claimed to have no children, whereas 85% of those from the non-intervention group had children. The results point to disparity in terms of participants with children in the non-intervention group as compared to those in the intervention group. From the

findings, there seems to be a relationship between children and domestic violence. For example, married women who have no children due to various reasons face domestic violence emanating from in-laws who demand they bear children for them. Furthermore, some men deny being the real fathers of the children their wives beget, which also causes domestic violence. Families which have financial constraints and have more children than they can support experience domestic violence because the perpetrators neglect their responsibilities of caring for the children.

The results also indicate that more than 90% of the participants were Christians while only 4.4% indicated that they were Muslims. Having a small percentage, one cannot generalize if domestic violence is more among Christian than among Muslims. The assumption can be that Christians seek help more promptly when assaulted than Muslims. Lastly, the results indicated that most of the participants were moderate high performers in school (primary, secondary and tertiary). In terms of primary school performance, 56% of the participants from the intervention group claimed to be moderate performers whereas 45% of the participants from the non-intervention claimed to have been high performers in primary school. In regard to secondary education, only 15% of participants indicated that they were high performers. This was a significant drop considering that 45% of the participants indicated that they were high performers in secondary school. Finally, in terms of tertiary education, it is clear that 46.7% of the participants were moderate-to-high performers, especially those from the non-intervention group where 60% of the participants claimed they were high performers.

The household income is crucial in management of marriage or partnership and in taking care of children. As mentioned earlier, financial constraints trigger domestic violence. However, the research findings show that domestic violence cuts across all levels of economic status, whether high, middle or low household income. Some of the women who participated in the study were engineers, accountants, human resource managers, medical personnel, business women and dentists, who said they earned high incomes of Kshs20,000 and above, yet they were also experiencing domestic violence in their home settings. The middle household income earners were women who were operating groceries, salons, food kiosks, earning between Kshs10,000 to Kshs19,000. They too faced domestic violence. Lastly, the women who had low income earning were those women who were unemployed, housewives, students, house-helps, who earned less than Kshs9,000 per month. Even they faced domestic violence (see Appendix C).

The study shows that household income has an indirect association with domestic violence in the sense that when a wife threatens her husband's authority as the head of the family in terms of her income contribution to the family, the man will turn violent to assert himself. On the other hand, wives who are completely dependent on the husband for financial support, may be victims of domestic violence since the husband looks at them as vulnerable, helpless and incapable of being on their own, hence they are subjected to abuse. The research reveals that middle household earners tend to experience low occurrences of domestic violence. This can be attributed to the fact that both the wife and the husband are in the same range of income, which make the two equal contributors to the household income, consequently reducing cases of financial conflicts.

Table 5: Distribution of the socio-demographic characteristics of the participants

Socio-demographic variables		Total		Intervention group		Non-intervention group	
		%	F	%	F	%	F
Age	18 to 28	24.4	11	32.0	8	15.0	4
	29 to 39	22.2	10	28.0	7	15.0	4
	40 to 50	24.4	11	28.0	7	20.0	5
	51 to 61	13.3	6	12.0	3	15.0	4
	62 to 72	15.6	7	0.0		35.0	8
Education Level	None	4.4	2	4.0	1	5.0	1
	Primary	13.3	6	16.0	4	10.0	3
	Secondary	33.3	15	40.0	10	25.0	6
	Tertiary	48.9	22	40.0	10	60.0	15
Marital Status	Single	26.7	12	32.0	8	20.0	5
	Cohabiting	6.7	3	8.0	2	5.0	1
	Married	46.7	21	44.0	11	50.0	13
	Separated	8.9	4	12.0	3	5.0	1
	Divorced	8.9	4	4.0	1	15.0	4
	Widowed	2.2	1	0.0		5.0	1
Having children	Yes	73.3	33	64.0	16	85.0	21
	No	26.7	12	36.0	9	15.0	4
Religion	Islam	4.4	2	8.0	2		
	Christianity	95.6	43	92.0	23	100.0	25
Performance in Primary Education	High	35.6	16	28.0	7	45.0	11
	Moderate	48.9	22	56.0	14	40.0	10
	Low	11.1	5	12.0	3	10.0	3
	Not applicable	4.4	2	4.0	1	5.0	1
Performance in Secondary Education	High	22.2	10	28.0	7	15.0	4
	Moderate	53.3	24	48.0	12	60.0	15
	Low	6.7	3	4.0	1	10.0	3
	Not applicable	17.8	8	20.0	5	15.0	4
Performance in Tertiary Education	High	20.0	9	16.0	4	25.0	6
	Moderate	26.7	12	20.0	5	35.0	9
	Low	2.2	1	4.0	1		
	Not applicable	51.1	23	60.0	15	40.0	10
Sample size		45		25		20	

Note: F-Frequency

To understand the influence of demographic variables on the levels of domestic violence, logistic regression analysis was used. One of the domestic violence variables (emotional and psychological abuse) was not included in the models because all the participants (100%) experienced emotional and psychological abuse. Six demographic variables that were used in the analysis included: age, education, marital status, number of children, religion and income.

The study found out that physical violence is not significantly influenced by any of the six demographic variables, $p > .05$. Sexual assault was found to be significantly influenced by only one demographic variable: household income ($\chi^2=10.13$, $p<.05$). Further analysis found that sexual assault is common among women from households with extreme household incomes. For instance, 100% of women from low income households and 84.2% of high income households claimed that they experience sexual assault compared to those from middle income households where only 50% were found to experience sexual assault. Financial control and deprivation was found to be significantly influenced by the number of children that the families had ($\chi^2=4.368$, $p<.05$). As a matter of fact, 81.3% of the women with no children were found to be financially controlled and deprived; 100% of women with one and more children were found to be financially controlled and deprived.

The last variable influencing the level of domestic violence was the use of children to control the other partner, mostly the woman. The findings of the study showed this aspect to be significantly influenced by age ($\chi^2=18.12$, $p<.01$) and marital status ($\chi^2=24.13$, $p<.01$) at 95% confidence level. For instance, only 18.2% of women aged 18 to 28 years were found to experience the use of children to control them while more than 50% of those aged 29 years and above experienced the use of children. The results therefore indicate that instances of the use of children to control women are common among older women than in young women. Similarly, as concerns marital status, only 8.3% of single women were found to experience the use of children to control them compared to 33.3% of those cohabiting, 85.7% of those married, 75% of those separated, and 100% of those divorced. This indicates that domestic violence is more prevalent in marriages. In other words, married women are more likely to suffer domestic violence than unmarried ones.

Table 6: Logistic regression analysis: influence of demographic variables on DV

Demographic variables	Witness of physical violence		Sexual Assault		Financially controlled and deprived		Children used to control her	
	χ^2	p-value	χ^2	p-value	χ^2	p-value	χ^2	p-value
Age	0.353	0.293	0.554	0.160	0.822	0.783	18.120	**0.001**
Education	0.512	0.828	0.719	0.509	1.597	0.500	0.349	0.322
Marital status	1.384	0.546	0.611	0.262	5.806	0.363	24.130	**0.001**
No. of children	1.072	0.689	1.409	0.069	4.368	**0.037**	0.005	0.987
Religion	0.001	0.999	1.275	0.121	1.496	0.203	0.133	0.715
Household Income	4.259	0.119	10.13	**0.006**	1.257	0.533	3.244	0.197

Note: Sig. at p<.05; χ^2-Chi-square (Measure of association).

4.1.4 Association of domestic violence with anxiety and depression

Pearson's correlation analysis was used to understand the association between anxiety, depression and exposure to domestic violence (physical assault, sexual assault, psychological assault, economic coercion and use of children to control partners). The results of the study found out a strong positive and significant correlation between anxiety and depression (r=.715, p<.01). The study also found anxiety to have significant positive correlations with sexual assault (r=.224, p<.05) and use of children (r=.227, p<.05). Similarly, depression was found to have significant positive correlations with physical assault (r=.302, p<.05), sexual assault (r=.392, p<.01) and use of children to control partners (r=.299, p<.05). Finally, the study found positive significant inter-correlations between psychological assault with physical assault (r=.533, p<.01) psychological assault and economic coercion (r=.369, p<.05). Also, sexual assault had positive correlations with physical assault (r=.347, p<.05) and economic coercion (r=.452, p<.01). However, anxiety had insignificant associations with physical assault, sexual assault, psychological assault, economic coercion and use of children to control a partner (p > .05).

Table 7: Pearson's correlation analysis showing association of anxiety, depression and DV

Variables	Anxiety before CBT module	Depression before CBT modules	Physical assault	Sexual assault	Psychological assault	Economic coercion	Use of children to control partner
Anxiety before CBT modules	1						
Depression before CBT modules	.715**	1					
Physical assault	0.041	.302*	1				
Sexual assault	0.224*	.392**	.369*	1			
Psychological assault	0.096	0.270*	.533**	.348*	1		
Economic coercion	0.139	0.251	.368*	.454**	.593**	1	
Use of children to control partner	0.227*	.299*	-0.006	0.152	0.158	0.239	1

*Note: N=50; Significance: *<.05; **<.01*

4.1.5. Efficacy of CBT in reducing levels of anxiety and depression

Multivariate analysis of covariance (MANCOVA) was used to determine the efficacy of cognitive behaviour therapy in reducing anxiety and depression. The mean level and Standard Deviation (SD) of anxiety for the intervention group decreased from (M=19.8, SD=2.2) when they were first invited, and M=5.6 (SD=3.3) after the CBT sessions was administered. On the other hand, the non-intervention group decreased from M=20.5 (SD=1.4) during the first invitation to M=19.8 (SD=2.4) after the second invitation. Similarly, average depression for the intervention group decreased from M=18.4 (SD=4.0) to M=6.1 (SD=3.4), whereas for the non-intervention group, it decreased from M=20.6 (SD=1.2) to M=19.7 (SD=2.4).

Table 8: Mean and SD of anxiety & depression levels on the first invitation and after CBT

Dependent Variable	Condition	Intervention	Mean	Std. Deviation	N
Anxiety	Intervention group	During the first invitation	19.8	2.2	25
		After the CBT Sessions	5.6	3.3	25
	Non-intervention group	During the first invitation	20.5	1.4	20
		After the CBT Sessions	19.8	2.4	20
Depression	Intervention group	During the first invitation	18.4	4.0	25
		After the CBT Sessions	6.1	3.4	25
	Non-intervention group	During the first invitation	20.6	1.2	20
		After the CBT Sessions	19.7	2.4	20

Note: M-Mean, SD=Standard Deviation, N=Sample size

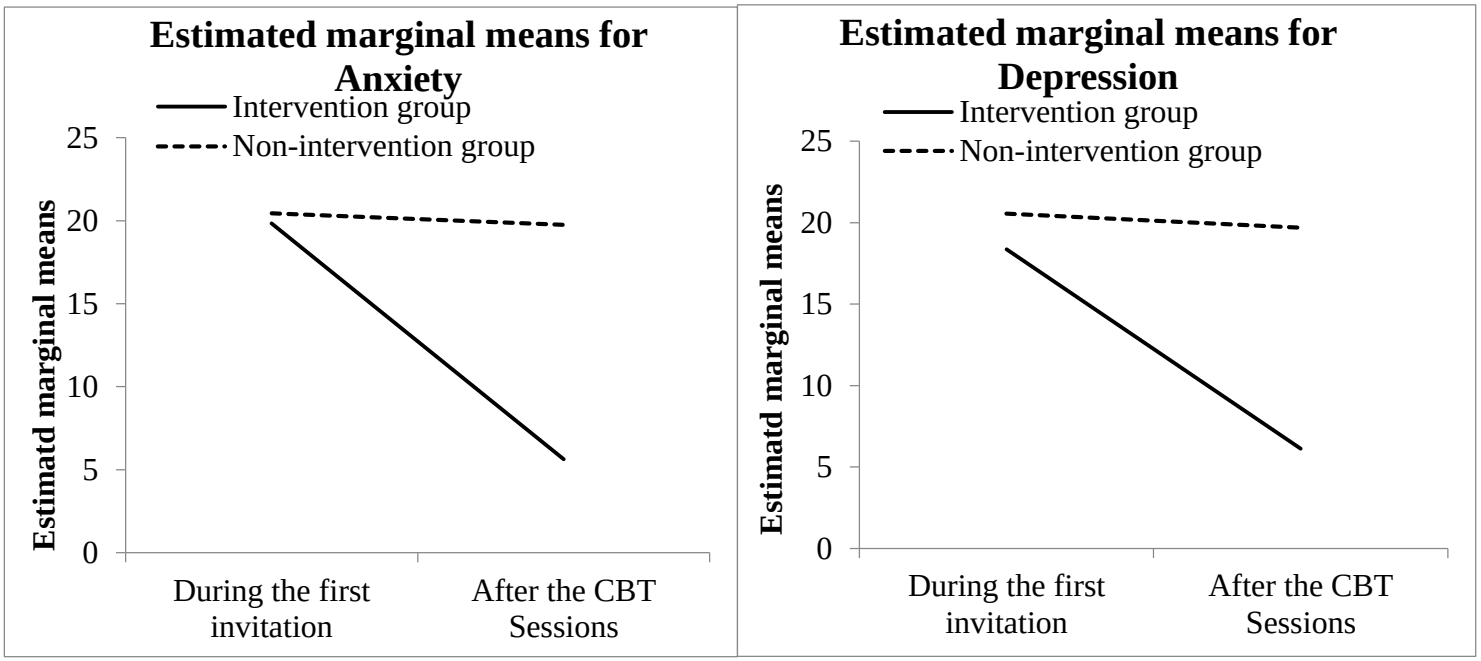
According to the above table, the key independent variables included intervention (first invitation and after CBT sessions) and condition (intervention and non-intervention groups). The relationship between the dependent variables (anxiety and depression) and intervention/condition was adjusted using the number of CBT sessions attended by the participants. The study found that the number of CBT sessions attended have a significant effect on the relationships with anxiety and depression. The MANCOVA analysis found significant decrease for the intervention group between the first invitation and after CBT sessions for both anxiety ($F_{(1, 85)} = 165.45$, $p<.001$) and depression ($F_{(1, 85)} = 77.20$, $p<.001$). The findings are supported by the profile plots shown in Figure 4.6 that found significant reduction in anxiety and depression for the participants who were exposed to CBT sessions and insignificant reduction in anxiety and depression for the non-intervention group ($p > .05$). This is an indication that CBT is an important avenue for significantly reducing the levels of anxiety and depression in women exposed to domestic violence.

Table 9: MANCOVA analysis on efficacy of CBT in reducing anxiety and depression

Dependent Variables	Independent variables	$F_{(1,85)}$	p-value	Effect size (η^2)
Anxiety[a]	Number of CBT Sessions	0.271	0.604	0.003
	Intervention	201.549	<.001	0.703
	Condition	62.957	<.001	0.426
	Intervention * Condition	165.454	<.001	0.661
Depression[b]	Number of CBT Sessions	0.002	0.963	0.002
	Intervention	101.968	<.001	0.545
	Condition	42.768	<.001	0.335
	Intervention * Condition	77.202	<.001	0.476

Note: a. R^2= .878 (Adjusted R^2= .872); b. R^2 = .804 (Adjusted R^2 = .795); Significance at α<.05

[2] Covariate in the model is the number of CBT sessions



Note: Covariates evaluated at "Number of CBT Sessions"=5.58 in the MANCOVA

Figure 9: Profile plots showing the variation in estimated mean scores for anxiety and depression

4.1.6. Factors associated with effectiveness of CBT in women exposed to domestic violence

In the current study, effectiveness of CBT was measured by the amount of reduction in both the anxiety and depression levels as summarized in Table 10. This reduction was computed by getting the difference between the levels at the start and after the last invitation/session. The study findings show several factors to have direct and partial associations with effective CBT. For instance, the number of CBT sessions is factors that have a strong significant association with effective CBT. Hence, women are advised to attend many CBT sessions in order to significantly reduce anxiety (β=1.548, $p<.01$) and depression (β=1.226, $p<.01$). Factors that had partial associations with effective CBT included educational level, performance in primary school, self-esteem and household income. As far as education level is concerned, the study findings revealed that, compared with tertiary education, women with primary education level have the least level of reduction in depression (β=-13.649, $p<.05$). This partial impact makes level of education a factor associated with effective CBT. Similarly, in terms of performance in primary school, the study revealed that CBT is significantly effective (in reducing depression) in women who were moderate performers in primary schools than those who were low performers (β=11.308, $p<.05$). Self-esteem was the third factor that had partial association with CBT effectiveness. Women with moderate self-esteem tended to experience significantly effective of CBT (in reducing depression) as compared to those with low self-esteem (β=4.353, $p<.05$). The last factor that had partial influence on effective CBT (in reducing anxiety) was household income. The study finding show that women of moderate income levels experience significantly effective CBT in terms of reduced anxiety as compared to those of low income levels (β=4.274, $p<.05$). On the flipside, other factors such as the number of children, age, marital status, religion, performance in either secondary or tertiary levels had insignificant associations with effective CBT (reduced anxiety/depression).

