Indo- and Afro-Trinidadian women's experience of domestic violence, somatization disorder and help-seeking: A mixed methodological analysis

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Abstract

In Trinidad, negative attitudes towards mental health and unwillingness to access mental health care because of cultural restrictions and stigma deter some women with somatization disorder and experiences of domestic violence from seeking help (Hadeed & El Bassel, 2006; Kassiram & Maharajh, 2010; Maharajh, 2010). Several theoretical explanations for these interrelated issues are discussed in this thesis; grounded in considerations of the influence of culture and ethnicity. Somatization disorder appears to be more prevalent among Asian populations, and has a higher comorbidity with domestic violence within this ethnicity (Bhui, 2002; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002) with some even stating that somatization disorder may be a culture bound ailment (Kassiram & Maharajh, 2010; Schrag & Trimble, 2005; Samelius, Wijma, Wingren & Wijma, 2008). In many Asian cultures emotional distress is still stigmatized compared to medical problems, resulting in delayed help-seeking (Hardin, 2002). To date, no research has been conducted regarding the possible links between somatization disorder, domestic violence experiences and help-seeking in Trinidad. This thesis utilized a mixed methods approach to explore the occurrence of somatization disorder and domestic violence among Indo- and Afro-Trinidadian women and their help-seeking choices. Drawing on data gathered from a combination of questionnaires (250; 150 with women and 100 with religious leaders and medical doctors) and interviews (12 participants; employing an Interpretative Phenomenological Approach) the key findings were that Indo-Trinidadian women were three times more likely to have symptoms associated with somatization disorder if they had domestic violence experiences compared to Afro-Trinidadian women. Both Indo-and Afro-Trinidadian women appear to internalize their distress as a means of coping. The women also reported mixed opinions about assistance received from both religious leaders and medical doctors when they sought help for their somatic symptoms and domestic violence experiences. Finally, despite medical doctors being more knowledgeable and reporting that they possessed better resources for assessing and intervening for both somatization disorder and domestic violence compared to religious leaders, they were less inclined to explore these intersecting issues with women patients. These findings are congruent with international research: culture emerged as the crucial component for the manifestation, reporting, and assistance sought for both somatization disorder and domestic violence experiences specifically in Trinidad, West Indies.

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Dedicated to:

My Lord and Saviour
Jesus Christ

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Chapter 1

Rationale and Introduction

1:1 Thesis Statement

Previous authors have concluded that some women who experience domestic violence also tend to have somatization disorder (Brown, Schrag & Trimble, 2005; Hegarty, Gunn & Small, 2004; Holloway & Zerbe, 2000; McCauley, Kern & Kolodner, 1995; Samelius, Wijma, Wingren & Wijma, 2007 & 2008; Righter, 1999). Maharajh (2010) stated that in Trinidad, negative attitudes towards mental health, and unwillingness to access mental health care (which can be attributed to cultural restrictions and stigma), deter some women who experience domestic violence, which may result in somatization disorder, from seeking appropriate help. This thesis sought to report and compare experiences of domestic violence and somatization disorder (not necessarily linked), among Indo-and Afro-Trinidadian women. It also mapped the routes of help they sought from other persons, which includes professionals such as religious leaders and medical doctors, and their specific knowledge and intervention strategies for these women. The findings add to the existing literature and also increase knowledge about somatization disorder and domestic violence, their occurrences and the resources and the help-seeking options available for women experiencing these intersecting issues. This body of work may encourage greater collaboration among religious leaders and medical doctors with regard to assisting women who experience these challenges.

1:2 Rationale

International research suggests that some women who experience domestic violence also have somatization disorder (Brown, Schrag & Trimble, 2005; Hegarty et al., 2004; Holloway et al., 2000; McCauley, Kern & Kolodner, 1995; Samelius et al., 2007 & 2008; Righter, 1999). Additionally, some researchers have argued that somatization disorder appears to be more prevalent in Asian populations and cultures (Bhui, 2002; Chaturvedi & Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Sarason, 199; Saxena, Nepal & Mohan, 1988), and among women (DSM-IV-TR, 2000; Hauh, Mykletun & Dahl, 2004; Kroenke, 2001; So, 2008). However, these findings may be disputed, since other researchers (Smith, 2004; So, 2004) have reported that some Western societies do have well-established psychological programmes to

cater for women with somatic symptoms, which suggest that somatization disorder is occurring in these societies (So, 2008). Additionally, it has been suggested that because the diagnostic criterion for somatization disorder is skewed towards women, this may account for the lower rates of diagnosis among men (Hartung & Widiger, 1998). Nonetheless, these findings have also been echoed in two independent studies conducted in Trinidad and Tobago. Kassiram and Maharajh (2010)[1] and Maharaj et al., (2010), explored the occurrences of somatization disorder among women of East Indian descent who had experienced domestic violence, in comparison to Indo-Jamaican women and other ethnic groups in Trinidad. Both studies reported that Indo-Trinidadian women were more likely to have somatic symptoms and experiences of domestic violence. However, what these studies did not investigate was if somatization disorder was also present among Afro-Trinidadian women. Therefore, this thesis attempted to advance the literature by investigating these intersecting issues (somatization disorder, domestic violence and help-seeking) among Afro-Trinidadian women, in an attempt to draw comparisons between the two dominant racial groups in Trinidad. It is hoped that the findings will increase awareness of Afro-Trinidadian women's experiences of somatization disorder and domestic violence.

Clarke (2001) contends that domestic violence occurs irrespective of a person's ethnicity or social class. However, this can be debated, as some researchers of domestic violence against women assert that this type of research is usually conducted on women of the dominant racial group within that specific research community (Crowell & Burgess, 1996; Rankin, Saunders, & Williams, 2000). The findings may not therefore be a true representation of the number of domestic violence cases in various ethnic groups (Crowell & Burgess, 1996; Rankin, Saunders, & Williams, 2000). However, a multi-country study by the World Health Organization (Violence against Women, 2012) states that 15 to 71 percent of women between the ages of 15 and 49 years reported physical and/or sexual violence by their partners. Nevertheless, despite limited research with regard to ethnicity and domestic violence in Trinidad and Tobago (Hadeed & El Bassel, 2006) there is still a common perception in Trinidad that East Indian women experience more domestic violence than their counterparts belonging to other ethnic groups (Campbell, 1995; Hadeed & El-Bassel, 2006). But in a study by Rawlins (2000), this belief was not supported, as there were no major differences in domestic violence between the ethnicities.

[1] This research was conducted by the present researcher (Ms. Astra Kassiram)

Still, domestic violence is a problem in Trinidad and Tobago as can be seen from statistics published by the Central Statistical Office (CSO; 2007); The Trinidad and Tobago Police Service (Crime and Problem Analysis Branch (2011) and Ibero-American Youth Organization (2011; as cited in the Trinidad and Tobago Guardian newspaper, "Artists United to End Violence Against Women" 2011). These statistics show that domestic violence is a growing problem for the islands (Caribbean), with 1276 reported cases between January and July 2011. Thus, this thesis also seeks to report and compare domestic violence experiences among Indo- and Afro-Trinidadian women.

Since international literature and some research in Trinidad has suggested that the link between somatization disorder and domestic violence is more common among Asians, and, in Trinidad, among Indo-Trinidadians, this thesis further explores this assumption, but also considers the experiences of Afro-Trinidadian women, the other main ethnic group. This is in an attempt to investigate if somatization disorder and domestic violence may be culturally linked. The benefits that could be derived from this study are numerous, since the East Indian and African populations of Trinidad and Tobago consist of approximately 41 percent each, in other words, they comprise 82 percent of the population (Government of Trinidad & Tobago, 2008; Hadeed & El-Bassel, 2006). Thus, pursuing an inquiry with these two ethnic groups in Trinidad provides valuable information regarding somatization disorder and domestic violence among Indo- and Afro-Trinidadian women.