Table 10: Likelihood estimation of parameters associated to effective CBT

Parameter		Change in Anxiety between the first and last invitation		Change in Depression between the first and last invitation	
		B	p-value	B	p-value
Intercept		-0.297	0.955	1.406	0.807
Number of children		-0.31	0.221	0.003	0.991
Number of CBT Sessions		1.548	**.0001**	1.226	**.0001**
Age	18 to 28	4.521	0.102	4.607	0.089
	29 to 39	0.221	0.935	1.737	0.512
	40 to 50	2.151	0.401	0.424	0.863
	51 to 61	2.512	0.329	3.911	0.121
	62 to 72	Ref	.	Ref	.
Education Level	None	-1.269	0.803	-7.083	0.237
	Primary	-8.347	0.094	-**13.649**	**0.011**
	Secondary	-5.927	0.206	-6.474	0.153
	Tertiary	Ref	.	Ref	.
Marital Status	Single	3.582	0.411	5.064	0.236
	Cohabiting	-0.256	0.955	4.245	0.338
	Married	2.686	0.488	3.996	0.287
	Separated	3.529	0.475	7.569	0.124
	Divorced	0.901	0.847	2.502	0.579
	Widowed	Ref	.	Ref	.
Religion	Islam	0.337	0.917	5.408	0.11
	Christianity	Ref	.	Ref	.
Performance in Primary Education	High	4.144	0.399	7.719	0.127
	Moderate	5.468	0.219	**11.308**	**0.024**
	Low	Ref	.	Ref	.
Performance in Secondary Education	High	-2.878	0.646	-6.919	0.283
	Moderate	-4.759	0.392	-9.08	0.133
	Low	Ref	.	Ref	.
Performance in Tertiary Education	High	-7.000	0.181	-9.472	0.068
	Moderate	-9.199	0.051	-8.441	0.064
	Low	Ref	.	Ref	.

Self-Esteem	High	5.606	0.18	2.035	0.253
	Moderate	1.279	0.628	**4.353**	**0.031**
	Low	Ref	.	Ref	.
Household Income	High	2.235	0.229	4.603	0.257
	Middle	4.274	**0.034**	-0.903	0.724
	Low	Ref	.	Ref	.
R-squared		0.919		0.911	
Adjusted R-squared		0.812		0.783	

Note: Reference value used to compare with other members of the group (Ref=1). Adjusted R^2 measures the level of variation explained by the combined effects of the variables in the multivariate equation. Significance at p<.05; β-is the regression coefficient in the likelihood equation (+ve value showing positive influence while –ve value showing negative influence). Effective CBT measured by change of levels of anxiety and depression between the first and last invitation.

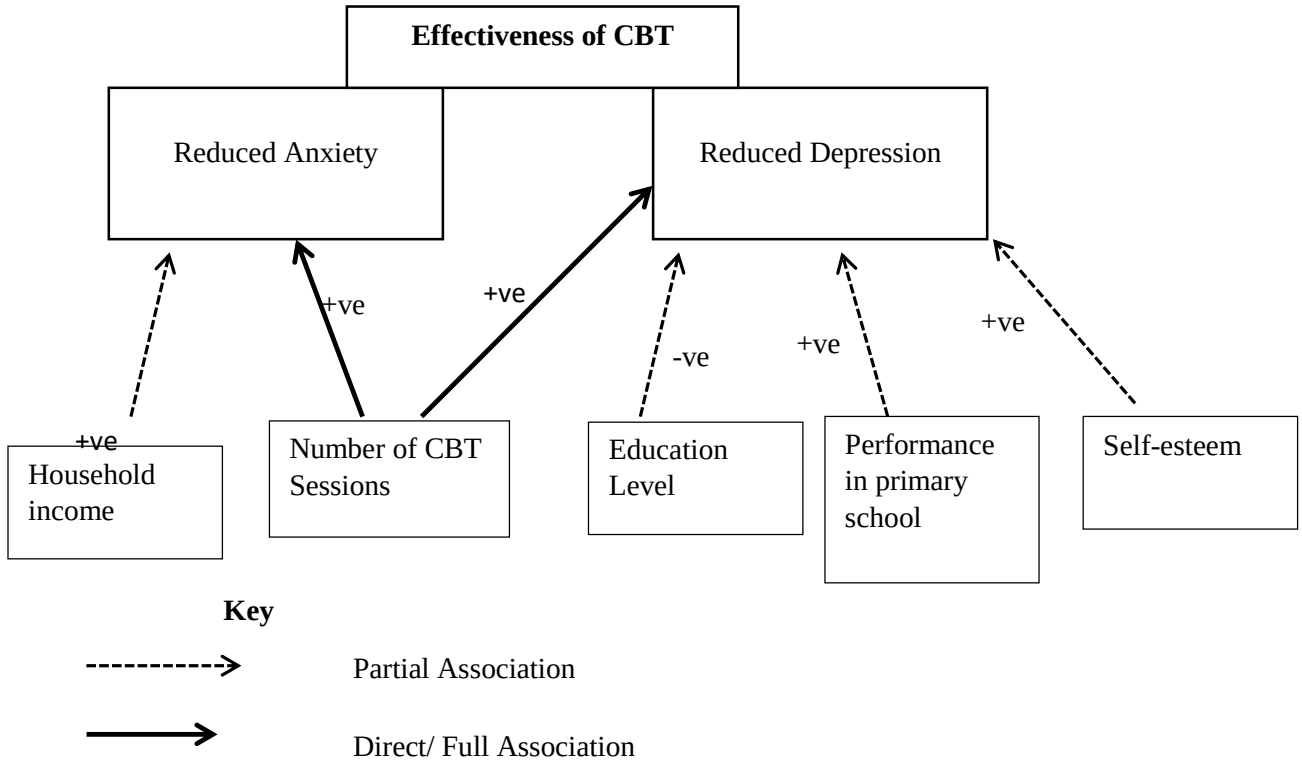


Figure 10: Summary of Factors associated with effectiveness of CBT

4.1.7. Impact of cognitive behavioral therapy among study participants

The study found out that CBT has both short-term and long-term impact on the lives of people who have been exposed to domestic violence and have undergone therapy using CBT. One of the observed

short-term impacts of CBT is its ability to change to the participating clients. For example, on the first day when the client sought the help of the therapist, it was noted that they had neglected their physical appearance, they were not grooming themselves well, not eating well and therefore they looked tired and fatigued. On the emotions part, they shed tears when they were sharing their experiences and some were not even able to express themselves on their experiences and what else may have been going in their minds. When the HADS was administered to them they scored high anxiety and depression levels. Having gone through CBT for a number of sessions, these clients started changing. They started taking care of themselves and their families in terms of grooming themselves and every time they shared their story during the therapeutic sessions, they were no longer shedding tears. They smiled and laughed when giving the bitter experience of domestic violence they had gone through. As cited earlier by the researcher, CBT has an impact in reducing the levels of anxiety and depression (see Figure 11). The average level of anxiety (M=19.8, SD=2.25) and average depression level (M=18.4, SD=4.02) during the first invitation for CBT sessions was high. However, after the victims underwent treatment using CBT for several sessions, the anxiety and depression levels significantly reduced.

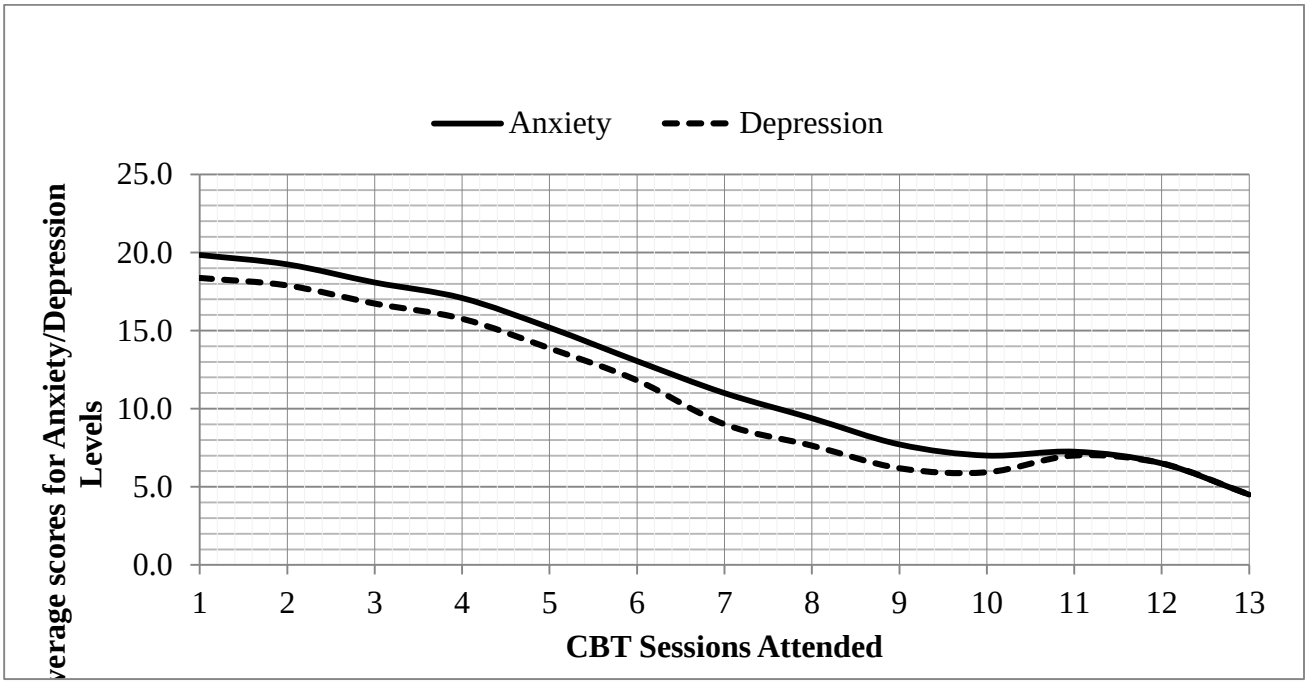


Figure 11: Trend of Anxiety/Depression levels across the CBT sessions attended

Furthermore, from the findings shown in Figure 11, the level of anxiety and depression decreased gradually, but with some increase around the 11th session. For instance, within the first four sessions, the level of both anxiety and depression decreased by averagely 5%. Between the 5th and the 9th sessions, the decrease was at an average of 15-16%. Thereafter, the level of decrease had reduced to 9.3% for anxiety and 4.2% for depression. It is also worth noting that on the 10th session, some of the participants had started stabilizing and were therefore released from the treatment. It is important to also note that on the 11th CBT session, there seems to be a relapse in which case the level of both anxiety and depression increase insignificantly at p>.05. Therefore, there was an increase of anxiety level by 3.6% as compared with the 10th session. There was also an increase in the average depression level on the 11th sessions by 18.1% over what was experienced on the 10th CBT session. Thereafter, the average level of anxiety and depression started decreasing by about 9% on the 12th session and by 30.8% on the 13th session. The researcher's explanation of on the 11th session is based on the relationship between the therapists. The suspicion is that the participating client becomes anxious about termination as the session gets close to the end. This explains why the levels of anxiety and depression went up. The researcher has recommended how the CBT should work effectively to prevent such cases from arising.

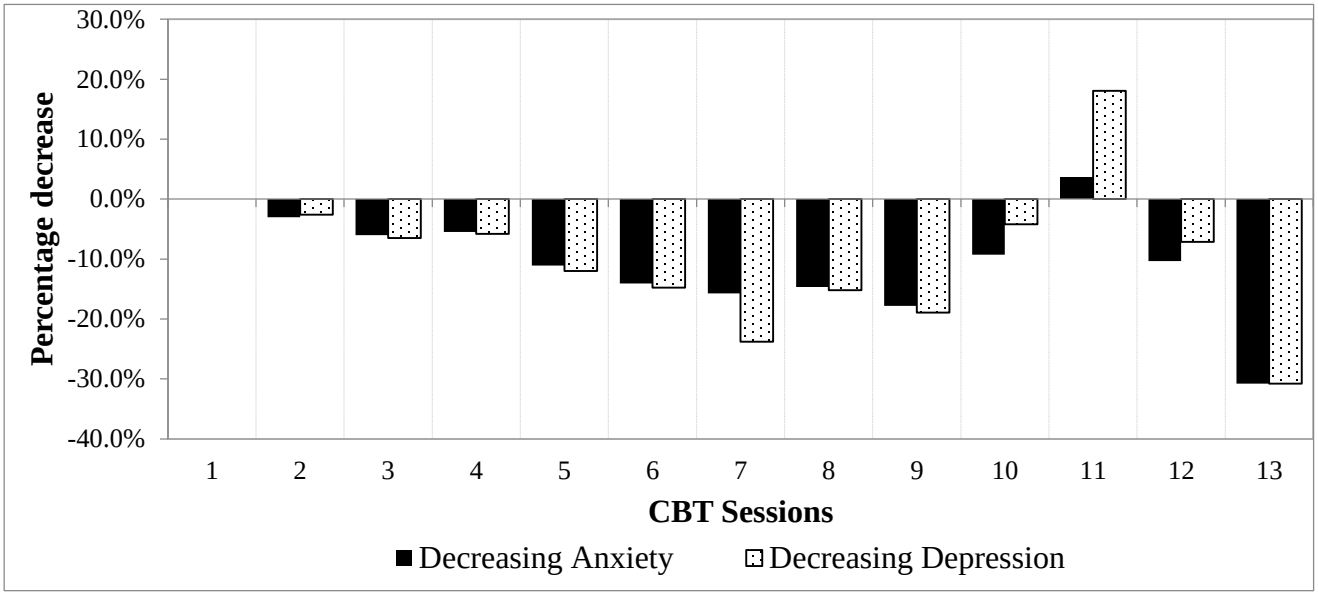


Figure 12: Decreasing levels/percentages of anxiety/depression across the CBT sessions

The long-term impact of CBT on the participant is the ability to restructure the cognitive capabilities of the person to live their own lives thereafter. Therefore, despite the challenges and the negative

impact of domestic violence which the participants had gone through, such as their children suffering, anxiety, depression, family disintegration, loss of jobs, and physical injuries, the participants acquired coping mechanisms through CBT. These coping skills help them to navigate their lives with positive approach to life, and to heal the trauma experienced earlier in their lives. For instance, some participants arrived at a decision to separate from their abusive partners while others made choices to do alternative income generating activities in order to be self-reliant and support their children instead of depending on the perpetrators who were victimizing them. This indicates that CBT has a significant short-term and long-term impact in reducing domestic violence.