With both these intersecting issues (somatization disorder and domestic violence) the decision to seek assistance may be considered a complex one, since factors such as stigma and cultural restrictions may deter the women from seeking help (Gerbert et al., 2002; Sharpe & Carson, 2001). It has been stated by Hadeed and El Bassel (2006); Maharajh (2010); Maharaj et al., (2010) and Nagassar et al., (2010) that women who have experiences of domestic violence in Trinidad tend to turn to religious leaders, God or some sort of formal organization (medical organization) for support. Findings reported by Maharajh (2010) support that women in Trinidad may turn to spiritual sources for assistance. This could be as a result of negative attitudes from persons in the general public towards mental health care and unwillingness to access it, which creates problems for the mental health professional in Trinidad. Two-thirds of all patients

presenting themselves to a psychiatric clinic will interpret their symptoms as being caused by "spiritual wickedness from high places", "obeah[2], "spiritual lash[3]" or evil influences (Maharajh, 2010, p. 52). Thus, some sort of spiritual or religious influence remains today as the first contact for the majority of patients in Trinidad. Seeking assistance from spiritual sources may be attributed to physical ailments being considered less stigmatizing than psychological ones (Cheung, 1995; Hardin, 2002; Jabinsky, Satorius & Gulbinat, 1981; Kirmayer & Sartorius, 2007; So, 2008; Tseng, 2005). As a result of this, Maharajh (2010) and researchers from outside Trinidad (Kress, Eriksen, Rayle & Ford, 2005) have recommended that a paradigm shift of the population and church leaders is needed, with greater collaboration among these groups. Thus, examining the role of medical doctors and religious leaders in help-seeking in Trinidad is beneficial as it provides an in-depth examination into the resources to which these agencies have access regarding their intervention strategies and knowledge with women experiencing somatization disorder and domestic violence.

Therefore, this thesis also seeks to map the routes that were taken by the women and explore the impact these routes had on their outcome. A study investigating women who somatize distress, its links with domestic violence and the sources of help sought has never been conducted in Trinidad. Accordingly, findings from this thesis will greatly add to international and national (Trinidad) literature on these topics, which may also challenge these inter-disciplinary boundaries. It should be noted that for the purpose of this research only Trinidad will be included and not Tobago, for various reasons. First, the ethnic population of Tobago is not as diverse as Trinidad (CSO, 2007). As a result, this will not allow much comparison to be made between the ethnic groups, which are essential at this point, given that such limited research has been conducted in the Caribbean regarding these issues. Second and third, the timeframe and financial restrictions for this PhD meant that it was not possible to include both islands.

[2] A kind of witchcraft or sorcery in the Caribbean; a survival of African magic rites (Mendes, J. 2012, p.136).
[3] To harm one physically with necromancy (Mendes, J. 2012, p. 177).

1:3 Introduction

In order to further examine the above, Chapter Two (literature review) provides an in-depth review of somatization disorder and domestic violence, including some of the theoretical perspectives and their relevance to this thesis. This chapter also critically discusses international and Trinidadian research regarding these topics, in an attempt to illustrate the gaps in the literature and how this thesis will attempt to fill this missing literature. Specific research is presented on the role that culture and ethnicity has on the manifestation of somatization disorder and the reporting of domestic violence experiences. Detailed attention is paid to help-seeking for both somatization disorder and domestic violence, with specific consideration to the perspectives of religious leaders and medical doctors on intervening with and treating women with somatization disorder and domestic violence. Chapter Two also presents findings from international research, addressing the link between somatization disorder and domestic violence. By so doing, it highlights the ethnic and cultural composition of Trinidad and the necessity of researching this link in this specific country, thereby providing the basis on which this thesis is grounded. This chapter concludes with an overview of the research questions addressed.

Chapter Three (methodology) offers a synopsis of the methodology adopted for this research. The research utilised a mixed methods approach; there has been a long-standing debate on whether combining methods (qualitative and quantitative) can and should be employed (Esterberg, 2002; Johnson & Onwuegbuzie, 2004, Leeuw, 2005 Sale, Lohfeld & Brazil, 2002). Therefore, this chapter addresses this issue by critically presenting research citing the advantages and disadvantages of mixing methods. By so doing, the reasons for adopting this approach for this thesis are also highlighted. The various types of mixed methods are also discussed. Specifically, the utilization of sequential mixed methods as opposed to other methods is highlighted.

Chapter Four, (study one: occurrences of somatization disorder, domestic violence and help-seeking) through a mixed methods approach (questionnaire and open-ended questions) seeks to highlight the differences and similarities between Indo- and Afro-Trinidadian women with regard to the occurrence of somatization disorder and domestic violence, and to ascertain if there are any links between the two. This is accomplished by the application of various statistical

analyses and the findings gleaned from these. Thematic analysis is employed to assist in exploring the various help-seeking routes the women took when seeking assistance for their somatic symptoms and domestic violence experiences. As a result, this chapter also highlights the methodology adopted and the rationale for achieving the above. The participants, research design, sampling method, materials used, and procedure to collect and analyze data and ethical considerations are also critically discussed. This chapter attempts to present the data gathered in a manner that merges both qualitative and quantitative information, so as to give a broader picture about Indo- and Afro- Trinidadian women who somatize their distress, experience domestic violence and the help they sought for these issues. Finally, a brief discussion comparing international and local (Trinidad) research with regard to the findings of this study is presented.

The research findings presented in Chapter Five (study two; IPA analysis of help-seeking for Indo- and Afro-Trinidadian women) build on study one (chapter 4; occurrences of somatization disorder and domestic violence), as semi-structured interviews with women who fit the criteria for somatization disorder and domestic violence experiences were employed. As noted in the rationale, seeking help can be a complicated experience for some women with these challenges. Thus, the women's help-seeking choices for these interconnecting issues will be the focal point of discussion. For this to be accomplished an Interpretative Phenomenological Approach (IPA) was adopted; IPA (Smith, Flowers & Larkin, 2012) was used to examine how the women manage and make sense of these major life issues. This perspective provides insight into the women's own understanding about their experiences of living with and seeking help for both somatization disorder and domestic violence. The relevance of adopting an IPA perspective, as well as the women's experiences is further illustrated by the utilization of verbatim quotes throughout the 'findings' section. Similar to study one, this chapter also highlights the methodology adopted and the rationale for achieving this. The participants, research design, sampling method, materials used, and procedure to collect and analyze data, ethical considerations and reflexivity are also discussed. Finally, this chapter provides a discussion centering on the various techniques (for example, community programmes) to further expand the present help systems currently available in Trinidad, and to provide improved help to these and other women.

Study Three (Chapter 6: religious leaders' and medical doctors' intervention) builds on the findings of studies one and two (chapters 4; occurrences of somatization disorder and domestic violence and 5; IPA analysis of help-seeking). Similar to study one (chapter 4), this study employed a quantitative-driven perspective (questionnaires) which focuses on medical doctors' and religious leaders' knowledge, resources, willingness to explore and intervention strategies they employ when meeting with women who may have domestic violence experiences and/or somatization disorder. The questionnaire addresses these various issues, and the results reflect how these professionals treat women who experience somatic symptoms and domestic violence, and their understanding of these intersecting issues. Similar to chapters four and five, this chapter also highlights the methodology and rationale for achieving this. It highlights the rationale for adopting a quantitative approach (questionnaires), demographics of participants, materials, procedure, analysis and ethical considerations. This chapter concludes with a discussion section that critically compares the findings of previous research to the findings of this study in order to highlight the areas in which these results have added to the existing literature.

In order to link the findings of all three studies with previous literature on somatization disorder, domestic violence and help-seeking, Chapter Seven (discussion) provides a summary of the major findings, and a discussion centering on if this thesis addressed the proposed research questions. Chapter Seven also debates the limitations encountered and implications. This chapter concludes with sub-sections on recommendations for future research and conclusions.

This research adopted a mixed method approach. In order to increase the trustworthiness and integrity of this research, there was the need to evaluate how inter-subjective elements may have influenced the research process. For this reason, it was essential that the researcher reflect on various aspects of the research process and how she may have impacted on the procedure. Thus, this thesis concludes with a chapter (Chapter Eight) on reflexivity. This process is also integral to IPA research, and provides an in-depth insight into the researcher's experiences with data collection; the role the researcher played; how the researcher's own experiences (both professional and personal) may or may not have impacted on the research process and personal reflections.

1:4 Originality of Contribution

International and Regional (Caribbean):

This thesis seeks to add to the international literature that Asians (in this case Indo-Trinidad women) have a higher occurrence of somatization disorder than other ethnic groups (Bhui, 2002; Chaturvedi & Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Sarason, 1991; Saxena, Nepal & Mohan, 1988). This thesis also seeks to map the sources of help the women sought for their somatic symptoms and domestic violence experiences, and how they felt about the help received. This is something that has never been accomplished before in Trinidad, and seeks to increase our knowledge and understanding of Indo- and Afro-Trinidadian women who have experienced domestic violence, who somatize their distress and the sources of help they sought specifically, in Trinidad. Finally, it is hoped that this thesis will provide insight into religious leaders' and medical doctors' own understanding of somatic symptoms and domestic violence experiences, something which has also had been lacking up to this point. This thesis paves the way to further inform and educate the international and Caribbean community about somatization disorder, domestic violence and help-seeking.

Trinidad and Tobago

The Trinidad and Tobago Government is funding this study; therefore it is hoped that the results of this thesis will inform the relevant authorities about the experiences of women who have somatization disorder, have experienced domestic violence and the help they have sought. Recommendations to the Government of Trinidad and Tobago are presented with the hope that the necessary implementations to some of the nation's institutions such as Health Care, Social Services, and education are made to further help women who have somatization disorder and have experienced domestic violence.

Chapter 2
Literature Review

2:1 Introduction

This chapter provides a detailed critical review of the literature covering culture, somatization disorder, domestic violence and help-seeking; exploring international, regional (Caribbean) and national (Trinidad) research on these topics. The chapter focuses on somatization disorder and domestic violence, specifically identifying the potential influence of culture and ethnicity. The links between somatization disorder and domestic violence are considered alongside the wider literature on domestic violence in terms of international and Caribbean statistics. Theoretical frameworks and the role of ethnicity in the manifestation of somatic symptoms and women's experiences of domestic violence are also discussed.

This is followed by a brief history of Trinidad in order to explain the ethnic composition and cultural influences that the different ethnicities have in Trinidad. This provides the basis for examining the links between somatization disorder and domestic violence with regard to Trinidad. The chapter examines medical doctors' and religious leaders' role in assisting women who seek help from them for their somatic symptoms and domestic violence experiences and the effects that these experiences may have had on some women, with specific focus on resources, willingness to explore and intervention strategies employed when meeting with women with these intersecting issues.

2.2 What is Culture?

Since the investigation of somatization disorder, domestic violence and help-seeking among Indo- and Afro-Trinidadian women is grounded in culture, and since culture emerged as the crucial component for the manifestation, reporting, and assistance sought for these intersecting issues, specifically in Trinidad, it is important to explore what is culture and how it is defined in the research. Thus, the various ways in which culture is defined in the literature and the benefits in relation to this thesis are briefly discussed.

Defining culture can be a challenging task (Birukou, Blanzieri, Giorgini & Giunchiglia, 2013; Cohen, 2009; Kasturirangan, Krishnan & Rige, 2004) as various factors can influence how one views and responds to culture. In researching the conceptualization of culture, one will notice that there exist wide-ranging and very contradictory opinions regarding for which beliefs, norms and values should be included to represent what is culture (Kirmayer & Sartorius, 2007; Straub et al., 2002). Despite culture being studied for over one hundred years in disciplines such as psychology and cultural anthropology scholars still struggle to define this concept; thus, definitions range from simple to complex, and some even contradict each other (Straub et al., 2002).

The word culture, according to Kroeber (1949), comes from the English usage of nature, that is, from test tube cultures in 1871 and agriculture and pearl cultures. In 1871, Taylor *Primitive Culture* sought to define culture as "that complex whole which includes knowledge, beliefs, art, morals, laws, customs and any other capabilities and habits acquired by man as a member of society" (p.1). Prior to this Krober and Kluckhohn (1952) identified over 160 definitions of culture. The proposed definitions of culture in the 1950s assisted in establishing distinctions between definitions (Cohen, 2009; Straub et al., 2002). According to Straub et al. (2002) the definition of culture may be classified into three basis categories; first, 'definitions based on shared values', second, 'definitions based on problem solving' and, finally, 'general all-encompassing definitions' (p.14).

In order to explore culture based on shared values; first, one must seek to understand what a value is. As defined by Rokeach (1973),

> *"A value is an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse. A value system is an enduring organization of beliefs concerning preferable modes or conduct or end-states of existence along a continuum of relative importance" (p.5).*

Thus, it has been argued that values are acquired early in life through socialization agents such as the family or school. Thus, once the value is learnt it becomes an integral part of that person's life. However stable it is, it may still change according to changes in culture or personal

experiences (Straub et al., 2002). As a result, there are many definitions of culture that are based on values, for example, Kluckholn's (1951) definition points to specific reference to 'shared patterns of thinking based on values" (Straub et al. 2002, p.15). In essence, the defining of culture based on shared values suggest that culture is a manner of thinking that is shared by many persons within a specific society, and this manner of thinking is based on certain values held by the collective society. Thus, these values may influence how persons react and behave in difference situations, thus indicating that culture is the manifestation of that society's core values. Therefore, it may be argued that culture is actually learnt (Sewell, 2005). This argument is further highlighted through this thesis when explaining the expression of distress (for example, abuse) as somatic symptoms.

Some researchers have suggested that Asians tend to somatize their distress because this form of expression of illness is seen as more socially and culturally accepted (Cheung, 1995; Hardin, 2002) and physical illness is considered less stigmatizing than psychological illness (Cheung, 1995; Hardin, 2002; Jabinsky, Satorius & Gulbinat, 1981; Kirmayer & Sartorius, 2007; So, 2008; Tseng, 2005). Therefore, it may be argued that as a result of a siege mentality; that is a shared feeling of helplessness that these shared cultural values helps to encourage the expression of emotional distress as physical ailments. Thus, it may be further contended that Indo-Trinidadian women may somatize their domestic violence experiences because this is the more culturally accepted means; the shared cultural value that physical illness is not as 'bad' as a psychological illness.

Moreover, it may be further argued that cultural definitions based on problem-solving assume that culture is a form of 'traditional' problem-solving that has been met with success (Cheng, 2001; Na & Kitayama; 2011; Kirmayer & Sartorius, 2007; Sewell, 2005; Straub et al. 2002). That is, society views the manner in which the person decides to solve the problem as an acceptable and socially approved means, and as such, has adopted this method as a means of coping. As a result, throughout its history, this society has come to accept certain behaviours as a form of survival, and thus, after some time these behaviours are seen as a part of their cultural identity (Straub et al., 2002). Thus, according to some researchers (Bhui, 2002; Chaturvedi & Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Sarason, 1991; Saxena,

Nepal & Mohan, 1988; So, 2008), somatic illness is a manifestation of the woman not being able to adequately express her distressing situation in another manner because of the fear of stigmatization or repercussion of further abuse by a partner.

On the other hand, some researchers (Birukou et al. 2013; Cohen, 2009; Na & Kitayama, 2011; Sewell, 2005; Straub et al., 2002) have argued that some definitions of culture are more general and all-encompassing; these are the researchers who define culture in various ways other than through shared problem-solving and values. These definitions have the tendency to be more abstract, in some cases, even spiritual or obscure. For example, a historical definition by Sheldon (1951) defines culture as "a theoretical model, and the abstractions and principles from which it is made up are free creations of the mind" (p. 39).

Therefore, it may be further debated that while such definitions of culture adequately explain behaviour at a macro-level, it does not explain behaviour at an individual level (Kasturirangan, Krishnan & Riger, 2004; Straub et al., 2002). Thus, such macro definitions seek to define and explain culture from the perspective of religion, professional organizations or social groups, but do not recognize that individuals differ vastly in their own interpretation of events and self-identity. Thus, it may be argued that the cultural identity that one person holds may be different from the cultural identity that a specific society or nation holds. Consequently, despite various persons residing within the same or similar environment, it may be presumptuous to assume that they hold similar or same beliefs about certain events (Cohen, 2009).

Thus, Cohen (2009) and others (Cheng, 2001; Kirmayer & Sartorus, 2007) have argued that people from different geographical regions within countries will differ in their interpretation of events. As a result, different regions of countries will possess their own practices, values and norms, in some aspects such as, reputation and honour. Furthermore, the researchers (Cohen, 2009; Cheng, 2001; Kirmayer & Sartorus, 2007) have also argued that people usually represent culture in their minds such that, there is more variation 'with-in' culture than 'between-culture'.

For example, the statement that Indo- and Afro- Trinidadian women may have similar expression of illness because their shared culture, may be an erroneous one. As despite being brought up in

same society, the cultures within each smaller community, of which they may a part, may differ vastly. Thus, the expression of illness as a result of traumatizing events (for example, domestic violence) may be expressed differently from one community to another, even within Trinidad. Therefore, it would be beneficial to explore how Trinidadian women in certain administrative boundaries express their distress compared to others (this is discussed in Chapter Seven).

It has been further argued that psychologists practicing in all areas within the field should possess a deep understanding of culture, because then a greater understanding of the persons interacting will be obtained; accordingly, more objective comparisons and conclusions may be drawn. However, because there still is not much unification with regard to defining culture in the literature among the disciplines, for the purpose of this thesis, the notion that all cultures will contain similar meanings and ideas will be adopted here (Cohen, 2009; Kasturirangan, Krishnan & Riger, 2004). That is, there are some aspects of living that will be shared or learnt by a group of people (Birukou et al., 2013).

Now that culture has been defined and explained with regard to this thesis, somatization disorder will now be defined and explored.