4.2 Analysis of Qualitative Data

This section analyses the qualitative data which was gathered from the field. The research study interviewed eight key informants who were purposively selected from the institutions under study. These provided more knowledge on the topic under study. In addition, through the help of the key informants, 110 women were purposively selected from institutions under study. These women were grouped into focus group discussion made up of 10 to 15 participants. Through the use of the interviewing guide, the principal researcher and the assistant researcher gathered and recorded information using a recording device and through note taking. These were later transcribed and analyzed following the order of questions in the interviewing guide and the responses given by the respondents (see Appendix F).

4.2.1. Definition of domestic violence

The participants interviewed defined domestic violence as physical assault, sexual assault, psychological and emotional assault, financial coercion and verbal abuse. They all agreed that physical assault is the most common, where the perpetrator inflicts body pain and injuries to the victim. Sexual assault was also mentioned by the participants, who said that women were forcibly assaulted sexually by the perpetrators especially after they had separated from the initial relationships. The participants stated that women experienced psychological and emotional trauma, especially when they suffer financial deprivation within the abuse of domestic violence. Lastly, verbal abuse was reported to be common among the victims, which involved name calling and putdown words. What was peculiar with the FGDs is their unwillingness to share openly and freely their experiences of sexual assault, this being a common form of domestic violence which themselves had identified. Sex

is a taboo topic of discussion in the African context, which explains why the participants shied off from freely speaking of their sexual assault experiences. The following are some of the responses from the participants when certain questions were posed to them during the interviews and focus group discussions.

When asked their *understanding of violence*, the participants confirmed what other literatures define to be violence. Violence according to the participants is any type of intimidation of one partner by another, imbalance of power or any action which inflicts pain on another person. The following are the definitions given by the key informants:

> PK7: Violence is imbalance exercise of power that may be physical, psychological or emotional.
>
> PK8: Violence is any action that inflicts pain on the victim, either emotional pain or physical pain.

When asked their *understanding of domestic violence*, the participants were able to express themselves directly on what they understand by domestic violence as any type of intimidation of whatever type of intimate partners which actually can include physical, sexual, psychological, emotional or verbal abuse that involves members of a family or trusted persons. When domestic violence occurs it leads to physical or psychological pain to the victim. The following are the direct responses from the key informants:

> PK3: Domestic violence is violence whether emotional or physical violence that involves spouses, siblings or family members.
>
> PK4: Domestic violence is an action that is done on either the husband or wife or children that is involving a family that the person does not give consent to and also it hurts the person emotionally, physically and mentally.
>
> PK5: Domestic violence is physical, emotional torture, or verbal torture; when someone uses force to attack an individual. So it will cause…emotional and psychological disturbance to the victim.

When the participants were asked *whether they ever dealt with a case of domestic violence and how they handled it*, they said that they first attend to the immediate needs of the victim such as giving

them medical care for those who are injured, counseling, and help them to file cases in court. The following are the responses sampled from a few key informants:

> PK3: …I listened to her as she told me the story then I involved other people because she had been injured physically. Then there was counselling and then we explored what she had done to basically know what her plans were….
>
> PK4 We get many cases coming to the casualty about domestic violence, maybe a husband has beaten his wife and even hurt her physically. In such cases, they usually come with injuries and they start by seeing a doctor. When the doctor discovers that it is domestic violence, he sends the patient to a counsellor who does trauma counselling. After trauma counselling, they go through a process; it is not a one day event. So they will be coming for sessions. After that, we involve a social worker who also deals with the legal part.
>
> PK7: The first thing that I did is something that we call psychological first aid. Since most of these people have an immediate need, that is what I normally deal with. The recent case that I dealt with, this particular lady was hungry so the first thing that I did was to give her food.

The participants were from different backgrounds and so on being asked *the forms of domestic violence in their communities*, they gave various responses such as name calling to the victim, intimidating the victim psychologically, physical assault such as beating, being assaulted sexually. All these assaults leave the victim with high levels of anxiety and depression. The following are some of the direct responses given by the key informants:

> PK2: There are several, like telling people you are good for nothing, controlling who you see, controlling where you go, how much money you spend, who can visit you, where you can visit, and embarrassing you in a social interaction."
>
> PK7: Mostly women are beaten by their partners; some are burnt and sometimes their clothes are burnt and sometimes their husbands extend the violence to their children, so the whole family is either beaten or their clothes are burnt."
>
> PK8: There is physical abuse, there is sexual abuse.
>
> PK6: Being beaten unnecessarily, you have a quarrel; maybe your husband is a drunkard, or maybe he brings another woman in the house or forces you to have sex when you are not ready and that is violence.

4.2.2 People mostly affected by domestic violence

The researcher sought to establish how the participants were able to describe domestic violence. Therefore, when asked the question *how they would describe domestic violence experienced in their communities, likely victims and likely perpetrators*, the key informants and the FGDs were in agreement that women are the most affected by domestic violence as well as children, especially the girl child. They attributed this to the vulnerability of women in patriarchal societies, where men seem to be more empowered than women. For girls, they face domestic violence especially through sexual assault from the people they trust such as fathers, step-fathers and uncles. Children are also abused in dysfunctional families where their relatives do not relate well with the wife. According to them, men who face domestic violence are mostly those whose wives discover they are HIV positive while the husband is negative; so she finds ways of infecting him. Furthermore, men who are into illicit brews and other drugs and are intoxicated and unable to control themselves face physical assault from their wives.

The participants of the study said that perpetrators can be people from within trusted community of persons. These include husbands who assault their partners for minor excuses to cover-up their limitations. They make assumption that what they do is what their wives are doing, especially in infidelity cases. In the same breath, children have been victims of their step-fathers and their uncles who assault them sexually. Aunts become perpetrators in cases where they are left to take care of children from their relatives whom the assaulted physically. Siblings are perpetrators when they fight with their parent, especially over land issues. In addition, mothers-in-law were identified to be perpetrators of domestic violence especially when the victims failed to beget children. In the event the husband died, brothers-in-law ganged against the widow to take the property left behind by the deceased, while others would want to inherit her as their wife. The key informants had the following to say:

> PK3: It is called gender-based violence…. It is something like undermining the women in the community because men are thought to be supernatural or to be on top of women. So most of the time gender-based violence would come as a result of a superiority complex from the man's side and with the lady feeling inferior…. It is acceptable culturally…to be beaten when you are told something and you don't do it; they would feel it is okay to beat their wives…

PK4: …African …tribes allow the beating of wives…. Wives suffer silently; they do not report such cases, but only come to report when the issue has gone too violent and they are injured…. Africans have not realized that there can be emotional violence where they are being mistreated by the husband by being deprived some needs…. Usually, the community does not understand emotional and mental abuse.

PK6: Some of the violence we cause ourselves…. For example, if you are married or living as a couple and maybe you are arrogant, somebody asks you a simple question and you answer very arrogantly. Most likely, the man would slap the wife so that next time the woman would think how to respond, especially if the man does not have self-control or has a bad temper…

4.2.3 When and how domestic violence happens

When the participants were asked *when domestic violence occur and how it occurs*, they domestic violence starts when there is a misunderstanding between spouses, for example, on how they dress or prepare meals. This eventually leads to a quarrel which triggers physical assault, psychological and emotional abuse and verbal assault. Also, marriages which are unstable, that is, where there are poor communication and problem-solving skills, are beset by violence. Sexual assault is reported among married couples who had separated and later reunited. Furthermore, the victims are blackmailed and threatened by the perpetrator that favors such as school fees and other basic things will be withdrawn from them in case they do not give in to the abusive demands of the perpetrator. This is normally prevalent where the victims are financially vulnerable and dependent on the perpetrator. This is especially seen when they ask for money to buy various things in the house or personal effects. The key informants had the following to say in regard to when and how domestic violence occurs:

PK2: At varying times, for example a man comes into a house and says, “What kind of food is this?” So it can begin from there and later on he apologizes or looks at you and tells you, “How are you dressed? Why can’t you dress like other women?” That is a putdown statement. So it can occur at any time. It is across gender.

PK3: It occurs when the victim is vulnerable, especially if it is the wife being beaten up by the husband or being emotionally abused by the husband. It will be as a result of when her inability to provide for herself. So it will get to a point where she is being violated or being abused and she still remains there because she is not financially stable…sometimes also when they are mentally disturbed. They cannot make decisions on their own… They can also be violated

> when they are hiding from something, maybe somebody knows something they did and they keep intimidating or manipulating them: if you don't do this I will say you are the one who did this. So it can also be as a result of that.
>
> PK7: It occurs when there is a conflict or misunderstanding in their homes and sometimes when they do not have finances. In most cases when men are retrenched from employment they extend this bitterness to their wives and to the children.

4.2.4 What triggers domestic violence

The information from participants indicates that previous abuses and assaults experienced by domestic violence perpetrators have an effect on their behavior when they settle down in relationships. According to the participants, perpetrators had been abused either by their cruel parents or trusted family members or had witnessed their father abusing their mother. Consequently, they suppressed these experiences or became numbed hence insensitive to abuse. The participants stated that *cultural expectations* cause conflicts in the families. This is because of the distribution of roles, where women are expected to do most of the chores in the family such as cooking, washing, taking care of animals, among others, while husbands are expected to be the breadwinner. Thus, in cases where the husband is irresponsible and neglects his gender roles, which are then taken over by the wife, violence occurs because the husband wants to assert himself as the head of the family. Furthermore, there is a misconception by some men who think that when they slap their wives or call them names or use putdown words against them, then it is a sign of dominance, control and authority. The following is a direct quotation from one of the key informants:

> PK2: Most of the time the perpetrators might be stressed by something. They come home and they are stressed and take it out on their most intimate person. Maybe somebody left the office and they could not abuse their bosses or the people they work with; the recipient is the closest person they are with at home: that is where they direct their stress and frustration.

Secondly, both the key informants and the focus groups noted that perpetrators who are into *substance abuse* such as alcohol and other drugs develop impaired thinking, loss of inhibitions, and they become addicted and dependent on these drugs. This leads them to mistreat their partners because of lack of self-control. They subject them to physical assault, psychological and emotional abuse, and force them into sexual activity when the partner is not ready. They also embarrass their partners in front of their children. In addition, the perpetrators who are into binge drinking have not only neglected their

responsibilities but also taken and sold items from the house such as TV, radio, cell phones, furniture, bicycles, cooking pots, farm produce and they misuse household income.

> PG4X2: Our partners are into drinking alcohol or abusing drugs…. When they are drunk they beat us, sell our properties and neglect the family.

Thirdly, the participants cited *stress* as a trigger and cause of domestic violence. According to them, when the perpetrator's resources are overstretched by the demands and s/he feels limited to those needs of the family in terms of finance, time, and work experiences, they are easily irritated and react negatively to any small matter, which eventually leads into violence in the family. The following are citations drawn from key informants and the focus groups:

> PK8: There is so much pressure on men as the head of the home. A man should provide. In most of our communities, it is not seen as right if the woman is the one who is out there working and the man is at home. So in the event the woman finds she is the provider of the home, the man feels the need to inflict authority in other ways, leading to domestic violence.

> PG1x4: I have experienced domestic violence. I was married for 17 years, but violence started when I asked for school fees. So we started fighting for two years and in 2013 we separated when the violence escalated to the extent that I was admitted into hospital.

Fourthly, *poor problem-solving skill* is another factor which was cited by the participants as a trigger of domestic violence. They affirmed that in relationships there are always challenges. However, what matters is how the two parties are able to solve the issues which they experience in their relationship. Poor problem-solving skills are as a result of negative attitude towards each other, misinterpretations of the partners' behavior and irrational thinking.

Fifthly, communication skills are closely related to problem-solving skills, as communication is a tool of solving problems. The participants noted that *poor communication skills* trigger domestic violence in families. This occurs when one of the partners fails to communicate effectively to the other, for example, when one of the partners has poor listening skills, is impatient, or has poor understanding of the issue at hand. Misinterpretations occur during conversations, which eventually leads to inappropriate or unexpected response. Consequently, this leads to domestic violence. Furthermore, arrogant or demeaning tone, body language and other inappropriate nonverbal expressions and the timing of a conversation are catalysts for poor communication skills.

> PG7X3: For me, I see it is lack of respect. He has given my neighbor the work of informing him of my whereabouts. Like for now I am not at work; I have left another lady to step in for me. He has already been told that I am not at work. When I go for *chama* he has to call someone to inquire if I am in the house. I see it is lack of trust. If I just leave the house, he is called and informed by people on the ground. I tried to warn him from putting neighbors to guard me because I am not a child. Bringing in a third party in our family is not good and it is the source of problems. How do you live with someone who beats you in front of children when you are naked?

Sixthly, *infidelity* was cited by both the key informants and the focus groups as a trigger of domestic violence. Violence occurs when the victim enquires about a discovery, say, unfaithfulness. The victim could have checked contacts of the perpetrator with other women/men on phone, email, or the victim was alerted by neighbors about the illicit relationship the perpetrator had. When the victim asks about the issue, the perpetrator becomes violent. In addition, an unfaithful perpetrator suspects the victim is also unfaithful. Therefore, they stalk and control the victim inappropriately. The following are responses drawn from some of the participants:

> PK1: I have also heard that when someone has that problem, they want to get the partner to be like them. They never want to suffer alone. They want somebody else to share in their suffering and the first person they think of is the wife.

> PG7X2: I am restrained to talk with other women. What he does is what he thinks I do. I found him with another woman but he denied it.

Seventh, the participants said noted that when the victim is *not financially empowered* and *dependent* onto the perpetrator, the mere statement of asking for money sparks quarrels and disagreement. Even when they are given the money, they are expected to account for it to the last penny. In the event that they are not able to account for each and every penny or if they used the money for other things, they are assaulted physically, psychologically, and verbally abused. Further, the participants observed that *peer pressure* triggers domestic violence. This occurs when the perpetrators share with their peers how they are treated by their spouses at home, as well as how they mishandle their spouses when they do not meet their demands. Through *social learning*, one picks that the only way to assert oneself is to exercise high level of control over the partner. Again, the perpetrator could be evaluating their

relationship and financial status in comparison to that of their peers who may seemingly be doing better. And the tendency is to blame their partners for their economic misfortunes.

> PK6: I think sometimes friends influence others, but you need to be yourself. You won't imagine that what is applicable in your house is applicable in mine. For example, women talk about what their husbands do not do for them, while men brag about the inability of their wives to talk because they are the ones who issue orders. It can be either. Some women even beat their husbands. Insincerity could be another factor in handling issues, especially finances. You tell lies and when you are asked it become an issue.
>
> PG4X3: Sometimes he may be jealous. When they see you advancing, they feel pain and start meddling.

Furthermore, in the event a perpetrator *loses their job* and is *unemployed* while the victim is still employed, the participants observed that this triggers domestic violence. The reason they gave for this phenomenon was that the perpetrators feel they are no longer in charge of the family as 'breadwinners' and so they become abusive to their spouses to assert themselves. This is also common in relationships where the wife is employed by the government or private sector while the husband is a casual laborer. In this case, the man behaves violently towards the wife in making financial decisions and demands that the wife must provide for his upkeep and lifestyle. Moreover, these perpetrators threaten their victims to give them money lest they leave for other relationships.

> PG1x5: I was married for 7 years. We lived quite happily because by then my husband did not have a good job. Once he got a better-paying job, fighting started. I can't tell if it was pride. Once there was some increase in income, crisis started. Furthermore, when we got the second child, this too worsened the situation.

Frustration coming from unmet goals was reported by the participants. They said that perpetrators who have issues with their bosses and are unable to fight back displaced their anger onto their family members to vent out their frustrations. Other failed relationships were also cited as causes of domestic violence. This occurs when the perpetrator may have abandoned the initial partner for another. When the new relationship fails, the perpetrator tries to get back to the previous relationship and faces resistance, which acts as a trigger for domestic violence.