2:3 Defining Somatization Disorder

Somatization disorder is defined in various ways in the medical and psychological literature (Creed & Barsky, 2004; DSM-IV-TR, 2002; Lesley, et al., 2006; Mai, 2004; So, 2008). Most of the definitions stem from a medical perspective, which is anticipated given that somatization disorder is classified as both a medical and psychological ailment. Somatization disorder is said to be culturally specific (Kassiram & Maharajh, 2010; Samelius, Wijma, Wingren & Wijma, 2008; Schrag & Trimble, 2005). Therefore, adopting one specific definition for somatization disorder can be challenging, as each culture may attach different meanings to the manifestation of psychological distress. Still, the desire to ‘diagnose’ mental illness, for example, somatization disorder has led to the formulation of ‘diagnostic criteria’ which do not take into consideration the underlying cause(s) of the somatic symptoms. For example, the Diagnostic and Statistical Manual (DSM-IV-TR; 2002) and ICD-10 which are the two mostly widely used diagnostic manuals internationally, have both sought to define somatization disorder. However, these

definitions and the diagnostic criteria specified in these manuals can be problematic because of a lack of cultural sensitivity (First, 2009; Kress, Eriksen, Rayle & Ford, 2005; Walsh, 2007). It is noted that definitions specified in both the DSM-IV-TR and ICD-10 are somewhat similar. For example, the ICD-10 requires "a total of six or more symptoms" (p.127) and the DSM-IV-TR specifies eight symptoms be present (DSM-IV-TR, 2002) for a diagnosis to be made.

Furthermore, the more recently introduced DSM 5 has received much criticism regarding validity, reliability and its role in the medicalization of society (Frances & Nardo, 2013; Khoury, Langer & Pagnini, 2014; Lacasse, 2013; Pickergill, 2013). Additionally, it has been argued that the DSM-5 provides little clarity regarding its definition of what is considered 'normal' (Lacassee, 2014, p.6; Möller et al., 2014). This is further discussed in section 2.4, Somatization Disorder and Prevalence. However, according to First (2009) there is still a need for the harmonization of both diagnostic manuals as the self-esteem and social needs of those who are diagnosed and their families need to be taken into consideration.

Despite numerous criticisms regarding its lack of cultural sensitivity, the DSM is one of the most widely used diagnostic tools in Western societies, (Kress, Eriksen, Rayle & Ford, 2005) including, in Trinidad. Most training as a clinical psychologist involves studying and diagnosing clients based on the specified criteria in this manual. Even so, some researchers (Lonner & Ibrahim, 2002) state that the DSM tends to encourage clinicians to underdiagnose, misdiagnose or over diagnose women within different cultures. The definition of somatization disorder provided by the DSM-IV-TR (2002) states: Somatization is a mental disorder that presents with multiple somatic symptoms and is seen mostly in women by age 30. The multiple somatic complaints cannot be otherwise explained by a general medical condition or substance use. It is characterized by a combination of pain, gastrointestinal, sexual and pseudo neurological symptoms. The symptoms must cause clinically significant distress or impairment in social, occupational, or other areas of functioning (DSM-IV-TR, 2002).

This definition does not specifically address what stressors may contribute to the woman expressing her distress in somatic form. In the general readings provided in the DSM, it does

state that women with somatization disorder may be impulsive, exhibit antisocial behaviours, have a history of suicide attempts, and marital discord (DSM-IV-TR, 2002). But nowhere does the manual attempt to prompt clinicians to enquire as to what underlying life stressors these women might be experiencing.

Historically, individuals who were regarded as not conforming to mainstream culture were often hospitalized, or not accepted in their communities (Kress, Eriksen, Rayle & Ford, 2005). However, underlying the marginalization of persons who do not conform to conventional societal norms is the issue of whom and what defines normal versus abnormal behaviours. Somatization disorder has the term 'disorder' attached to it. Kress et al., (2005) state that at the core of the word 'disorder' are judgments regarding what and who defines abnormal behaviour. Judgments regarding what constitutes abnormal behaviour are rooted in what society deems as improper and proper behaviour and what ones ideal life should be (Marecek, 1993). Thus, usually it is mental health professionals who make decisions and judgments concerning what behaviours are 'normal' and those that are not. The problems that arise when this occurs are that these professionals are usually evaluating persons based on a predetermined set of standards and may not take into consideration the impact that culture may have on the manifestation of various symptoms (Pedersen, 2000).

The failures of mental health professionals in acknowledging the impact culture may have on psychological complaints, specifically somatization disorder, becomes more apparent at a macrolevel, such as discrimination, racism or patriarchy which may affect the individual's daily functioning. As a result, many definitions of somatization disorder focus on the woman's illness being rooted in the individual themselves and does not take into consideration other factors such as emotional distress stemming from for example, an abusive situation. Thus, by focusing primarily on symptoms rather than possible causes, for example, life stressors, almost eliminates or makes such other contributory factors invisible (Kress, Eriksen, Rayle & Ford, 2005). For example, Creed and Barsky (2004) state "the main feature of somatization disorder is recurrent and frequently changing physical symptoms, which cannot be explained by any known medical condition" (2004, p.391). Here, the main focus on defining somatization disorder is placed on the symptoms. As noted, this can hinder women from receiving a complete assessment of their problem and the major factor(s) contributing to their somatic symptoms are overlooked. Thus,

adopting such a definition may unconsciously encourage health and mental health professionals to conceptualize the symptoms solely from an intra-individual standpoint rather than from one that takes into account cultural practices and the context of women's lives (Kress, Eriksen, Rayle & Ford, 2005)

Some researchers have gone so far as to question whether the DSM and ICD manuals are based on science (Kress, Eriksen, Rayle & Ford, 2005). As far back as 1997, Kutchins and Kirk asserted that the development of the diagnostic criteria utilized by these diagnostic manuals has been overloaded with political agendas regarding what disorders and criteria should be included. Additionally, historically, research into cultural issues has been politically complex. For example, classifying persons solely based on racial or mental characteristics in the 1900s was viewed as promoting racial superiority. However, cross-cultural studies have shown that culture does influence the manifestation, duration, and prognosis of mental illness. For example, it is reported that culture influences how the individual perceives their reality (Kress, Eriksen, Rayle & Ford, 2005; Lehman, Chiu & Schaller, 2004). That is, what meaning is attached to their symptoms, how the symptoms are perceived, how persons in that culture express their illness, and how the community might respond to the person's symptoms. There are no cultures that do not attach meaning to one's ailments, intelligence or abilities (Kress, Eriksen, Rayle & Ford, 2005). Thus, Velasquez, Johnson and Brown-Cheatham (1993) asserted that the diagnosis of minority groups is vulnerable to human error. The major diagnostic tools used in Trinidad for somatization disorder were formulated in either the United States of America or in the United Kingdom. Hence, these countries may not have taken into consideration that Indo- and Afro-Trinidadian women experiencing distress may manifest these stressors as physical symptoms differently from persons residing in another country.

So (2008) defines somatization disorder as "the process by which psychological distress is expressed as physical symptoms that have no known organic base" (2008, p. 167). This definition does not probe what extenuating circumstances may have contributed to the somatic symptoms. Indo-and Afro-Trinidadian women, because of stigma and cultural restrictions may consciously or unconsciously manifest their experiences of domestic violence as bodily complaints in an effort to 'hide' their stressful situations. A health professional who follows the definitions and diagnostic criteria outlined in the manuals may not enquire about the underlying

cause(s) of the symptoms, but instead may treat the symptoms and send the woman back into the distressing situation. Therefore, more comprehensive definitions and diagnostic criteria are needed for somatization disorder. Additionally, clinicians should be encouraged to ask questions about domestic violence when women present with otherwise unaccountable somatic symptoms.

Mai (2004) states that: "in general terms, somatization refers to the condition wherein mental states and experiences are expressed as bodily symptoms" (2004, p. 653). While this definition provides a basic general description of what somatization disorder is, it does not offer any insight into what 'mental states' are, nor does it provide knowledge about in what manner these mental states are expressed or the possible underlying cause(s) of the somatic symptoms. This may lead to the misdiagnosis of somatization disorder, when in actuality it may be the life stressors that are the source of the symptoms, so if the stressful situation is remedied the somatic symptoms may also cease.

There have been many efforts to reduce or eliminate the issues of misdiagnosis and of clinicians overlooking the underlying causes, or potential sources of clients' psychological distress and/or somatic symptoms. However, working with culturally diverse groups still presents with numerous challenges. Thus, it has been suggested that health professionals' critically examine definitions and criteria for somatization disorder and seek to identify the flaws that can be considered oppressive and unethical to persons from diverse cultural backgrounds (Kress, Eriksen, Rayle & Ford, 2005). Additionally, each culture is dissimilar and will attach different meanings to their experiences and symptoms. As a result, health professionals should seek to not categorize everyone into one definition or use the same criteria without thoroughly exploring the individual's own meaning attached to their symptoms, which may also be serving as an adaptive coping strategy (Kress, Eriksen, Rayle & Ford, 2005).