The problem of *childlessness* can be as a result of health complications in either partner, rejection of either of the spouses or family lineage, limited financial resources, career pursuits, body figure and beauty pursuit especially by models and celebrities, among other reasons. The participants noted that childlessness can trigger domestic violence. This is sparked by cultural expectations, from an African perspective, for couples to have children of their own. Mothers-in-law and other family members put

pressure on their sons and daughters, sometimes without the care to appreciate the reason for their childlessness. Consequently, the couple begins blaming each other for their predicament.

Lastly, the participants noted that some triggers of domestic violence arise from *personality traits* of the perpetrators who are born into and prone to violent behavior. This was cited in reference to the incomprehensibility of cases where a father molests his six-year-old daughter. Such perpetrators are pedophiliacs, a condition which could be as a result of either past experience or genetic disorders. In addition, some temperamental states of personality predispose some people to lose self-control thereby triggering domestic violence.

> PG1x8: My husband took my child and made her his wife. There was no sleep anymore. There was no communication or understanding each other. It was like I kill him or he kills me. This is where fights started. By then I was 7 months pregnant. He would choke me. Lucky enough, the baby survived despite the beatings. He also destroyed my business and he never participated in taking care of our five children. This was difficult and moving on with a new baby was not easy.

4.2.5 Behavioral patterns and occupational characteristics of perpetrator

According to the participants of this study, perpetrators have characteristics and behavioral patterns which define them to be who they are. They are overly controlling as they never give in to their partner's views and want their views and opinions to be followed to the letter. Perpetrators threaten their spouses and children, so that they can have their way without being answerable to anybody. This phenomenon is observed in most Kenyan communities which are patriarchal; where women and children are marginalized. In addition, the participants described their perpetrators as uncaring, drug addicts, neglecting their duties and responsibilities. They leave the role of bringing up their children and providing basic necessities such as school fees and food to their spouses. They are manipulative, crafty and cunning people, especially to their spouses. They readily apologize to their spouses, especially when they have abused them together with or in the presence of their children, to prevent the victims from taking any action against them. Furthermore, perpetrators are intimidating, unfriendly, negatively aggressive, rough-mannered, and very insulting, especially as an escape route for their ill behavior, such that they become irreproachable. Lastly, participants noted that some perpetrators are pedophiliacs. Nevertheless, when a case of sexual abuse takes place it is covered up

by the family members to protect family image. When asked *the behavioral patterns of perpetrators of domestic violence*, the participants had the following to say:

> PK1: They are rough-mannered, they are not caring, they neglect their duties, and they are not responsible.
>
> PK2: Very controlling, during interaction they can look at you in very threatening ways, like they always know everything and they threaten you like you cannot speak.
>
> PK7: They are aggressive and violent.
>
> PK8: They are narcissistic. They want to be seen as the ones with the most power; that they are strong. How they make decision is how it should be; no one can change their opinion on what should happen and how it should happen.

The researcher was interested to know if there are some occupations which predispose either the victim or perpetrator into domestic violence. When asked *the occupational characteristics of those associated with domestic violence*, both the key informants and the focus group discussion participants were of the view that work contributes directly or indirectly to the occurrence of domestic violence. Women who are unemployed experience more cases of domestic violence as compared to those who are financially independent. The participants had the following to say:

> PK3: Maybe in whatever they do they are not economically stable. So they are going through a lot of stress and they get aggressive as a result of it. I cannot meet all my needs and this person is asking for too much. Then the other thing is that some jobs/occupations may also lead to stress. So, some of them may get into substance and drug abuse. For others, it is as a result of where they work. For example, if you work in a place where you sell alcohol, with time, but not always, you start drinking and become aggressive.
>
> PK5: A majority of them are housewives…you will find that they are not working, or the perpetrators are under the influence of drugs. I would say it is largely because they are in the house and with no source of income.

However, some participants saw occupation to have no association with domestic violence. For example PK8 had the following to say:

> I don't think we can particularly pin an occupation to either the perpetrator or the victim; the perpetrator can be anyone. It can be a banker or someone working in construction. I think it can be anyone. It is the mind-set that determines who it can happen to.

4.2.6 Behavioral patterns and characteristics of victims of domestic violence

The participants described victims of domestic violence as people who feel inferior and worthless. Such feelings that make them develop low self-esteem. Victims of domestic violence have been abused on several occasions and for a lengthy period of time by the perpetrators, to the extent that they begin to accept the abuses as normal. Consequently, this affects their psychological wellbeing which may lead to a feeling of worthlessness and low self-esteem. The participants noted that some victims of domestic violence blame themselves as being the ones who cause or make the perpetrator to assault them probably for what they did or did not do as expected by their partners. In other words, they think the perpetrator is justified to abuse them. Moreover, the participants described the victims of domestic violence as people who have a feeling of helplessness and are resigned. The victims have given up the fight for their rights and do not take any step to emancipate themselves from the abusive environment. The victims choose to remain in abusive relationships because they are dependent on the perpetrator; some victims find it difficult leaving their children behind because they are likely to be negatively affected.

The participants characterized the victims as ignorant people who kept quiet or silent even if they were experiencing domestic violence. For example, some victims do not know that verbal, psychological and emotional abuses are categorized as forms of domestic violence. The types of violence which they are familiar with are physical assault, sexual assault and economic coercion. This is because the latter forms of violence are physical in nature while the former forms are felt indirectly. In the event of violence, victims opt to keep quiet and persevere hoping that the perpetrator will change with time only for them to later realize that the situation is getting worse.

Lastly, the participants noted that victims of domestic violence are people who have poorly paying jobs, are underpaid or unemployed. These people mostly work as casual laborers, grocers, house-helps, housewives, hairdressers, or food vendors. Such jobs demand long hours of work with little pay. Consequently, these people are faced with financial constraints, especially where the family is unstable. On being asked *the behavioral patterns of victims of domestic violence,* some of the participants had the following to say:

> PK3: Most of the time their self-esteem is low, they feel valueless, they don't have any value. Other times they accept it because they have lived with it; it has become acceptable for them so they ask what they can do. They become hopeless. Others also want to contain domestic

violence because they don't want to get humiliated by sharing their stories with others. They remain quiet because they don't want to expose their domestic squabbles.

PK4: They kind of live in shame; they are scared. They are afraid that if they say anything the husband will hurt them more. They kind of fear even to socialize. At times they are in denial; they do not want to say that they are being abused or being beaten.

PK7: These women are fearful. Mostly they fear they might lose their marriage and they do not seem to trust anyone. They want to protect their marriage.

Having asked what influences perpetrators to abuse the victims, there was need to ask *what influences the victim's behavior, or some of their values in life*. To find out if there could be some factors which predispose them to domestic violence, some of the participants gave the following responses:

PK2: Perhaps this could be a relationship they value very much. Even when they go for counseling, it is like they are hiding; they don't want their husbands to know that they have gone for counselling or to see a doctor.

PK3: When it comes to wives being abused physically, most of them kind of resign to fate. They ask what they can do: "He is the one working. I am not. And even if I decide to leave this relationship, what will happen?" They worry about taking care of the children. So the financial wellbeing of the victim and ignorance are factors. They don't know the channels to follow in order to report the person. They just persevere and feel it is alright because the community allows it.

PK7: I do not think there are things that they do or they have not done. An example that I can give is when the woman does not cook on time or feed the children on time and the man comes and starts slapping her. She did not do this on purpose. Maybe she had more work to do. So it is not that she brought this violence or the beating to herself, but it is something she is not able to control in most cases. I think most women value their marriages and they would do anything to protect their marriages. That is why they talk about wanting to shield their family and their marriage. And they do not want to share their agony with anyone, not even with their sisters or brothers. She wants to be seen to be okay. Sometimes they want to be seen as that powerful lady managing her home well.

4.2.7 The negative impacts of domestic violence on victims

When the participants were asked *the life challenges experienced by people who have been exposed to DV and the negative impact of DV,* they were in agreement that domestic violence leads to depression in people who are affected. The loss of the victim's valuable relationship, time, children, finance and what s/he has put in cannot be recovered. Therefore, the victim sinks into depression which manifests itself in symptoms such as feeling worthlessness and helplessness. Women who are continuously exposed to domestic violence develop low self-esteem. In addition, the form of domestic violence affects the degree or the level of low self-esteem. For instance, women who are psychological and emotionally abused, physically beaten, and sexually assaulted in the presence of their children have low self-esteem compared to women whose partners control financially. Furthermore, women who are depressed experience loss of sleep, loss of or too much appetite, disinterest in activities they initially enjoyed doing and overall forgetfulness especially in taking care of themselves. The following was the response from the key informant:

> PK2: Most of the effects are psychological trauma, panic attacks and anxiety.

Secondly, the participants noted that domestic violence affects children directly, which lead them to experience suffering and pain. Domestic violence exposes children to suffer physical abuse when one parent vents their anger on them through beating or hitting them with crude objects, burning them with hot things, denying them food, tossing them on walls, among other indescribable acts. Moreover, children experience psychological and emotional abuse when they witness their father or mother being humiliated or insulted in their presence. Children have been assaulted sexually by their parents, older siblings, or other relatives who have taken advantage of their vulnerability. When children are verbally abused by family members they are left psychologically traumatized. Furthermore, when they are in an environment of abuse, it leads to low academic performance and low self-esteem in school. Children are not able to concentrate in class because of the experiences they have gone through or seen their parents go through at home. Lastly, there is a long-term effect of domestic violence on children, who may later grow to become perpetrators if they do not receive therapy. One of the focus group participants and a key informant had the following to say:

> PG5XV: It also gets to a point that if the intensity is high especially to the woman, some women retaliate. They also start fighting back. It gets so bad; when the woman starts hitting

> back the marriage ends. Children get affected negatively in a way that they are not able to get into marriage relationships and they also tend to do the same to their girlfriends or boyfriends because of the way they have seen things being done.
>
> PK5: They are not being empowered economically. These housewives cannot walk out because they are not able to pay rent, cannot be able to put food on the table or make life comfortable for the children. Social-economic factors come in. Another challenge is the desire to protect family. People look down upon you because your marriage has failed. So such women really try to make things work although it may not be possible.

Domestic violence has a direct negative effect on families. The participants said that families disintegrate when there is violence going on within the household. When this is not resolved in time it erupts to serious consequences. For example, violence can start with a minor quarrel or argument on something such as poor preparation of meals or getting home late. Due to lack of proper communication skills and problem-solving skills, the couple is not able to stick together. Other issues noted as leading to family disintegration include infidelity, alcohol and drug abuse, irresponsible spouse, and child sexual abuse. The participants noted that where one spouse is a workaholic the family is negatively affected, because they do not have quality time with their family and time to bond together. These bad behavioral patterns within the family lead the couples to report each other to their parents, chief, police, legal firms and courts, and eventually they separate, break-up, or finally divorce. The following is a response from one of the key informants:

> PK7: The first challenge would, of course, be family break up, because if a partner feels this is too much she will go back to her maternal home. Another thing is financial difficulties. If the man was the provider, this lady will not be in a position to feed the children. Also health-wise both will be affected; even the man beating or punishing this woman will also be affected health-wise, because when the woman leaves the home he will be stressed thinking about the wife, the family and how he will be able to cater for himself. She will also be mentally ill. Both of them are also affected emotionally. Her mind will not be settled. She is not sure whether to go back to the home where she is being beaten or to stay with the parent, because when she goes to her maternal home it may also not be a good place because her parents may also tell her she is not able to take care of her marriage or family and that is why she is there. So emotionally she will not be at peace.

The participants also stated that family members who are in an environment of abuse, experience psychological disturbances such as anxiety which manifests itself in ways like panic attacks, impulsive behavior, obsession, apprehensiveness, compulsiveness, and gastro-intestinal disturbances such as ulcers. Another negative effect of domestic violence is non-productivity. This comes as a result of people going through domestic violence developing psychological disturbances, consequently making the body system fail to coordinate normally. For example, when somebody is stressed, depressed, or anxious, this affects their physical energy, psychological and emotional well-being. They suffer blood pressure, loss of appetite, insomnia, headaches; they are temperamental, and uncooperative at work. Due to this, some of these people end up losing their jobs, resorting to alcoholism and drugs, which leads them to being unreliable people in the society. Excessive use of alcohol and other drugs make someone psychotic. All the above factors make people become non-productive members of the family and society in general. This further affects the family's income-generating capacity, leading to poverty, as two of the focus group participants noted:

> PG3T8: Non-productivity. Women who are mostly physically and psychologically abused are not productive even in their work. I remember my neighbor many times would just stay indoors because either she has a red eye or a broken…so she could not even go to work. Even around the house, there are so many things she would ignore because she couldn't…. She would call people to come and assist her, which was embarrassing.

> PG5XJ: You find that most women end up getting depression. They will be dying quietly because you do not want to shame yourself in front of your friends. So you die internally. Something else, someone may go into alcoholism just to try not to talk about the problem.

Another serious negative impact of domestic violence noted by the participants is occurrence of physical injuries, especially when family members fight each other. When a heated disagreement occurs, some perpetrators slap, hit, kick, stab, strangle, choke, throw objects, knocking somebody against the wall, use hot liquids, spraying and splashing inflammatory liquids such as acid and paraffin. The victims are hurt severely by such actions, which leads to severe body harm such as broken bones, disfigured faces, burns, painful deep cuts, scars, amputations, brain contusion and concussion, nervous system injuries. In addition, the participants reported that serious cases of domestic violence resulted to death of a spouse or children. This occurred when the perpetrator lost control of emotions and strangled their partner and their children. Eventually the perpetrator commits

suicide to avoid being punished by the community or arrested by the police. Other perpetrators have opted to poison the entire family as a result of the violence going on among them. One of the key informants noted:

> PK3: There are physical injuries which sometimes are hard to treat, like if somebody is beaten and they lose their eyesight or somebody is raped and they lose their uterus. Those are issues that are not repaired. Emotionally they are so disturbed and depressed. They live in fear of the unknown and do not trust of anybody. Some even blame themselves. If they are not helped some can even become crazy and psychotic in the process because they do not know how to deal with the situation. If the violence continues it can be worse as they try to commit suicide.

4.2.8 Coping mechanisms for victims of domestic violence

The participants said that counselling plays a big role in addressing issues of domestic violence. Victims who aware that they are experiencing domestic violence seek help before the condition worsens. The participants noted that there are two categories of victims of domestic violence in terms of when they seek counselling services. The first category is those victims who knew what they were going through, and sought help from counselling facilities on time. On the other hand, there were victims who had been referred to the counsellor after first going for medical treatment. This category of victims had delayed taking action on the onset of domestic violence and consequently suffered severely as they took longer to overcome their challenges as most of them had suffered physical and sexual assault.

Secondly, the participants cited that apart from the individual counselling service, victims of domestic violence utilize support groups to deal with the negative experiences in the families. In the support groups, the victims get encouraged when they discover they are not alone. Furthermore, the victims have an opportunity of sharing and being listened to insofar as their painful experiences in life go. Lastly, the victims also learn coping skills and other alternatives available for them in dealing with domestic violence.

The participants reported that victims of domestic violence also cope through perseverance. The reasons given are that the victims persevere while hoping that the situation will get better. Secondly, the victims think they have no better way of living. They have the assumption that they are insecure and dependent on the perpetrator such that, in the event they left the current family set-up, they will

find it difficult to settle down elsewhere without being inconvenienced. Thirdly, the victims persevere in abusive relationships when they are not informed that they are being abused by the perpetrator, especially psychological, emotional and verbal abuse. Another reason given for perseverance is the social status quo which the perpetrator and the victim have in the society so that they find it hard to separate or get out of the abusive relationship. Some victims opt to remain in the abusive environment because of their investment in the family or relationship, especially in terms of finance and time. Other victims persevere because of children, especially when the children are still young and they do not want them affected in case they opt to separate.