Lonner and Ibrahim (2002) have suggested that these professionals assess clients' worldviews in order to gain a comprehensive understanding of what may be contributing to their symptoms instead of simply categorizing them according to diagnostic manual criteria. In so doing, health professionals are also acknowledging the client's sense of self as also being culturally constructed. That is, although two persons may share the same worldview their cultural identities may differ vastly. For example, allocating women into Indo- and Afro-Trinidadian categories can

be problematic in terms of identifying somatic symptoms because Indo-Trinidadian women may be expressing their symptoms as a result of not having social support, whereas Afro-Trinidadian women may express their distress as somatic symptoms because this is a more culturally approved expression of distress and may not be as stigmatized as the act of disclosing domestic violence. Thus, identity models may assist with these issues as they help in understanding the role that culture may have on the woman's expression of distress (Kress, Eriksen, Rayle & Ford, 2005).

If health professionals only seek to treat the woman's symptoms and not the cause of these the prognosis is likely to be poor. In adopting a definition for somatization disorder, the issue of culture needs to be at the forefront. There needs to be an understanding of the woman's beliefs about the 'causes' of their symptoms. As a result, the woman's social environment, worldviews and life and family circumstances all need to be taken into consideration, in addition to her cultural background. There will always be a struggle to define somatization disorder for various reasons, for example, who should be the ones defining what behaviour should be considered 'normal'. Thus, no one true definition can be applied to all cultures or situations (Kress, Eriksen, Rayle & Ford, 2005; Muehlenhard & Kimes, 1999).

2:4 Somatization Disorder: Prevalence

Somatization disorder, historically referred to as "Briquet's syndrome or hysteria" (Baron, 1998; DSM-IV-TR, 2002; Kerry, 2002; Mai, 2004) presents with physical symptoms which would suggest a medical condition, but cannot be fully explained by the effects of substance use or a general medical condition (DSM-IV-TR, 2002). Somatization disorder is predominately seen in women, with symptoms generally improving only after the age of forty. According to the DSM-IV-TR (2002), the criteria for diagnosis are usually met before the age of 30, but symptoms can present in adolescence. Somatization tends to have a long chronic development and causes the person to seek treatment for its impact upon occupational, social, or other important areas of life (Baron, 1998; DSM-IV-TR, 2002; Kerry, 2002; Mai, 2004).

Despite the detailed criteria used for the diagnosis of somatization disorder by the DSM-IV-TR (2002), the DSM's criteria have been criticized. In 1998 Hartung and Widiger argued that one of the major concerns for the then DSM-III was to provide a more "user-friendly" and "simpler"

criteria because the existing diagnostic criteria were "too cumbersome for general use" (p.270). Therefore, based on the analysis of a sample of 1,116 women from five varied clinical settings, the number of diagnostic symptoms required for the diagnosis of somatization disorder was reduced from 59 to 37 for the publication of the DSM-III-R, making it 'easier' for women to meet these diagnostic criteria (Hartung & Widiger, 1998).

In a more recent review of the diagnostic criteria for somatization disorder (provided by the DSM-IV), So (2008) stated that in order for the diagnosis to be made there needs to be the presence of 14 symptoms for women and 12 for men. For example, body aches, shortness of breath and memory loss (among others), and any organic cause must be ruled out. So (2008) described this diagnostic criterion as "stringent" and contributed to the low prevalence rates of somatization disorder where less than 1% met the criteria for somatization disorder. As opposed to more persons being diagnosed with undifferentiated somatoform disorder for less restrictive criteria (79% met the less restrictive criteria for somatization disorder, Creed, 2006).

In the United Kingdom, Burton (2003) searched Cinahl and PsycINFO databases from 1980 to 2001 for any of the following terms: 'somatoform disorders', 'somatization', 'medically unexplained symptoms', combined with any of these terms: 'general practice', 'primary health care' and 'family practice'. A total of 1072 cases were reviewed and Burton (2003) reported that 15 percent of the reasons for medical consultations by primary care consultants were for physical symptoms without likely organic disease. Prevalence rates for somatization disorder in the United States of America range from 0.2 to 2 percent among women, and less than 0.2 percent in men (DSM-IV-TR, 2002). But according to the DSM-IV-TR (2002) these rates may depend on whether the individual screening for the disorder is a physician or not, and the method of assessment used; when non-physician interviewees conducted diagnostic assessments of somatization disorder, the diagnosis of somatization disorder was much less frequent (DSM-IV-TR, 2002). The reason for the discrepancy between genders is not totally clear, despite several suggestions, for example, that women are more likely to seek medical attention than men (Kroenke, 2001). Also, since somatization disorder has a comorbidity with anxiety and depression, the women's main reason for seeking help is not usually for the intensity of the

symptoms, but for the anxiety and worry about the symptoms (DSM-IV-TR, 2002; Hauh et al., 2004).

Other factors that may contribute to women having a higher prevalence of somatization disorder include: having a history of sexual or physical abuse, cultural factors permitting greater expressiveness in women, lower threshold for seeking help, and gender differences in social roles and responsibilities (DSM-IV-TR, 2002; Hauh et al., 2004). So (2008) also states that the gender differences in somatization disorder are significant, and proposes that this can be as a result of women being more aware of their bodily functions and sensations, and as a result, displaying different help-seeking behaviours than men. Additionally, men may be less likely to complain about their physical symptoms than women, because of the way in which masculinity is constructed in Western cultures (So, 2008).

DSM-IV-TR (2002) states that in some Asian cultures, more women are diagnosed with somatization disorder since it may be more acceptable for them to voice their distress, because of less restrictive cultural practices compared to some Western cultures, therefore, it may be argued that they have learnt the acquired responses that society accepts. But as far back as 1998, Hartung and Widiger suggested that differences in somatization rates could be a result of improper diagnostic criteria used by the DSM. They reported that the "gender-specific criteria" used by the then DSM-III may have inhibited, if not prevented, somatization disorder from being recognized in men. Because the then criteria included symptoms mostly associated with the female manifestation of the disorder (for example, irregular menstrual cycle) and the inclusion of erectile or ejaculatory dysfunction for males was not based on any scientific findings, and "the criteria for men were based on work with women" (1998, p. 270), the diagnosis of somatization disorder was confined to females (Hartung & Widiger, 1998). Thus, it appears that more females present with somatization disorder than men but "clinically, male and female patients with somatization disorder show(ed) more similarities than differences" (Golding et al., 1999, p. 234 cited in Hartung & Widiger, 1998).

Even more recently, the DSM-5 was introduced. The replacement of the DSM-IV-TR by the DSM-5 is the first extensive revision since the introduction of the DSM-IV-TR in 1994 (Lacasse,

2013). The DSM-5 was developed "to better fill the need of clinicians, patients and researchers for a clear and concise description of each mental disorder" (American Psychiatric Association, 2013, p. 5). The DSM-5 Task Force committee tried to ensure that cultural factors be included in this edition. As a result, though not for all disorders, much of the text includes references to age, gender and cultural factors that may contribute to the disorder. This according to some authors, for example, Regier, Kuhl and Kupfer (2013) is a vast improvement from the DSM-IV (Regier et al., 2013). However, the DSM-5 also received much criticism, specifically with regards to its validity, reliability and its role in the medicalization of society (Frances & Nardo, 2013; Khoury, Langer & Pagnini, 2014; Lacasse, 2013; Pickergill, 2013) and its symptom-oriented, descriptive and traditional approach to mental disorders (Möller et al., 2014). Furthermore, it has also been argued that the APA's development of the DSM-5 is fueled by the pharmaceutical industry. That is, it has been debated whether or not an organization with such close ties to the pharmaceutical industry should be trusted with the task of formulating a diagnostic manual of such importance (Cosgrave & Krimsky, 2012; Greenberg, 2102). Then the interest would not be on helping, but rather on the diagnosis of mental disorders in order to sell medications, which puts into question reliability and validity issues (Lacasse, 2013; Pickergill, 2013) and further supports the medicalization of society (Pickersgill, 2013).

These criticisms have mostly originated within the United Kingdom and The United States of America, and critics (Frances & Nardo, 2013; Khoury, Langer & Pagnini, 2014; Lacasse, 2013; Pickergill, 2013) have argued that the DSM-5 tries to place and understand psychological and bodily mechanisms solely from a medical framework, thereby, the medicalization of persons (Pickersgill, 2013). Thus, Allen Frances (the chair of the DSM-IV Task Force) states that the DSM-5 would only serve to 'medicalise society', in which there would be grave consequences (discussed below; Pickersgill, 2013). Additionally, the DSM-5 is said to provide little clarity regarding its definition of what is considered 'normal' and not, as the categories are vague, thus, providing the basis for the argument that the DSM-5 is a "medicalized dictionary" (Lacassee, 2014, p.6), that only serves to provide criteria for diagnoses to be made without actually stating what is a mental disorder.

As a result, alongside these arguments, it has also been proposed that the validity and reliability of the DMS-5 can also be questioned (Möller et al., 2014; Pickersgill, 2013), that is, how and where diagnoses are made and how they aid in the inclusion and exclusion of persons accessing certain benefits and services. Moreover, Lacassee (2014) has also argued that the DSM-5 contributes to the formation of mental disorders despite there being evidence to show otherwise, that the person may not have a mental illness, but may be experiencing psychological distress (Wong, 2014). Thus, while it has been argued that the DSM-IV was mostly concerned with 'false-positive' diagnoses, the DSM-5 has been so expanded that it medicalized more human challenges (Lacassee, 2014).

Moreover, both the DSM-IV and the DSM-IV-TR have included sections regarding the limitations of the categorical approach, which provide the practitioner with information concerning the weaknesses of this approach; the current DSM-5 omits this. The exact reason(s) for this omission is unclear. However, it is worth noting as it limits the clinician's knowledge about the effects of psychiatric treatment (Lacasse, 2014). Additionally, when the publication deadline of the DSM-5 was missed, quality control was cancelled and the DSM-5 was prematurely introduced, thus, contributing to various issues with reliability and validity (Frances & Nardo, 2013).

The DSM-III has stated that there was a high interrater-reliability for this edition. However, analysis has found problems with this claim (Kirk & Kutchins, 1992), as the high interrater-reliability was based more on biased interpretation of the data and poor research design than on the reliability of the DSM (Kirk et al., 2013). Therefore, the DSM-5 sought to rectify this, but the present research design contained biases. For example, the researchers pre-screened participants prior to the field trials at sites that had a high prevalence rates for the disorders that were being studied. Thus, the DSM-5 field trail may be said to have demonstrated that the current categories are unreliable (Kirt, Gomory & Cohen, 2013; Frances & Nardo, 2013; Kraemer, Kupfer, Clarke, Narrow & Regier, 2012; Lacasse, 2015; Möller et al., 2014; Regier et al., 2013). A lack of reliability can affect the defining of the client's problems, thereby leading to improper diagnosis,

inappropriate treatment, and thus, poor prognosis (Lacasse, 2014). As a result, because of this, validity may be challenging to prove (Möller et al., 2014[4]).

Thus, the implications of such are numerous, as these errors may lead to the increase of 'pathologizing previously considered normal' persons, thus making society appear to be almost saturated with mental illness (Frances, 2013). Additionally, since each culture differs from each other in what is defined as 'normal', the further implications of categorizing mental illness based on a pre-determined set of criteria lead once again to (as discussed earlier) the medicalization of society, and thus the over diagnosis of mental illness within particular cultures (Khoury et al., 2014). Furthermore, these issues may create major differences in the diagnosis of patients, which, in turn, contribute to confusion among clinicians, patients and diagnostic consistencies in research (Möllen et al., 2014).

Despite these negative reviews of the diagnostic criteria employed by the DSM for somatization disorder, it is still considered one of the major diagnostic manuals available, and seen as a "necessity for professional practice" (Kress, Eriksen, Rayle & Ford, 2005, p. 98). In North America, despite criticisms, it is one of the "clearest and most thorough diagnostic systems", and "an enduring system that is not about to be replaced" (Kress et al., 2005, p. 98). In the Caribbean, specifically Trinidad, the DSM-IV-TR remains one of the most used manuals, for example, clinical psychology programmes in Jamaica and Trinidad (The University of the West Indies, Mona and St. Augustine) center their teaching of mental disorders solely on this manual. However, it may also be noted that when the DSM is used alternative perspectives should also be considered, such as, the individual's social, political, cultural and environmental dimensions. Moreover, clinicians should also be mindful of reinforcing the person's strengths and resilience instead of only highlighting their weaknesses (Khoury et al., 2013). Since this thesis is grounded on a sample of Trinidadian women, the information presented in the DSM-IV-TR (2002) will be adopted as it may be seen as the most relevant to that culture.

[4] The DSM-5 was compared with the DSM-IV and the DSM-IV-TR to order to identify any important changes to psychiatric diagnosis. Additionally a PubMed search for papers in the past 20 years was conducted with the aim of identifying diagnostic criteria and general classification of mental disorders.

Summary

From the literature presented above somatization disorder is viewed as a chronic illness that mostly appears in women by the age of 30 years (DSM-IV-TR, 2000). It has been suggested that women present more often with symptoms of somatization disorder because they are more likely to seek medical attention, not necessarily for the physical complaint but for the anxiety and depression that accompany the physical symptoms (DSM-IV-TR, 2002; Hauh et al., 2004). Additionally, women are more attuned to their bodily functions (DSM-IV-TR, 2002; Hardin, 2002; Mai, 2004; So, 2008), and it is more culturally accepted for women to express their physical symptoms, hence more women are diagnosed as having somatization disorder (So, 2008). As mentioned, this thesis will explore the experiences of both Indo-and Afro-Trinidadian women in an effort to further add to the already established literature on somatization disorder by investigating the extent to which there may be a cultural link between somatization disorder and ethnicity.

2:5 Aetiology of Somatization Disorder

According to Mai (2004), there is still no single cause of somatization disorder; the disorder seems to have its origins in the interplay of genetic factors and various events in the individuals' life. So (2008) argues that the determination to find a biological cause for somatization disorder has been at the expense of cultural and social models. This section therefore seeks to provide a brief critical discussion regarding the origins of somatization disorder, followed by an in-depth exploration of somatization disorder being possibly culturally influenced. Mai (2004) states that current theories of the causes of somatization disorder can be grouped into three categories: genetics, organic and psychosocial. A fourth category, psychological, will also be explored, as this will assist in providing a wider understanding about the possible causes.

Genetic and Organic

During the 19th century Briquet found that cases of hysteria tended to occur where there was a strong tendency for family clustering (Briquet, 1859). Additionally, according to the DSM-IV-TR (2002), somatization disorder has also been reported in ten to twenty percent of women who have first degree biological relatives with somatization disorder. But the tendency for an individual to develop somatization disorder as a result of genetic factors has been refuted by Mai

(2002) and to some extent by the DSM-IV-TR (2002). According to Mai (2002) in a study sampling 859 women who were adopted by nonrelatives at an early age somatized more than the non-adoptive control group. Adoption studies have also indicated that not only genetic factors contribute to the risk of somatization disorder, but also environmental factors; suggesting that regardless if one has a biological or adoptive parent with somatization disorder, there is an increased risk of also developing somatization disorder (DSM-IV-TR, 2002). It can therefore be concluded that even though genetic factors seem to play a role in somatization disorder, the effects are limited as environmental factors also influence the development of somatic symptoms (Mai, 2002).

Niemi, Portin, Aalto, Hakala and Karlsson (2002) conducted a study consisting of ten female patients with somatization disorder or undifferentiated somatoform disorder and 10 non-somatizing controls who participated in neuropsychological examinations. The researchers reported that patients with somatization disorder were more inclined to present with deficiencies on neuropsychological testing compared with a control group. Kristal-Boneh et al., (1998)[5] and Reif, Shaw and Fichter (1998)[6] reported a link between somatization disorder and elevated 24-hour cortisol levels and an association between systolic blood pressure and somatization disorder. Cortisol is also an index of stress levels (Elzinga, Schmahl, Vermetten, van Dyke & Bremner, 2003). Thus, life stressors may also be implicated; however these researchers did not explore this possibility. These studies therefore suggest a non-specific association between organic disease (in particular cerebral) and somatization disorder. Another possible cause of somatization disorder is that neuropeptides, (chemicals that are active both in the brain's emotional centers and in organs in the body) orchestrate the connections between emotional distress and its expression in physical complaints, thereby making the person more susceptible to somatization disorder (Goleman & Gurin, 1993). But again, even though these studies argue for an organic origin of somatization disorder, they fall short of providing a precise explanation.

[5] Twenty-four-hour ambulatory systolic and diastolic blood pressure was monitored in 114 healthy normotensive participants, aged 28 to 63 years, engaged in similar physical work. The participants were interviewed about somatic complaints, demographic data, and health habits, and body mass index was measured.

[6] The researchers compared 58 patients with somatization syndrome and 21 healthy controls employing physiological measures, cortisol levels, and subjective well-being during rest and during a mental stress task as well as selective attention and memory for illness-related words.