The participants stated that other victims of domestic violence cope by keeping quiet. They do not want to talk about their bad experiences in the family with anybody, not even the closest family members for various reasons. Some of the reasons cited were that the victims are embarrassed about the situation experienced within the family setting such as incest. Other victims opted to remain silent to preserve the image of the family because they were afraid of gossips within the community. They also fear confronting the perpetrator because of the consequences which they may face such as being slapped, verbally abused, humiliation, and financial deprivations, among others. Other victims keep quite assuming that it is the best way to prevent worsening the situation.

Separation of the partners was cited by participants who saw it as one of the strategies in coping with domestic violence. They categorized separation as either short term or long term. Short-term separation is when the victims opt to take temporary escape from the perpetrator so as to allow time for adjustment or dialogue with support systems available such as parents, chiefs, or by looking for counselling services. On the other hand, victims may opt for long term separation in the event domestic violence escalates to life-threatening levels or severe bodily harm is involved.

The participants mentioned that another coping mechanism available for victims is going to a health facility to receive medical attention for self-assurance. This does not only happen when the victims have major assault such as sexual or physical body injuries but also when they have other complaints of psychological dimension such as headaches, stomach upset, rapid heart rates, dizziness, feeling fatigue, and general body aches, among others. The victims go to be treated for these medical problems even though they are not bacterial infections.

Other victims sought divine intervention by going for prayers. The participants said that the victims sought their pastor to pray for them so that their situation at home could change. Other victims joined spiritual groups for overnight prayer and fasting sessions to avert their bad experiences which they were going through. Other victims invited church groups and pastors to visit their homes to offer prayers, not only for them but also for the perpetrators to change for the better.

The participants said that some victims went to search for jobs so that they could empower themselves and emancipate themselves from being dependent on the perpetrator. By so doing they were making effort to avoid the perpetrator from continuing to take advantage of their vulnerability. In addition, victims who had already opted to separate from the perpetrator saw the need to improve themselves financially. This is because they had to carry on with responsibilities of bringing up the children singlehandedly without the help of the perpetrator. According to the participants, the victims who have no or low education and cannot be employed in government or private institutions opted to look for anyone who could help them start up a business and be self-reliant. This coping mechanism is an indicator that the victim can make a decision to start a new life on their own. When responding to the question on *the coping mechanisms for families experiencing domestic violence*, some of the participants had the following to say:

> PG4X9: You go for counselling.
>
> PG4X1: I tried to talk to the parent of the wife (my daughter-in-law) but up to date solution has never been achieved. Sometimes you may decide to take each other to the chief.
>
> PG4X6: Another way in our families when such things happen is to ask for forgiveness. When you ask and forgive your partner it helps to solve so many issues.
>
> PG5XJ: To someone who is outspoken you can get a support group; some women call them *chama*. When you go for *chama*, it is also a way for you to vent, to share to encourage each other, or if it is the church you get a support system something that will help you.
>
> PG5XL: There are some initiatives within the community. Maybe you are educated on how you can depend on yourself. Maybe you come together as a group and start a small business as a source of income so that at least it keeps you busy and you get distracted from what is happening at home.
>
> PG3T10: Many keep quiet and try to rush it.

> PG3T11: Others would go to their church leaders, mostly pastors and priests, just to talk to them, and they are told to persevere. Many keep quiet. When they look at their children, they tell themselves, 'These children need a father. How will I bring these children up if I leave this man?' This happens mostly if he is the breadwinner.

4.2.9 Available support for victims of domestic violence

When answering the question on *what help is available to people who have suffered DV*, the participants cited several places where help is available. One of the places cited is Non-Governmental Organizations (NGOs). Some of these NGOs are operating within the community, dealing with issues affecting the community. Secondly, the participants said that victims of domestic violence have easy access to health facilities within the locality where they can get medical assistance as well as counselling services. Two key informants had the following to say:

> PK3: The help can be both physical and psychological. Physical help would involve being treated for whatever they have suffered like cuts. In emotional help, they would go through counseling. We do counseling in the hospital and it helps to heal the emotional part of it.

> PK7: One thing I want to say is that in our country people do not believe that counseling can help. They do not trust that the therapist can help them, so most people go to the Bible to seek for help. As much as the Bible will help, sometimes the victims need more than the Bible. A person is all round; they do not only need spiritual but also emotional support. They need to also be equipped. If there is an issue they can change or learn, they can only be helped through psycho-education. They can get this from a trained professional counsellor.

Furthermore, the government has waived hospital bills for victims of domestic violence. Another avenue for help available to victims of domestic violence is the chief's camp, where they go to seek assistance when in crisis. The chief facilitates the visit and assessment of the site of the violence and tries to intervene. Secondly, the participants said that neighbors are a support system available to victims of domestic violence. This is because, immediately they hear a cry for help from the victim, they rush to the place and intervene. Victims of domestic violence are also assisted by the police officers when they report the abuse. The perpetrators are traced and arrested. Furthermore, police officers facilitate the victims to take the matter to a court of law. One of the key informants systematically gave the researcher the following steps which they take when a victim gets into their health facility:

> PK5: The immediate help we can give is health care, that is, treatment and then we link them with a counsellor. Depending on the situation, we also refer. If the victim has children to be rescued, we talk to these other partners and we involve the children's office. If we know of an organization, we link them to such, like during the case conferences we present difficult cases, the ones that maybe need help which the hospital cannot provide. We refer them so they are able to be taken through vocational training on courses that will last between three to six months, like Pendokezo-Letu supports such cases. We also refer to CREAW if a victim feels that s/he wants to go legal. We have the Wangukanja Foundation. For commercial sex workers attacked by their colleagues or clients, we treat them then refer to an organization called Bar Hostess so that they can continue with the case, because we only deal with what we can get within the facility. For children we used to refer to CRADLE but mostly we refer children cases to children's officers so that they are able to take it up. But even as we refer, we also follow up to get to know what actually happened.

Another support available to victims of domestic violence is the intervention by family members. They attempt to have a dialogue between the perpetrator and the victim to find a solution for the misdeeds that have taken place within the family. The participants said that children of women exposed to domestic violence are taken to shelter homes to keep them away from the perpetrators. These children are referred to these shelter homes through the children's department. The victims notify the children's department, which takes action to rescue the children from those abusive families. When victims of domestic violence are rescued, there are vocational training centers which offer them skills to empower them to be self-reliant. One of the key informants explained how victims of domestic violence are helped by some organizations to be independent:

> PK8: There are many organizations that are willing to support victims through counselling, and giving ways to get their minds out of that place of violence. There are also very many organizations that are coming up and are willing to give victims of domestic violence a way to start afresh. It might not be necessarily financial; it might just be changing your mindset on how to earn a living, because if I gave you 1000 bob, I am enabling you to come back to me every other day. But if I impact you with the knowledge that you can start any business, this is what you are supposed to do to run a successful business however small it is…. Yes, they have gone through the psychological help they need, but they find themselves going back to the perpetrator because they do not have way of earning a living and their kids need to go to school and rent needs to be paid. So there are many organizations that bridge that gap and help

> the women who cannot stand on their own and do not to feel the need to go back to whoever inflicted any pain or harm on them.

Lastly, the individual has a room to do self-evaluation and make informed choices, especially to move on with life regardless of the abuse inflicted on them and how it impacted on them negatively. They achieved this choice through self-acceptance.

In conclusion, the questions posed to the participants were satisfactorily responded to. The researcher sought to understand what the participants thought or understood by domestic violence. Having gathered information from both the key informants and focus group discussions, domestic violence is understood be in the form of physical, sexual, psychological and emotional abuse, financial coercion and verbal abuse, while some perpetrators use children to control their partner. The study found out that a majority of the victims of domestic violence are women and children. Men were reported by the participants to be the majority of perpetrators. Both the perpetrators and victims display some behavioral patterns which trigger domestic violence. Domestic violence impacts negatively on the lives of the victims and also on lives of the perpetrators. People experiencing domestic violence make different attempts to cope with it using either short-term or long-term strategies, depending on the available resources.

Of all the support mechanisms available to prevent, to treat and to heal incidents of domestic violence, CBT was found to be effective on observing the peoples decisions of how they live henceforth. Some of the strategies of CBT observed were: willingness to look for jobs, improved problem-solving and communication skills, self-care and personal management, ability to recognize abuse and decision to move out of an abusive relationship and environment, positive thinking, self-acceptance, improved self-esteem, among others.

4.3 Summary of Study Results

When the participants were asked to define domestic violence, most of them characterised it as physical assault, verbal abuse, psychological or emotional assault, financial coercion, use of children and sexual assault. The most affected group are women and children, whereas perpetration is common among both men and women in almost equal proportion. Domestic violence is mostly triggered by previous abuses/assaults, alcohol and drug abuse, existence of other relationships, poor

communication skills, poor problem-solving skills, cultural expectations, stress, unemployment, among others.

The study found that the most common form of domestic violence that women are exposed to is emotional/psychological assault. Sexual assault was mentioned by 77.8% while only 62.2% mentioned the use of children to control a partner. The study also found that the proportion of women turning to perpetrators was 24.4%. In order to understand the impact of demographic variables on the forms of domestic violence among women, sexual assault was found to be significantly influenced by women's income. Financial coercion was found to be influenced by the number of children while the use of children was found to be significantly influenced by both participant's age and marital status.

The study found anxiety to have significant correlation with depression. As part of examining the connection, anxiety was found to have significant correlation with sexual assault and use of children, whereas depression had significant correlation with physical assault, sexual assault, psychological assault and use of children. Economic coercion did not, however, show significant association with both anxiety and depression. In examining the efficacy of CBT, the study found CBT sessions to be efficient in reducing anxiety and depression.

CHAPTER FIVE
DISCUSSIONS

5.0 Introduction

The discussion in this chapter is guided by the aims and objectives of the study and by showing how other researchers in the world may have carried similar investigations. This research was done in conveniently selected health facilities within Kibra Constituency, Nairobi County. The research has determined the effectiveness of cognitive behavioural therapy (CBT) in reducing the levels of anxiety and depression among women aged 18 years and above, who had suffered the side effects of domestic violence, also referred to as psychological disorders. There are several forms of psychological disorders but this study focused on anxiety and depression, testing the effectiveness of CBT on African women in an African setting.

5.1 Influences of Social Demographics on various Forms of Domestic Violence

The finding with respect to the first objective reveals that most women and girls in Kenya experience various forms of domestic violence. Most women and girls suffer from psychological disorders such as anxiety and depression. Women in developing countries are known to be the backbone of the economy. Therefore, when women are not healthy physically and psychologically, eventually that country will suffer economic crisis. If women continue wearing dull faces while attending to their daily chores and families, it will be difficult for them to have motivation and strength to face another day.

The study shows that the common forms of domestic violence experienced by women are physical assault, verbal abuse, psychological/emotional assault, financial coercion, use of children and sexual assault. The research findings are in line with the findings of a study by (Budd, 2003) and other studies which have been carried in other parts of the world, especially in America and Europe. Brush (1990) confirms that domestic abuse is the leading cause of injury to women even in the world's most "developed" countries like the United States. Studies have found domestic violence to be a global problem that cuts across age, ethnicity and religious groups and has been on the rise in recent years (Jewkes, 2002). According to Kurt (1997), women are the common victims of domestic violence.

The current study reveals that all the participants surveyed had been exposed to at least one or more forms of domestic violence. In every ten women in Kibra, eight have experienced physical assault. The findings of the UK National Survey Report (2003) noted physical assault incidents to be more than 50%, which is in line with the current findings in this study. According to Dimovitz (2015), in Nairobi's informal slums (Kibera, Kawangware and Kangemi) 86% of women are exposed to physical assault. Goodrum (2001) found that men who were physically violent to their partners portrayed a positive non-violent self- image, holding the idea and evidence of their violent selves at a distance. Many expressed frustrations when their partners described them as violent as they did not feel that such characterization reflected their true selves. Many blamed their partners for the violence in what the author called the "this is not me" empathy failure and resistance to influence.

The current study found the level of sexual assault to be at 78%. Compared to other research findings, Myhill and Allen (2002) found the level to be at 71%. This is an indication that the incidents are many. A study by Dimovitz (2015) in Nairobi's informal slums (Kibera, Kawangware and Kangemi) found out that cases of sexual assault were more than 70% among females aged between 12 to 35 years, with those aged 19 to 35 years being at the highest risk.

All the study participants in the current study indicated that they had experienced psychological abuse in their households. O'Leary (1999) associates psychological abuse to continued physical abuse. The author segments psychological abuse to different types among them recurrent criticism and ridicule, threats and verbal aggression, acts of isolation, control and domination. The study by O'Leary also found that abusive men have repertoire of emotionally abusive methods. Another study by Babcock (1993) found incidents of psychological abuse at about 80% among abusive men, realizing that interactive pattern of high male demands and criticism followed by female non-resistance which correlated significantly with physical abuse. The researcher also found out that abusive men with lower perceived decision-power and poorer objectively assessed communication skills were associated to frequent psychological abuse.

Six demographic variables were assessed in the current study to check for their influence on domestic violence among the study participants. These demographic included age, education, marital status, number of children, religion and individual income. The current study found age of the women surveyed to significantly influence the use of children to influence the victim. Fundamentally, women aged 29 years and above experience high incidents of children being used to control them as opposed

to those aged between 18 to 28 years. On the flipside, age did not have a significant association with physical assault, sexual assault and financial coercion. This is an indication that these forms of domestic violence occur on almost equal level among the age groups of the study participants. This confirms the contention by Budd (2003) that domestic violence cuts across age. The current study contradicts a finding by Piispa (2002) which found that younger couples are associated with domestic violence perpetration and victimization in most community surveys. The author also realized that domestic violence tends to decrease with an increase in age.

The current study found no association between education and domestic violence (physical assault, sexual assault, financial coercion and use of children). However, a study by Kusanthan, Mwaba and Menon (2016) found education to strongly influence physical assault, sexual assault and psychological/emotional abuse. The study that aimed at assessing factors affecting domestic violence among married women in Zambia observed that women with primary education levels were highly susceptible to physical and sexual assault and psychological/emotional abuse as compared to those with secondary or higher education.

The results of the current study found marital status to have significant association with domestic violence. A study by Mwenesi, Buluma, Kong'ani and Nyandarua (2003) found high cases of physical, sexual, and emotional assault common among the married and the divorced. The study also found high cases of domestic assaults to be common between 3 to 5 years for married women and between 1 to 2 years for divorced and separated women.

The results of the current study found the number of children to have significant influence on financial coercion. Women with more than one child were found to experience a lot of financial control as opposed to those with no children. Contrary to the results of the current study, a study by Kusanthan, et al. (2016) found that the number of children significantly influence physical and emotional violence. There are several factors which trigger domestic violence such as previous abuses/assaults, drinking alcohol and drugs, other relationships, poor communication skills, poor problem-solving skills, cultural expectations, stress, unemployment, among others.

In order to understand this phenomenon of domestic violence, various researchers have advanced different theories which explain what could be the main cause or trigger of domestic violence. These theories agree with our findings. In brief, we will critically examine these theories. Goode's (1971), while stressing the use of violence by husbands who want to retain a dominant position when they

lack other resources like education and job prestige, espoused the resource theory. Resource theory suggests that the more resources a husband brings to a relationship, the more power he has but the less likely he will actually resort to violence. In this light, household income, as the research findings reveals, is a variable which contributes to the occurrence of domestic violence. Goode continues to state that when the man of the house is threatened by his wife's access to educational or job-related resources, he may resort to violence to re-establish himself as the dominant partner. This confirms the responses given by the women who participated in the FGDs: that immediately they got new jobs better than their husbands, their husbands started quarrels and fights.

In addition, Whaley (2001) agrees with Goodes view that gender inequality has an influence on the occurrence of violence especially sexual assault. Our findings show that women were assaulted sexually by their partners as a result of gender inequality which exists in most of the Kenyan communities where women are seen as part of the property of their husbands. Occurrence of domestic violence, particularly sexual assault, is as a result of disparity in household income, education level, and disparity in access to high-status, among other factors. Our findings show that as the levels of education, economic independency, participation of women in political roles and policy making increase, domestic violence decreases.

The second theory which confirms our research findings is the exchange theory. This theory suggests that domestic violence will be particularly high in societies where its benefits to perpetrators are high; and particularly low in societies where the costs to perpetrators are low (Levinson 1989; Kacen, 2006). The research findings show that in many societies in Kenya, the penalties for domestic violence are low because of inadequate social controls placed on the offenders. Perhaps this is due to the emphasis on male aggressiveness. Levinson posits that as the costs of domestic violence rise in a society, the practice of domestic violence will decline (Levinson 1989:15). According to the findings of this research, offenders of domestic violence have the capacity to corrupt the justice system and be released. Other offenders of domestic violence are given penalties which do not measure to the crime they committed. With such finding, the study is in congruence with Levinson’s findings that countries which have strict laws against domestic violence will have lower levels of domestic violence than those without such laws. On the other hand, countries that do have domestic violence laws but do not enforce them will have higher rates of domestic violence.

The other theory which is related to this study is the culture of violence theory. This theory was first hypothesized by Wolfgang and Ferracuti in 1967. They confirm our research findings that culture is one of the demographics which trigger domestic violence. The culture theory suggests that violent societies are more likely than nonviolent societies to permit domestic violence, partly because where violence is used for conflict resolution generally, it is likely to be accepted as a means of conflict resolution within the household as well (McWilliams, 1998). Some of the participants of the study revealed that, their partners had a history of violence in their families of origin. Other women confirmed that their perpetrators were facing challenges with their bosses in their places of work, thus when they got home they vented their violence upon the family members. The research findings show that people who had earlier been victims of any sort of violence either at home, school, or work place at some later stages of life became perpetrators of violence.

Another theory which confirms these research findings is patriarchal theory championed by Martin (1973) and Dobash & Dobash (1979). This theory suggests throughout history males have dominated society and women have been to be treated as men's possessions. Patriarchal norms protect men's ability to control their wives and justify their use of violence to do so. These norms have historical roots that emphasize female subordination. Most ethnic communities in Kenya are largely patriarchal. Women have limited rights, especially in their reproductive health. In some marginalized areas, girls have no right to choose their husbands and are forced into early marriage by their parents for the exchange of bride-wealth. In addition, there are some cultural practices which demean women such as Female Genital Mutilation (FGM). Our findings show that women are dominated in patriarchal societies and when their rights are violated, some feel men have the right to do so. These women keep quiet and persevere hoping that all shall be well. Thus perseverance is used as a coping mechanism to deal with domestic violence.

5.2 The Association of Domestic Violence with Anxiety and Depression

The current study reveals that there is a significant association between domestic violence and psychological disorders, anxiety and depression, which is an indication that domestic violence results to depression, while anxiety is not a source of domestic violence. This could be associated with the loss experienced after one has suffered side effects of domestic violence. The fact that domestic violence is significantly associated with depression and anxiety is an indication of the depth of domestic violence on the health of the victim. The research findings show that when women are faced

with domestic violence, they end up suffering from depression and anxiety. This is very unfortunate, considering the fact that a greater percentage of women experiencing domestic violence do not have access to counselling services and other support systems which can prevent, limit, minimize and treat the negative effects of domestic violence.

Studies by Johnson et al., (2011) and Kubany et al., (2004) show that there is a strong relation of anxiety and depression with the frequency and duration of domestic violence among the women they sampled. The findings in this study show that women who were still living with their perpetrator had higher levels of anxiety and depression. Furthermore, women who were frequently exposed to violence on a daily or weekly basis recorded higher levels of anxiety and depression. Lastly, women who had a prolonged period of trauma exposures recorded high levels of anxiety and depression. To better understand the association of domestic violence with anxiety and depression, we will briefly evaluate each form of violence and its association with anxiety and depression.

First, there is a significant association of sexual assault and use of children with anxiety for various reasons. Women who have been assaulted sexually by their partners often experience panic attacks because they do not know when the perpetrator will strike again. In addition, women who have experienced children being used to fight them tend to have anxiety because their partners may take their children from them or they may hurt the children. In other words, they live in constant fear of not knowing what is going to happen to them and their children.

Depression has a significant association with physical assault, sexual assault, psychological and emotional abuse. Women who are battered and left with serious injuries are likely to sink into depression if no quick assistance is given to them. This is because there are scars and body pains, which constantly remind them of the perpetrator and the violence which they went through. Sexual violence leads to depression especially in cases of incest, rape by trusted members of the family such as uncles and consequently a pregnancy or sexually transmitted diseases such as HIV and AIDS arises. Psychological and emotional abuse leads to severe depression, especially in cases where the victim is constantly intimidated and verbally abused in front of the children and significant others. Therefore, the role of the counselor using CBT is to include adequate techniques and information to such women, including thought inhibition, distinguishing irrational thoughts and reality, how to be self-reliant and independent and how to deal with other negative effects such as drug abuse.

5.3 The Efficacy of Cognitive Behavioral Therapy

With respect to the third objective, the research findings reveal that CBT is effective in reducing the levels of anxiety and depression among women who have experienced domestic violence. Cognitive behavioral therapy has been in use in the Western countries for decades. A well-trained counselor has a duty to respond not only promptly but also satisfactorily to victims of domestic violence who come for help. The inability to do so leaves the victims of domestic violence dissatisfied and in deeper crisis since it is only through counseling that psychological healing takes place.

Cognitive behavioral therapy interventions approach violence as a learned behavior. According to a CBT model of psychology, nonviolence can also be learned by domestic violence perpetrators. Cognitive behavioural therapy attempts to change the behavior by identifying the thought processes and beliefs that contribute to the offenders' violence. For example, physically abused women are encouraged to think about the violence they experienced and change their understanding of it, examine the circumstances surrounding their experience of violence, and to disrupt the cognitive chain of events that lead to them experiencing the violent acts of domestic abuse.

The study adopted the model of Naeem & Kingdom (2010) and tailored it to the African cultural context of the participants. During the CBT sessions, the therapist demonstrates to the victims how the perpetrators use violence as an anger outlet, to obtain compliance from the victim, and to empower themselves with a sense of control. The therapist encourages change in the victims' thinking about violence while teaching them cognitive behavioural techniques such as communication skills, nonviolent assertiveness, social skills, and anger management techniques. Usually, CBT models of treatment for domestic violence also address the emotions underlying the violent behaviours, as well as the perpetrator's attitudes towards women. People taking part in CBT programs learn specific skills that they can use to effectively solve daily problems, as well as skills they can use to achieve legitimate goals and objectives. This research shows that CBT is effective in reducing the levels of anxiety and depression. When the victims of domestic violence opted for counselling, the therapist journeyed with them for a period of not less than ten sessions. These sessions were well structured to ensure the effectiveness of CBT.

On the first phase, the therapist did the assessment to try and find out why the client had come to seek therapy. The second phase involved efforts of the counsellor and the client to try and reconceptualize the violence for which the client was being treated. In other words, it involved trying to reframe the

situation to see how best it could be approached from another angle. The third phase involved skills acquisition, where the client is familiarized with various skills of dealing with violence. The fourth phase involved skills consolidation and application on their daily lives, where they were given various assignments to enable them to cope with the situation which they had experienced earlier. Some of the specific therapeutic techniques used in CBT programs may include: Self-instruction using imagery, affirmations, or motivational self-talk, coping techniques for negative thoughts, relaxation techniques, exposing the person to a fearful situation, gradually undoing the automatic negative response, and presenting a positive response, role-playing and graded task assignments.

The next two phases include generalization and maintenance, where the client has acquired all the necessary coping skills and is free to part with the therapist. The last phase is a follow-up treatment, where the client is invited at least once in a month for follow up to see how they are moving on with life. It is fundamental to note here that the role of the CBT program is to help the victims of domestic violence to recognize distorted or unrealistic thinking when it happens and to then change that thinking or belief to eliminate problematic behaviour. The condition of women who were treated during the individual counselling sessions using CBT for a period of ten to thirteen sessions proved that CBT is effective. This is because, in comparison, the levels of anxiety and depression remained high in the non-intervention group who were not treated until the tenth session. These results support findings from previous studies that report significant reductions in PTSD, depression, and anxiety in female victims of IPV following participation in intervention programs in groups (Graham-Bermann & Miller, 2013).

5.4 Factors Associated with the Effectiveness of Cognitive Behavioral Therapy

The key factors that were found to have significant association with the effectiveness of CBT included: household income, the number of CBT sessions attended, level of education, performance in primary school and self-esteem. As far as household income is concerned, women from middle income households experienced effective CBT sessions as compared to those from high and low income households. Low income earners are going through hard situations at home in managing themselves and the family. In this view, even when they are treated using CBT, their anxiety and depression take time to go down because they are constantly worried about their financial status.

In regard to the number of sessions attended, the research findings show that the more the number of sessions the participants attended, the more the reduction of anxiety and depression scores, which is a sign of the effectiveness of CBT. This was arrived at after comparing the scores between the intervention group and the non-intervention group. From the research findings, the intervention groups, having attended the counselling session using CBT, recorded gradual decrease in their anxiety and depression levels as compared to the non-intervention group who were not treated until the 10^{th} session coinciding with the intervention group. The latter group's anxiety and depression levels remained high until after the treatment using CBT.

The level of education has partial effect on the effectiveness of CBT. For instance, women with primary education were seen to be slower in benefiting from CBT as compared to those with higher education levels. The study also found that participants who had moderate performance in primary schools were seen to improve faster when treated using CBT as compared to those who had low or high performance. This disparity in effectiveness of CBT as influenced by education can be attributed by the level of awareness of what comprises domestic violence and the perception of the counsellor-client relationship especially on the part of the women who have high education levels.

In addition to the factors which contribute to the effectiveness of CBT, the willingness of the client to change their thinking and embrace new skills to deal with life challenges is paramount. The role of the counselor is to journey with the client. The client herself makes the first step to look for counseling and not vice-versa. Therefore, the client should be ready and willing to journey with the counselor administering the CBT in a good counseling relationship. In this way, CBT work better for women who are open and cooperative as compared to women who are not ready to embrace the coping skills taught during CBT sessions.

Given the high cost of the intervention programs, especially here in Kenya, many clients who have faced domestic violence do not look for counselling services. This study was successful because the researcher facilitated the commuting fees for the clients who were attending the sessions. This made the CBT to be more effective since the clients did not miss the sessions as a result of financial constraints. In addition they were not expected to pay any charges for the treatment as compared to other therapeutic sessions where they are expected to meet the charges. In view of this scenario, effectiveness of CBT depends on financial support from the government, NGOs and well-wishers, which can help in addressing the menace of domestic violence. According to Rachman and Wilson

(2008), one of the factors which have led to improvement in access to therapies in the United Kingdom is the effort which is made by the National Health Commission.

5.5 The Impact of Cognitive Behavioral Therapy on Domestic Violence

With respect to the fifth objective, the study notes that CBT has an impact in the lives of women who had earlier been exposed to domestic violence. The overall aim of the CBT was to provide the women with a sense of control over their physical safety as well as their psychological and social wellbeing. This was realized during the sessions where the women were helped to stabilize their psychological symptoms. The coping skills acquired during the CBT sessions helped the women to deal with psychological reactions to the traumatic experiences they went through and got themselves into better positions to rebuild their lives once again and move on with their daily routines. Furthermore, during the CBT sessions, the women were helped to have control of their financial and economic situation in order to provide for their children with basic needs.

Therefore, women completing the whole treatment program revealed significant reductions in all psychological symptoms following the intervention using CBT. The research findings show that CBT is effective in reducing levels of anxiety and depression. In addition, the entire life story of the former victims of domestic violence was seen to have changed following the reports they were giving the counsellors during the CBT sessions; their relationships had changed at home in terms of social relationships with their spouses, relatives, neighbours and friends. Some of them reported that they had forgotten they were ever depressed or anxious.

Another positive impact of CBT to women faced by domestic violence was seen on the choices they made after meeting the counsellor. Women who were still being exposed to abuse from their former partners were helped to make choices of securing new places of residence far from the perpetrator's environments. Others were helped to design a potential escape plan, in case the threat was too much. Furthermore, to overcome social problems, such as dependency syndrome, women were helped to acquire control over their financial situation, by starting businesses and having separate accounts, among other intervention mechanisms.

In conclusion, CBT as an intervention program for women faced with domestic violence is effective in treating harmful consequences following trauma exposure. Treating women using CBT was found to significantly reduce their psychological trauma symptoms during the intervention period. Despite

some few limitations and challenges in the process of using CBT, we recommend it as an effective method which can be used to deal not only with anxiety and depression but also with other psychological disorders.

CHAPTER SIX
SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This section provides a summary of the main findings of the study as per the objectives. The study had five objectives: to examine the forms of domestic violence and how demographic variables influence the occurrence of domestic violence; to determine the association of domestic violence, anxiety and depression; to establish the efficacy of CBT in reducing the levels of anxiety and depression among the intervention group; to explore factors associated with the level of effectiveness of CBT between the intervention and non-intervention groups; and to establish the impact of CBT on domestic violence among the study population. The conclusion presented in this chapter was drawn from the findings of the research study. The recommendations have been offered to fill the gap on how to treat African women facing domestic violence using cognitive behaviour therapy. Finally, this chapter points to areas for possible further study.

6.1 Summary of Findings

The participants of the study understand the core issues and aspects of domestic violence. The participants are able to define domestic violence as physical, sexual, psychological and emotional abuse, financial coercion, verbal abuse and use of children to control a partner. The study shows that a majority of victims of domestic violence are women and children, and men are commonly the perpetrators of domestic violence. However, there are some cases where men fall victims of domestic and women are the perpetrators. Causes of domestic violence are mostly as a result of behavioral patterns of the perpetrators and victims and other social demographics. Occurrence of domestic violence leaves the victims with negative impacts, but when they attend CBT sessions the impacts reduce on a large scale. During CBT sessions, the therapist equips the victims with coping skills to deal with their domestic situations.

6.1.1 Forms of domestic violence and influences of social demographics

The study findings show that all the participants had been exposed to emotional and psychological abuse. The second common type of abuse among the participants is economic coercion, at 91.1%, where the victims said they are financially controlled and deprived by the perpetrators. Victims of

DV approached by the researcher had experienced physical violence at 88.9%. Sexual assault was reported by 77.8% while the use of children to control a partner was mentioned by 62.2% of the study participants. Furthermore, the study investigated how perpetration occurs as a result victimization. From the findings, 24.4% of the study participants become perpetrators as a result of victimization. This occurs in instances where there is physical assault and psychological and emotional abuse. The study shows that 75.6% of the participants are only victims of domestic violence and not perpetrators while 24.4% of the study participants are both perpetrators and victims.

Logistic regression analysis was used to establish the influence of demographic variables on the forms of domestic violence. In this analysis, emotional and psychological abuse was not included as a variable because all the participants experienced it. Six demographic variables that were used in the analysis include age, education level, marital status, number of children, and household income. The study shows that more than 70% of the total participants are between 18 to 50 years of age. The study also revealed that 48.9% of the participants had tertiary education levels while 33.3% had O-levels, while the rest had primary and below levels at an aggregate of 17.8 %. The study shows that there is a relationship between domestic violence and education because those with lower levels of education and performance experience higher levels of domestic violence.

On household income, the study findings show that domestic violence cut across all levels of economic status: high, middle or low household income. However, sexual abuse is influenced by the amount of household income. In regards to marital status, 46.7% of the participants are married, with 26.7% being single, 12% of the participants from the intervention group being separated and 15% of the participants from the non-intervention group being divorced. The findings indicate that married women are the ones who experience higher frequencies of domestic violence as compared to other marital statuses. From the research findings, there is a relationship between the number of children and domestic violence, because 73.3% of the participants had children.