Despite the arguments that somatization disorder may have a genetic or organic origin; there are many researchers who refute these assumptions and contend that somatization disorder is actually grounded in psychological or psychosocial experiences.

Psychosocial and Psychological

While some researchers (e.g. Burton, 2003) argue that psychological issues are important contributors in the presentation of somatization disorder, the ability to distinguish these from physical or psychiatric ailment remains challenging. Burton's (2003) research has suggested that somatization disorder was as a result of flawed processing or latent learning, where the woman was unable to recognize that she had a problem and this then led to her ongoing psychological distress (Burton, 2003). However, Brown, Scrag and Tremble (2005) suggest that somatization disorder may be linked to childhood abuse that is, that the traumatic abuse was mentally blocked out or repressed. As a result, later in life, the somatic symptoms may be prompted by these childhood activating events (Brown et al., 2005).

Conversely, De Gucht and Maes (2006) emphasized that the development of somatic symptoms may not be associated with childhood trauma but it is usually learnt behavioural responses acquired through social reinforcement and modeling. Thus, social learning theory can offer an explanation about the ways in which the family can contribute to the tendency to develop somatization disorder (De Gucht & Maes, 2006). Social learning theory (Bandura, 1977) assumes that behaviour is learnt from various experiences; therefore, behaviours that are rewarded are reinforced and continued, and those that are not rewarded are stopped. Somatization disorder can therefore be viewed as a maladaptive way in which the individual obtains social needs (Mai, 2004). Therefore, it may be contended that the child observes the sick parent or sibling and thus, by accommodating these behaviours into their schemas, may learn the illness behaviour, and particularly if the symptoms are chronic or severe, may also, when older, contribute to the development of somatization disorder. It has been further suggested that when parents fail to attune and respond to the child's needs this makes the child unable to distinguish between internal states, for example, differentiating anger from sadness. Thus, later in life this inability will interfere with social connections; physical symptoms will now become their means of reaching out for attention (Goleman et al., 1993).

Kassiram and Maharajh (2010) reported that from their study employing a questionnaire with a sample of 100 Indo-Trinidadian women that 41.9 percent of Indo-Trinidadian women with a female relative who had somatic symptoms reported high somatization scores as compared to 21.9 percent of Indo-Trinidadian women with no female relative with somatic symptoms. Thus, this leads to the conclusion that within the Indo-Trinidadian community somatic symptoms may also be learnt from a female relative. However, arguments have been put forward that in some cases the parents may unknowingly reward the child for displaying or having such symptoms, for example, allowing the child to stay at home because he/she is "sick". In either case, physical symptoms are likely to be an expression of deep emotional needs (Goleman et al.,1993). On the contrary, Mai (2004) argues that the aetiology of somatization disorder stems from the concept of "alexithymia" (2004, p.656). Literally, this means "no words for feelings" (2004, p.656). Mai (2004) states that the woman may somatize because she is not able to express her distress in words because of cultural restrictions, therefore it is conveyed as bodily symptoms. Thus, one of the possible reasons why women who experience domestic violence may somatize is because they may not know how to express their distress in any other manner (Mai, 2004).

Despite the arguments that somatization disorder is learnt; Freud's psychological theory states that somatization disorder is not learnt but originates when the individual experiences inner struggles; that is, the id and the superego are in conflict with the ego defense mechanism and this causes the individual to unconsciously convert their psychic energy into physical symptoms (Kerry, 2002). Freud further suggested that persons experiencing unacceptable conflicts will convert these conflicts into various symptoms. When individuals do this, they reduce the anticipatory anxiety generated by the conflicts, and, at the same time, secondary gain is received as much sympathy and attention may be given to them. Even though this point of view could be disputed, it does seem accurate in one respect: individuals suffering from somatoform disorders do benefit from these disorders in terms of eliciting sympathy from important people in their lives, who may be a spouse or parent (Baron, 1998). It has been further suggested (Kassiram & Maharajh, 2010; Maharajh & Ali, 2004) that middle age Indo-Trinidadian women sometimes feel neglected by their significant other and thus present their distress in the form of physical symptoms (this is discussed in the next section). Since the women feel a sense of neglect, they in turn may be trying to obtain some attention by expressing physical ailments, thus gaining

attention from their significant others (Baron, 1998). However, according to Mai (2004) there have been no empirical studies on large samples to confirm these suggestions.

Summary

From the above literature it can be seen that there are various theories about the aetiology of somatization disorder, but none seems to be conclusive about its exact cause or origin. Some researchers suggest a more organic/genetic basis (DSM-IV-TR, 2002: Kristal-Boneh et al.,1998; Mai, 2002; Nicmi, Portin & Hakala, 2002; Reif, Shaw & Fichter, 1998), while others have taken a more psychological/psychosocial perspective (Affleck et al., 2001; De Gucht & Maes 2006; Kerry, 2002 & Levi et al., 2001). This thesis, with the inclusion of both Indo- and Afro-Trinidadian women, will seek to establish if somatization disorder may have a cultural and ethnic element to its presence, manifestation and occurrence by investigating the experiences of women of both ethnicities.

2:6 Somatization Disorder: Culture and Ethnicity

It should be noted that somatization disorder, even though it appears to be culturally specific that is, more prevalent in Eastern cultures; (Bhui, 2002; Chaturvedi & Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Sarason, 1991; Saxena, Nepal & Mohan, 1988), may not be so. In some Western cultures there are already well-established psychological treatments for mental illness which include somatization disorder (So, 2008). Thus, despite somatization disorder being viewed as more prevalent in Eastern cultures, the Western world still structures some of their mental health programmes to cater to the needs of women with somatic symptoms. Nevertheless, Western psychiatry continues to view women with somatization disorder as engaging in dysfunctional coping behaviours and that is psychosomatic in nature (So, 2008). This assumption may be the result of stigmatization by the general public (Hardin, 2002), which only serves to place labels on the individuals (So, 2008). However, some international research has indicated that somatization disorder varies across cultures and may be culturally specific (Bhui, 2002; Chaturvedi & Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Sarason, 1991; Saxena, Nepal & Mohan, 1988). It has been suggested that Asian-Americans somatize instead of "psychologize," (Hardin, 2002 p. 55) or that they tend to express psychological symptoms less than European Americans (Chaturvedi & Venugopal, 1994;

Hardin, 2002). Therefore, it may be further debated that this abreaction then forces the problem into their everyday awareness thus, pushes them to seek out ways of resolving the distress being experienced. However, some studies (e.g. Kingery, Ginsburg & Alfano, 2007; Miranda, Saddique, Belin & Kohn-Wood, 2005; Nadeem, Lang & Miranda, 2008) have shown that African-American women also tend to somatize their distress more than their White-American counterparts.

This may be as a result of medical problems being thought of as less stigmatizing than psychological problems and expression of an individual's overt feelings is seen as socially undesirable, as it is considered an admission of weakness. Thus, Asian-Americans will manifest physical symptoms to avoid shame and maintain family honour, because somatic complaints do not have the same social consequences as psychological complaints (Chaturvedi & Venugopal, 1994; Hardin, 2002; Sarason, 1991). Conversely, some researchers have reported that African-American women, Africans in Nigeria and Caribbean immigrants to the U.K. have a similar pattern of feeling stigmatized about having a psychological ailment. Some of the women stated that they were concerned about being perceived as "crazy" if they were thought of as having a mental illness (Nadeem, Lange & Miranda, 2008)[7]. Additionally, some of the women also held negative attitudes towards others who had been diagnosed with mental illness (Bailey, Blackmon & Stevens, 2009; Nadeem, Lange & Miranda, 2008). However, the researchers (Nadeem, Lange & Miranda, 2008) did indicate that the link between accessing care and stigma was not strong.

In the Caribbean population, there are only two studies that have been conducted in this area and these initial studies suggest that somatic symptoms are more commonly observed in the Indo-Caribbean population (Kassiram & Maharajh, 2010; Maharaj et al., 2010). According to Kassiram and Maharajh (2010), in Trinidad, unlike findings from other countries, there seem to be an excess of somatic symptoms among women between the ages of 35 and 50 years. This finding has resulted in the coining of the descriptive term 'the Middle Age Indian Woman Syndrome' (Kassiram & Maharajh, 2010). This is a syndrome characterized by masked depression in pre-menopausal and menopausal women who are forever quarrelling with their

[7] The researchers investigated the role of somatization, ethnicity and stigma as these were related to perceived need for care. Participants consisted of 1577 low-income women who met criteria for depression.

children and husbands who have neglected them because of extra-marital affairs or through drug use. Therefore, it may be reasoned that she may experience angst when faced with the thoughts and feelings of being lonely and isolated thus, instead experience numerous somatic complaints, often presented as complaints of physical diseases (Maharajh, & Ali, 2004).