In conclusion, the study shows that physical violence is not significantly influenced by any of the six demographic variables, $p > .05$. Sexual assault is significantly influenced by household income ($\chi^2=10.13$, $p<.05$). Financial control and deprivation is significantly influenced by the number of children that the victims have ($\chi^2=4.368$, $p<.05$). The use of children to control the partner is

significantly influenced by age (χ^2=18.12, p<.01) and marital status (χ^2=24.13, p<.01) at confidence level of 95%.

6.1.2 Association of domestic violence with anxiety and depression

Pearson's correlation analysis was used to determine the association between anxiety, depression and exposure to domestic violence. The results of the study show that there is a strong positive and significant correlation between anxiety and depression (r=.715, p<.01). The study shows that anxiety has a significant positive correlation with sexual assault (r=.224, p<.05) and use of children (r=.227, p<.05). Similarly, depression has a significant positive correlation with physical assault (r=.302, p<.05), sexual assault (r=.392, p<.01) and use of children to control partners (r=.299, p<.05). Finally, the study shows a positive significant correlation between psychological assault with physical assault (r=.533, p<.01), psychological assault and economic coercion (r=.369, p<.05). Also, sexual assault has a positive correlation with physical assault (r=.347, p<.05) and economic coercion (r=.452, p<.01). However, anxiety has insignificant association with physical assault, sexual assault, psychological assault, economic coercion and the use of children to control a partner at p > .05.

6.1.3 Efficacy of CBT in reducing levels of anxiety and depression

Multivariate analysis of covariance (MANCOVA) was used to establish the efficacy of CBT in reducing anxiety and depression. The findings show that there was a decrease in anxiety and depression levels among the intervention group. On the first invitation, this group had a mean level of anxiety at M=19.8, SD=2.2 and an average level of depression at M=18.4 (SD=4.0). After undertaking CBT sessions, the means of anxiety and depression decreased to M=5.6 (SD=3.3) and M=6.1 (SD=3.4), respectively. On the other hand, the non-intervention group, on the first invitation, had their average anxiety levels at M=20.5 (SD=1.4) and depression at M=20.6 (SD=1.2). Since there was no CBT intervention for this group, on the last invitation their anxiety and depression levels had decreased to M=19.8 (SD=2.4) and M=19.7 (SD=2.4), respectively. The study reveals that the number of CBT sessions attended have a significant effect on anxiety and depression. The MANCOVA analysis show a significant decrease for the intervention group between the 10^{th} – 14^{th} sessions of CBT, for both anxiety ($F_{(1, 85)} = 165.45$, p<.001) and depression ($F_{(1, 85)} = 77.20$, p<.001). This shows that CBT is effective tool for reducing the levels of anxiety and depression.

6.1.4 Factors associated with effectiveness of CBT among the study sample

In arriving at the factors associated with effectiveness of CBT, the researcher measured reduction of the anxiety and depression levels. The reduction was computed by getting the difference between the levels at the first and the last session. The study findings show that several factors have direct and partial associations with effectiveness of CBT. The key factor is the number of CBT sessions the participants attend in order to significantly reduce anxiety ($\beta=1.548$, $p<.01$) and depression ($\beta=1.226$, $p<.01$). Other factors that have partial associations with effective CBT include education level, performance in primary school education, self-esteem and household income. The study shows that when tertiary education level victims are compared with primary education level victims, the latter have the least reduction in depression ($\beta=-13.649$, $p<.05$). Similarly, in terms of performance in primary school, the study shows that CBT is significantly effective in reducing the level of depression among women who are moderate performers in primary schools than those who are low performers ($\beta=11.308$, $p<.05$). Self-esteem has a partial association with CBT effectiveness because victims with moderate self-esteem experience a significant effect of CBT in reducing depression in comparison to victims with low self-esteem ($\beta=4.353$, $p<.05$). The last factor with partial influence on effectiveness of CBT in reducing anxiety is household income. The study findings reveal that victims having moderate income levels experience a significant effect of CBT in terms of reduced anxiety in comparison with victims of DV with low income levels ($\beta=4.274$, $p<.05$).

6.1.5 Impact of CBT in reducing negative effects of domestic violence

Cognitive behavioural therapy has both short-term and long-term impacts on the lives of people who have been exposed to domestic violence and have gone through therapy using it. The study reveals that participants attending CBT sessions experience positive cognitive and behavioral adjustments. Cognitive behavioral therapy has an impact in reducing the levels of anxiety and depression. The long-term impact of CBT on the participant is the ability to restructure the cognitive capabilities of the person. Therefore, despite the challenges and the negative impacts of domestic violence which the participants had gone through, they acquire coping mechanisms through CBT. These coping skills help them to approach and navigate their lives with positivity and healing.

6.2 Conclusion

The study's main objective was to examine the effectiveness of cognitive behavioral therapy among women exposed to domestic violence to mitigate the negative effects of domestic violence within Kibra. The study had five objectives: to establish the forms of domestic violence among the study participants in order to tell the source of the problem and the influence of demographic characteristics in occurrence of domestic violence; to explore the association between domestic violence and anxiety and depression; to establish the efficacy of CBT in reducing the levels of anxiety and depression among the intervention group; to explore factors associated with the level of effectiveness of CBT between the intervention and non-intervention groups; and to establish the impact of CBT on domestic violence among the study population.

Chapter provides an introduction and background to the study. Chapter two provides a review of available literature. It also develops the conceptual and theoretical framework upon which the study is based. Chapter three addresses the methodology of the study. In chapter four, the researcher analyzes both the quantitative and qualitative findings. Chapter five is a discussion of the study findings as supported by other researchers in the field. In chapter six, the researcher provides summary of the findings, recommendations and areas for further study.

The researcher had hypothesized that cognitive behavioral therapy would alleviate anxiety and depression among the intervention group. It was also assumed that victims receiving cognitive behavioral interventions would score low on the hospital anxiety depression scale (HADS) as compared to those victims in the non-intervention group. The study findings show that all the participants reached by the researcher had been exposed to physical violence, psychological and emotional abuse, sexual assault, economic coercion, the use of children to control a partner and verbal abuse. The six demographic variables influence domestic violence partially or significantly were found to be age, education level, marital status, number of children, and household income. The study also revealed that there is a strong positive and significant correlation between anxiety and depression but not domestic violence. The study revealed that CBT is an effective tool for reducing the levels of anxiety and depression. This was achieved in the attempt to identify the factors associated with the level of CBT effectiveness among the intervention and non-intervention groups, where CBT was found to be very effective on the intervention study group because they responded well to its treatment. The main factors which make CBT effective are the number of sessions participants attend.

In conclusion, CBT has positive impact in reducing, preventing, healing, and equipping victims of domestic violence with coping mechanisms so that they can live a better life. Therefore, the researcher achieved the objectives under study and gave appropriate recommendations on what should be done to curb and mitigate the problem of domestic violence in Kibra Sub-County specifically and Kenya in general

6.3 Recommendations

- The study recommends that the community should be educated on how to overcome gender disparity between men and women especially in patriarchal societies.
- The study recommends that women should be empowered economically so as to reduce dependency on their husbands/partners who sometimes take advantage of their financial vulnerability and subject them to abusive treatment and relationships.
- The curriculum of learning institutions should be planned to accommodate life skills learning from as low as primary school, where the pupils and students are introduced early enough on how to use cognitive awareness to understand their irrational thoughts which lead to unbecoming behavioral patterns
- People should be well trained and adequately equipped with proper coping skills, especially communication and problem-solving skills so as to mitigate marital conflicts in marriage life.
- The study recommends that clients who require psychological therapy using CBT to attend a minimum of 14 to 16 sessions for CBT to be more effective.
- The government of Kenya, the county government, NGOs and other stakeholders should facilitate therapists to carry out CBT among people experiencing domestic violence without charging the victims. This will enable victims of domestic violence to access therapy without financial limitations.
- The government of Kenya should enact stiffer penalties for all perpetrators of domestic violence by increasing the jail term and attendant fines.

6.4 Areas for Further Study

a) A research, including large-scale longitudinal studies with data on couples, would be needed to elucidate the causal relationships between domestic violence and psychological disturbances.

b) A similar research should be done with only male participates to find out if CBT is effective in helping them deal with domestic violence.
c) A similar research should be carried out in a rural set up to test the validity of the study to compare it with this study which was done in an urban setting.

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APPENDICES

Appendix A: Data Collection and Analysis Matrix

Objectives	Research Design and the Research Questions	Method of Data Collection	Sampling techniques and Sample Size	Instruments	Data Analysis
To determine the impact of CBT among women exposed to domestic violence to mitigate the negative effects of DV within Kibra Sub-County, Nairobi City County.	Mixed Method Study Design: Qualitative and Quantitative approaches	Qualitative Survey: Key-Informants and Focus Groups discussions. Quantitative Survey: Using structured questionnaires, administered self-report inventories, applying repeated data collection methodology.	General Population: of women aged 18 years and above within the selected health facilities. Techniques: Snowballing and Purposive.	Social Demographic; Assessment of DV Questionnaire; Hospital Anxiety Depression Scale (HADS).	Test-retest approach was used to determine the recovery rate. For continuous measures, analysis of variance will be computed and the level of significance will be set at the 5% level of significance. DV will be cross-tabulated with all the other variables: anxiety, depression and other demographic characteristics. The level of significance will be pegged at 5%. Variables observed to be significant at $p<0.15$ will be included in the Multivariate analysis to determine the factors associated with the DV. See below.
1. To determine the level of exposure to DV among the study subjects; and establish the influence of demographic variables on the forms of DV among the study subjects;	What is the level of exposure to DV among the study subjects? (Cross Sectional Survey)	Using the demographic questionnaire and Assessment of DV: Victims and Perpetrator's Pattern of Assaultive and Coercive Behaviors. Interviewing the women as key informants and in focus group discussions	General Population: As above	Using a demographics questionnaire for general population and Assessment of DV: Victims and Perpetrator's Pattern of Assaultive and Coercive Behaviour	Univariate approach: Frequencies for all variables were computed, and summary measures – minimum, maximum, means and proportions will also be computed.

	How do the demographic variables influence the forms of DV among the study subjects? (Design is as above)	Demographic questionnaire and Assessment.	Ibid.	Demographic questionnaire for general population. Assessment for DV questionnaire	ANOVA Multivariate Analysis.
2.To determine the association of domestic violence, anxiety and depression among the study sample;	Is there an association between domestic violence, anxiety and depression among the study sample? (Both Qualitative and Quantitative)	Instruments: Retesting and interviewing guide provided	Screening, Systematic-Random Sampling for intervention and control groups	Hospital Anxiety Depression Scale (HADS) for identifying Anxiety and Depression.	Bivariate analysis: where all the categorical variables will be cross tabulated with DV. The Chi-square test will be computed and the level of significance will be determined at $p< 0.05$.
3.To establish the efficacy of CBT in reducing levels of anxiety and depression among the intervention study sample;	What is the efficacy of CBT in reducing levels of anxiety and depression among the intervention study sample? (Quantitative)	Give CBT therapy then retest. Compare intervention and non-intervention groups	Systematic Random Sampling of 50 subjects: 25 in each group.	Using instruments as above and therapy.	Summary statistics such as means, standard deviations, correlations, and MANCOVA and Profile plots for comparison of means by groups and interpretation will be used.
4.To explore the factors associated with the level of effectiveness of CBT between the intervention and non-intervention groups;	What factors are associated with the level of effectiveness of CBT between the intervention and non-intervention groups?	Using Key informants and Focus Group Discussions; and Repeating measures.	Women interested in in women welfare using purposive sampling techniques. Then subjects already in the study.	FGDs questions and in-depth interview guide.	Thematic Analysis, ATLAS-ti. Descriptive statistics and graphical presentations, constituting exploratory analysis, will be used. A step-wise logistic, regression analysis using the forward and/or backward

	(Both Quantitative and Qualitative)				selection process will be used to establish factors associated with the dependent variables, and a
5.To establish the impact of CBT on DV among the study sample	What is the impact of CBT on DV among the study sample?	Comparing the Mean levels	Two groups: intervention and Non-Intervention	Repeated measures using HADS	Logistic regression analysis, Times series-analysis will be applied.

Appendix B: Informed Consent Form for the study participants

Please read this consent form carefully. Ask as many questions as you like before you decide whether you want to participate in this research study.

You are free to ask questions at any time before, during, or after your participation in this research.

Project Title: Cognitive Behavioral Therapy on Women Exposed to Domestic Violence: An Intervention Study within Kibra Constituency, Nairobi County.

Principal Researcher: Josephine Muthami

Telephone: 0722796256

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Organization: University of Nairobi

Location of Study: Kibra Constituency/African Women's Studies Center

Purpose of this Research Study:

You are being asked to participate in a research study involving only women, designed to be conducted as part of the researcher's doctorate program in the University of Nairobi. The principal researcher is a psychologist in the African Women Studies and Counseling Psychology. She is doing research in the area of counseling psychology, focusing on the "effectiveness of cognitive behavioral therapy" on women aged 18 years and above, who have been exposed to domestic violence and may have developed anxiety and depression which are the selected psychological disorders, for the study.

Procedures:

You will be expected to sign a form of consent to freely participate in this study. Your participation is by giving information and answering some questions asked in the questionnaires. This process will be guided by counselors/research assistant on face-to-face, and will take about 30 to 40 minutes. This first part of the study will help to determine whether you are above 18 years category and if you have been exposed to domestic violence, and progressed to developing anxiety and depression.

In case the researcher has established signs and symptoms of anxiety and depression, you will be given counseling sessions using CBT for a minimum of 10 sessions which will be free of

charge. During the counseling sessions, the counselor will be measuring the recovery rate by test-retesting method.

Possible Risks:

This is a therapeutic relationship and there are no known or possible risks involved. This is a therapeutic study which will help you to deal with cases of domestic violence. Please know that any questions you may have about this study will be answered by the Investigator or Counselor present. If you have any questions about your rights as a research participant, please ask the principal investigator. In case of any research-related emergency, call the principal investigator on the number provided.

Possible Benefits:

The researchers' expectations are that you should get reasonable benefits from the exercise in gaining better skills of life, better mental health status, better physical health, improving your social economic status, and better relationships. Your participation will not only directly benefit you, but also your significant others, will be positively impacted by the achieved family welfare. This will also improve your workforce and normal functioning in life.

Financial Considerations:

You will not incur any costs as a result of your participation in this research nor will you receive any financial compensation for your participation. Costs such as bus fare from the city center to the research center and a snack will be provided for those coming for the sessions.

Confidentiality:

Your identity in this study will be treated as confidential. Results of the study, including all collected data, may be published in the dissertation and in possible future journal articles and professional presentations, but your name or any identifiable references to you will not be included. However, any records or data obtained as a result of your participation in this study may be inspected by the persons conducting this study. Review Board members provided, legally obligated to protect any identifiable data from public disclosure, except where disclosure is otherwise required by law or a court of competent jurisdiction. These records will be kept private in so far as permitted by law.

One of the steps taken to protect confidentiality is by use of number codes or pseudonyms for identifying data or the participants instead of your name. All study data will be retained for a minimum of three years or as required by the University Research Ethics Board, and then destroyed.

Termination of Study:

Please know that you are free to choose whether to participate in this study or not.

You may also choose to withdraw from the study or to decline to answer any questions at any time. You will not be penalized or lose any benefits to which you are otherwise entitled if you choose not to participate or choose to withdraw. You will be provided with any significant new findings developed during the course of this study that may relate to or influence your willingness to continue participation. In the event you decide to discontinue your participation in the study, please notify the principal researcher or counselor present, of your decision so that your participation can be terminated in an orderly fashion. Your participation in the study may be terminated by the investigator without prior notice to, or consent in the event that you get an illness and unable to participate, or other reason(s). All data collected on, about, or by you will be destroyed and not used in the data analysis or writing of the findings if you choose to withdraw.

After the study is completed:

After the study is completed, you can get the findings and analysis of the entire project, this will be provided through the University of Nairobi Website, if you would like to access it. You can also reach out to principal investigator through the phone number or email provide for related issues in the future.

Signing the Consent:

I have read and I understand this consent form, and I volunteer to participate in this research study. I understand that I will receive a copy of this report if I ask. I voluntarily choose to participate and, I understand that my consent does not take away any legal rights in the case of negligence or other legal fault of anyone who is involved in this study. I further understand that nothing in this consent form is intended to replace any applicable national, government, or local laws.

Signatures:

Participant Name (printed): _____

Participant Signature: _____

Date: _____

Principal Researcher's/Assistant's Name (printed): _____

Principal Researcher's /Assistant's Signature: _____

Date: _____

Person obtaining consent, if other than principal investigator (printed):

_____

Signature: _____

Date: _____

Client anonymous code: 

Appendix C: Social Demographic Characteristics of Participants

This tool will capture data related to emotional disturbances and health seeking behaviors after occurrence of episodes of domestic violence. Participation in this study is voluntary and there are no monetary benefits attached. The data will be treated confidentially and will only be used for the purpose of the study. The individual is free to withdraw from the study without being penalized. The serious cases will be referred to specialized hospitals for further management.

Please note that all participants are referred to as Respondents (R1, R2, R3,) for confidentiality's sake. ***Have you freely accepted to take part in the study?*** ☐

1. Your age in years: ☐
2. Gender: (1=M, 2=F, 3=other) ☐
3. Educational Level completed:

    0. None…… ☐

    1. Primary …… ☐

    2. Secondary …… ☐

    3. Tertiary /College/ University ☐

4. Marital status: (1) Single (2) Cohabiting (3) Married (4) Separated (5) Divorced ☐
5. Do you have children? (1) Yes (2) No ☐
6. If yes how many are they? ☐
7. What is the gender of the children? B ☐ G ☐ Other Gender ☐
8. What is your religion? (1) Islamic (2) Hindu (3) Christianity (4) Other (5) None ☐

9. What was your school performance at: (Tick the appropriate box)

a. Primary

Performance in school	
3. High Achiever (70 & above)	
2. Moderate Achiever (50 to 69)	
1. Low Achiever (49 & below)	

b. Secondary

Performance in school	
3. High Achiever (70 & above)	
2. Moderate Achiever (50 to 69)	
1. Low Achiever (49 & below)	

c. Tertiary

Performance in school	
3. High Achiever (70 & above)	
2. Moderate Achiever (69 to 50)	
1. Low Achiever (49 & below)	

10. Occupation: what do you do for a living? ☐

11. Location: a). where do you live? 1. Town 2. Rural ☐

b). How long have you lived in this location _____Months? ☐

12. What complaints did you have that brought you to this facility? .....

13. Have you visited this health facility before with similar complaint? _____ ☐

14. If yes, were you attended to? ☐

15. Contextual factors: Are you afraid of your partner.	Never ……. ☐ Rarely……. ☐ Sometimes …. ☐ Often …… ☐
16. Controlling behavior score: Where **1** is the lowest and **10** is the highest, how controlling is your partner?	≥11 ☐ 09 to 10 …….. ☐ 07 to 8 …….. ☐ 05 to 6…….. ☐ 03 to 4…….. ☐ 01 to 2 …….. ☐
17. Rate your self-esteem	Highest…… ☐ Moderate …… ☐ Low …… ☐
18. Rate your household income per month (Testing for low income) (Codes: 3-highest 2-Moderate 1. Low)	High (Above ksh.20,000) ☐ Middle (Between ksh.10,000 -19,999) ☐ Low (Below Kshs. 9,000) ☐

Appendix D: Interview Questions Assessing Domestic Violence on Victims and Perpetrators

Interview question assessing Domestic Violence, victims and perpetrator's pattern of assaultive and coercive behavior, to determine the level of exposure to DV and the associated factors		
For each question listed below, if the adult, victim or domestic violence perpetrator, **answers yes,** encourage the individual to describe exactly what happened. *Monitor responses as they unfold and adjust your inquiries accordingly. You do not have to ask every suggested question here below. For example, sometimes in telling a story of an episode, the victim or perpetrator will supply many illustrations of domestic violence.*		
1. Physical Assault	Victim [No-0, Yes – 1]	Perpetrator [No-0, Yes-1]
	1.1 Have you witnessed physical violence?	1.1 Have you witnessed physical violence?
	1.2 Has anyone assaulted you physically?	1.2 Have you used physical force against anyone?
	1.3 Has your partner/anyone pushed, shoved, grabbed, shaken you?	1.3 Have you pushed, shoved, grabbed, shaken anyone?
	1.4 Has your partner/anyone restrained you, blocked your way, and pinned you down?	1.4 Have you restrained, blocked the way, or pinned down your partner/anyone?
	1.5 Has your partner/anyone hit you?	1.5 Have you hit your partner/anyone?
	1.6 Has your partner/anyone choked you? Used weapons against you?	1.6 Have you choked or used weapons against your partner/anyone?
	1.7 Has your partner/anyone assaulted you physically or in any other way?	1.7 Have you assaulted your partner/anyone physically or in any other way?
2. Sexual Assault	2.1 Victim [No-0, Yes – 1]	2.1 Perpetrator [No-0, Yes – 1]
	2.1 Have you ever witnessed sexual assault incident anywhere?	2.1 Have you ever witnessed sexual assault incident anywhere?
	2.2 Has your partner/anyone pressured you for sex when you did not want it	2.2 Have you ever pressured your partner/anyone for sex?
	2.3 If Yes, describe how_____	2.3 If so describe how_____

	2.4 Has your partner/anyone manipulated or coerced you into sex at a time or in a way that you did not want?	2.4 Have you manipulated or coerced your partner/anyone into sex at a time or in a way that he/she did not want?
	2.5 If so how?	2.5 If so how?
	2.6 Has your partner/anyone injured you sexually?	2.6 Have you injured your partner/anyone sexually?
	2.7. Has your partner/anyone forced you to have unsafe sex?	2.7 Have you forced your/anyone partner to have unsafe sex?
	2.8 Has your partner/anyone prevented you from using birth control?	2.8 Have you prevented your partner/anyone from using birth control?
3. Psychological Assault	[No=0 Yes=1]	[No=0 Yes=1]
	3.1 Has anyone ever humiliated you?	3.1 Have you ever humiliated your partner/anyone?
	3.2 In what ways do your partner/anyone hurt you emotionally?	3.2. In what ways did you hurt your partner/anyone emotionally?
	3.3 What names or put-downs do your partner/anyone use against you?	3.3 What names or put-downs have you used against your partner/anyone?
	3.4 Does your partner/anyone attempt to isolate you?	3.4 Do you attempt to isolate your partner/anyone?
	3.5 Does he/anyone attempt to control your time, your activities, and your friends?	3.5 Do you attempt to control his/her /anyone time, activities, or friends?
	3.6 Does he/anyone follow you, listen to your phone calls, and open your mails?	3.6 Do you follow, listen to his /anyone phone calls, open mail
4. Economic Coercion	[No=0 Yes=1]	[No=0 Yes=1]
	4.1 Who makes the financial decisions in your life?	4.1 Who makes the financial decisions in your life?
	4.2 are you involved in financial decisions?	4.2 How are finances handled?

	4.3 Has your partner/somebody else tried to control you through money?	4.3 Have you tried to control your partner /somebody through money?
	4.4 If so, how?	4.4 If so, how?
5. Use of children to control partner	[No=0 Yes=1]	[No=0 Yes=1]
	5.1Has your partner/anyone threatened or used violence against the children?	5.1 Have you threatened or used violence against the children?
	5.2 Has your partner/anyone tried sexual abuse against children?	5.2 Have you tried sexual abuse against children?
	5.3 Does your partner use the children against you?	5.3 Do you use the children against your partner?
	5.4 If so, how?	5.4 If so, how?
	5.5 Does your partner/anyone sabotage your parenting?	5.5 Do you sabotage your partner's /anyone parenting style?
	5.6 Does your partner/anyone obstruct visitation of your children in school?	5.6 Do you obstruct your partner/anyone from visiting your children in school?
	5.7 Has your partner/anyone taken or threatened to take the children?	5.7 Have you threatened your partner/anyone that you would take the children away with you?
	5.8 Has your partner/anyone interfered with your care for the children?	5.8 Have you interfered with you partner /anyone care for the children?
	5.9 Has your partner/anyone made the children watch or participate in your being abused?	5.9 Have you made the children watch or participate in abusing him/her?
	5.10 Has your partner made the children spy on you?	5.10 Have you made the children watch or participate in abusing him/anyone?
	5.11 Has your partner/anyone ever threatened to report you to Child Protective Services?	5.11 Have you ever reported your partner/anyone to Child Protective Services?

Appendix E: Hospital Anxiety Depression Scale (HADS)

For each of the 14 statements below, please choose one response from the four phrases given. Answer how it describes your feelings over the past week. Do not think too long about your answers.

For each column here below follow the order of 0, 1, 2 &3

Key: Totals: 0- Not unwell, 1- Unwell Sometimes, 2- Moderately unwell, and 3- Abnormal or severe.

A.1.	I feel tense or 'wound up':	3. All the time ☐	2. A lot of the time ☐	1.from time to time ☐	0. Not at all ☐
D.2.	I still enjoy the things I used to enjoy:	Definitely as much ☐	not quite so much ☐	only a little ☐	Not at all ☐
A.3.	I get a sort of frightened feeling as if something awful is about to happen:	3.very definitely and quite badly ☐	yes, but not too badly ☐	1.a little, but doesn't worry me ☐	0. not at all ☐
D.4.	I can laugh and see the funny side of things:	0.As much as I always could ☐	1.Not quite so much now ☐	2. A little ☐	3.Not at all ☐
A.5.	Worrying thoughts go through my mind:	3.A great deal of the time ☐	2. Not as much as before ☐	1.From time to time, but not too often ☐	0. Not at all ☐
D.6.	I feel cheerful:	3.Not at all ☐	2.Not at all ☐	1.Sometimes ☐	Most of the time ☐
A.7.	I can sit at ease and feel relaxed:	definitely ☐	usually ☐	not often ☐	not at all ☐

D.8.	I feel as if I am slowed down:	3.nearly all the time ☐	2.very often ☐	sometimes ☐	not at all ☐
A.9.	I get a sort of frightened feeling like 'butterflies' in the stomach:	not at all ☐	occasionally ☐	quite often ☐	very often ☐
D.10	I have lost interest in my appearance:	3. definitely ☐	2.I don't take as much care as I should ☐	I may not take quite as much care ☐	I take just as much care as ever ☐
A.11.	I feel restlessness as I move on with life:	3.very much indeed ☐	2.Fairly much ☐	1.not very much ☐	0.not at all ☐
D.12.	I look forward with enjoyment to the future:	0.as much as ever I did ☐	1.rather less than I used to ☐	2.definitely less than I used to ☐	3.hardly at all ☐
A.13.	I get sudden feelings of panic:	3.very often indeed ☐	2.quite often ☐	1.not very much ☐	0.not at all ☐
D.14.	I can enjoy a good book or radio or TV program:	0.often ☐	1.sometimes ☐	2.not often ☐	3.very seldom ☐

Psychological disorders (anxiety and depression) are determined through use of hospital anxiety and depression scale (HADS). This a 14-item Scale with each item having 1 to 7 items. Individuals are summed as follows: 0-7 is Normal, 8-10 is Borderline, and 11-21 is Abnormal.

HADS (Zigmond & Snaith 1983 & 1972) is a 14- item self-rating assessment tool that has two subscales with seven items each, measuring anxiety and depression separately.

Appendix F: Key Informants & Focus Group Discussion (Qualitative study)

Key Informants

Key Informants, in-depth interviews participants will be people interested in other peoples' welfare: such as retirees, those who served in administration positions in past, people respected in the society, women leaders and especially professionals such as counselors, nurses and social workers.

Questions for Key Informants:

Do you accept to freely participate in this study?	**Yes/No**

1. What is violence according to your understanding?
2. In your opinion, what is domestic violence?
3. a) Have you ever dealt with a case of Domestic Violence? If so, how did you handle it?

   b) From the community where you come from, what forms of Domestic Violence (DV) have you encountered in the past?
4. How would you describe DV experienced in your community?
   a. Who are likely to be victims of Domestic Violence?
   b. Who are likely to be perpetrators of Domestic Violence?
   c. When does it occur?
   d. How does it occur?
5. What triggers or causes domestic violence?
6. What are the behavioral patterns of perpetrators of domestic violence?
7. In your own opinion what influences the perpetrators behavior?
8. What are the behavioral patterns of women exposed to domestic violence?
9. In your own opinion, what influences the victim's behavior, or what are some of their values in life?
10. What are the occupational characteristics of those associated with DV?
11. What are the challenges in life experienced by people who have been exposed to DV?
12. What are the general implications of DV in your community?
13. What are the coping mechanisms for families experiencing DV?
14. What help is available to people who have suffered DV?
15. What if it does not work or help the persons?

a) **Focus Groups Discussions Guide (FGIDs In-depth Interviews)**

I am Josephine Muthami from the University of Nairobi. I am doing a research on domestic violence, and I request you to assist me with information to do the research. Please allow me to use a recorder so that I can get the information accurately. I assure you of confidentiality.

Consent: I accept to freely participate in this study **(Yes) (No)**

Group members of these FGDs will be those who have experienced the problems of DV but not psychologically challenged and will be recruited through community leaders. They will be grouped according to their age categories: 18 to 29, 30 to 39, and 40 to 49 years of age. Therefore there will be three groups formed around each of the selected study areas, and each group will comprise of 7 to 10 women.

Focus Groups Interview Guide

1.1 In your opinion, what is violence?

1.2 Have you ever experienced DV?

1.3 If so, when and by who?

1.4 How did this happen?

1.5 Who are more likely to trigger DV?

1.6 What issues are associated with DV?

1.7 How does DV manifest?

1.8 In your own opinion what influences the perpetrators' behaviors?

1.9 From the community where you come from, what forms of DV do you encounter?

1.10 What are the implications of DV?

1.11 What are the most likely occupations of people who are associated with DV?

1.12 What are the coping mechanisms for people exposed to DV?

1.13 What are the challenges experienced by people who have been exposed to DV?

1.14 What is the available support system for people exposed to DV?

1.15 If there is no available support in place, what else do you do?

Dear friends, we have come to the end of our discussion. I thank you very much for participating in this discussion.

Appendix G: Letters and Permits for the Research

1. Eligibility for PhD Admission (Provisional)
2. Full Admission to Postgraduate studies (Doctorate)
3. Letter of Self Introduction
4. Introduction Letter for Ms. Josephine Muthami by African Women Studies Centre - 2015
5. Introduction Letter for Ms. Josephine Muthami by African Women Studies Centre - 2016
6. Letter of Approval of the Research by Ethical Research Committee of Kenya from Kenyatta National Hospital and University of Nairobi
7. Research Authorization by Nairobi City County Health Services-Mbagathi Hospital
8. Research Authorization by Ministry of Education State Department of Basic Education
9. Research Authorization by National Commission for Science Technology and Innovation (NACOSTI)
10. Research Clearance Permit from NACOSTI
11. Letter of Acceptance of TF-CBT Research in Nairobi Women's Hospital – Gender Violence Recovery Centre (GVRC)
12. Letter of Field Work for Josephine Muthami- St. Mary Mission Hospital. Nairobi Kenya
13. Sample of the Informed Consent Form to be signed by participants (See Appendix B)