A possible reason for the prevalence of somatic symptoms in Indo-Trinidadian women may be interconnected to the ethnic composition of the population of Trinidad and Tobago. The islands have a population of approximately 1.3 million people; with the ethnic composition of Trinidad comprising 41 percent Indo- Trinidadians, 41 percent Afro- Trinidadians, while the rest can be traced back to Chinese, European or Middle Eastern ancestry (Government of Trinidad & Tobago, 2008; Hadeed & El-Bassel, 2006). The culture of Trinidad can be defined by the ethnic and religious composition of the country (Ali, 2006; Brereton, 1996). These traditions and various religions brought to the islands by the early immigrants are still, to a great extent, practiced today. Hence, it can be argued that Indo-Trinidadians ancestral traits are still closely linked to their ancestors in terms of some of the ideas about what contributes to a person being regarded as important in the community. Additionally, some have claimed that Indo-Trinidadians seem to still place a lot of emphasis on "looking good" (2010, p. 322) to their fellow neighbours, and hence because of this affiliative motivation this results in expressing their illness differently from Afro-Trinidadians (Kassiram & Maharajh, 2010).

However, the Afro-Trinidadian population is also 41 percent of the total population of Trinidad. According to So (2008), "individuals with similar cultural backgrounds are more likely to have illness experiences that reflect a common cultural heritage" (2008, p. 168). Therefore, it could also be argued that Afro-Trinidadian women may have also retained some of their culture from their country of origin. This is evident in the types of food, clothing and public holidays such as Spiritual Baptist Shouters Day (Coutsoukis, 2001) in Trinidad. It is also possible that each ethnic group because of the accelerated interaction between them may have influenced the other in terms of expression of illness, after residing in Trinidad together for over one hundred years. This thesis seeks to explore if each ethnic group may have influenced each other in terms of expression of illness by investigating the occurrences of somatization disorder among women from both majority ethnic groups.

All research conducted thus far in Trinidad regarding somatization disorder has been among Indo-Trinidadians, and it has been suggested that Indo-Trinidadians somatize because of the close cultural link to their country of origin (India). Therefore, it may be informative to review the literature regarding somatization disorder among similar cultural groups. Bhui (2002) investigated common mental disorders among Indian and Pakistani peoples residing in these countries. He found that Asian patients have their problems identified less often; hence they are not treated, whereas Caucasians tend to verbalize their complaints and seek formal treatment. Bhui's (2002) findings, that Asians rarely present with depression in primary care, and that they are thought to present with somatic manifestations of distress more often, led the researcher (Bhui, 2002) to conclude that somatic symptoms are manifestations of the person experiencing anhedonia or masked depression. Beiser (1986) notes that somatic symptoms may be especially common among some depressed patients who view physical symptoms as a more legitimate reason for seeing a doctor than subjective feelings of depression. These findings have led to the refutation of a commonly held belief in the 1960s that the prevalence of depression in Asia and Africa was low (Bhui, 2002).

However, despite there being research reporting that somatization disorder seems to be culturally specific and more prevalent among Asian cultures (e.g. Bhui, 2002; Chaturvedi & Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Sarason, 1999; Saxena, Nepal & Mohan, 1988) it is also useful to explore somatization disorder among other ethnic groups. Miranda, Saddique, Belin and Kohn-Wood (2005)[8] and Okluate, Olayinka and Jones (2004)[9] noted that while somatization disorder is not confined to African-American women, it is more prevalent among this ethnic group when compared to White-American women. African-American women accounted for 15 percent of somatic cases in their study, whereas, White-Americans accounted for just 9 percent (Miranda, Saddique, Belin & Kohn-Wood, 2005). The researchers did note that even though they had a higher occurrence of somatization disorder, African-American women tend to have milder somatic symptoms than White-American women (Miranda, Saddique, Belin & Kohn-Wood, 2005).

[8] The researchers screened 10,043 black women attending women's services such as, family planning clinics. 7,965 were born in the U. S., 913 were born in Africa, and 273 were born in the Caribbean. All information was obtained from semi-structured interviews by the 'women entering care' staff.

[9] A sample of 829 persons completed the Patient Health Questionnaire which was modified to include somatic symptoms.

Okluate, Olayinka and Jones (2004) have also argued that somatic symptoms appear to be more prevalent in Africa and in other developing countries, and even among Africans in Diaspora. These findings may be comparable to the experiences of Afro-Trinidadian women, that is, they too may have also retained aspects of their culture from their country of origin, for example, expression of illness. The researchers also reported that African-American women's somatic symptoms were often centered on the head, with feelings of skin-crawling, emptiness, and sensation of heat among others (Okluate, Olayinka & Jones, 2004). However, a limitation of this study was that the researchers did not investigate the possibility of the contribution of organic disorders to the manifestation of somatic symptoms. Nonetheless, similar to the suggestions regarding Asian cultures (e.g. Bhui, 2002; Chaturvedi & Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Sarason, 1999; Saxena, Nepal & Mohan, 1988) the clustering of somatic symptoms of the head has led the researchers to theorize that this phenomenon may also be culture-specific (Okluate, Olayinka & Jones, 2004). This suggests that the expression of distress among women of Eastern cultural backgrounds may be conveyed in similar behaviours (Smith, 2004).

As previously noted Western societies tend to have well-established mental health programmes designed for the treatment of somatization disorder (Bhui, 2002; Chaturvedi & Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Sarason, 199; Saxena, Nepal & Mohan, 1988). Despite research showing that somatization disorder is more prevalent in Asian/Eastern cultures, Smith (2004) states that the manifestation of somatic symptoms in Western cultures may be due to different reasons compared to Asian cultures. Somatic symptoms may be interpreted in many ways: as an index of disease, manifestation of intra-psychic conflict, cultural expression of distress or as an expression of social or personal discontent (Bass, 1990; Kirmayer, 1984). Consequently, this may be a reflection of the cultural burdens on this society, specifically, women, and the social "permission" given to the women to be sickly and physically weak (Smith, 2004). Somatic symptoms have been interpreted as "coded messages and communicative acts" which are conveyed in bodily terms by the individual who is experiencing difficulties in several areas of life (Bass, 1990; Kirmayer, 1984). Therefore, it is the particular cultural stigma associated with expressing emotional distress that will determine how that distress will be expressed (Kirmayer, 1984). The findings of these studies can be related to Trinidad. As noted

previously, Indo-Trinidadian women and Afro-Trinidadian women may be still closely linked to the culture of their country of origin. Thus, they may be expressing their emotional distress through somatic symptoms because fewer stigmas are attached to physical ailments. As a result, some of the women can be said to be 'crying out' for assistance in the form of bodily symptoms (coded messages and communicative acts) as these expressions may be more socially and culturally acceptable, thus, conforming to the pre-conceived ideas regarding the expression of illness.

Summary

The research reviewed in this section suggests that somatization disorder may have some sort of cultural link, by manifesting itself in Asian cultures in the form of mostly bodily aches and pains (Bhui, 2002; Chaturvedi & Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Kassiram & Maharajh, 2010; Sarason, 1991; Saxena, Nepal & Mohan, 1988). However, African-American women also presented with more somatic symptoms than their White counterparts, suggesting another cultural link (Miranda, Saddique, Belin & Kohn-Wood, 2005; Okluate, Olayinka & Jones, 2004). Further, many women who present with symptoms associated with somatization disorder would rather be considered as having physical complaints instead of a psychological problem, as they viewed physical ailments to be less stigmatized (So, 2008; Tseng, 2005).

Additionally, findings from the only study conducted in Trinidad to date (Kassiram & Maharajh, 2010), are similar to what some international studies have found; that somatization disorder is more prevalent among Asian women than women from other ethnic groups. This thesis seeks to further explore this notion by surveying both Indo- and Afro-Trinidadian women, drawing comparisons between the experiences of women from both ethnic groups.

Having discussed definitions of somatization disorder, and the manifestations, rates, occurrences of this disorder and its possible links to ethnicity and culture, a critical analysis of the treatment options for somatization disorder will now be explored. As noted, somatization disorder is an illness stigmatized by some primary care physicians, and the patient is often said to be "faking," (Cheung, 1995, p.168) and as a result, may not be taken seriously by their primary care physician

(Cheung, 1995; So, 2008). Also, because of the fear of stigmatization, some women may not seek help for psychological ailments but rather physical ones (Kassiram & Maharajh, 2010) and this may contribute to women somatizing their distress rather than seeking assistance for the 'cause', or stressful life-source, of their symptoms (for example, domestic violence). Therefore, various help agencies (specifically, medical doctors and religious) will now be discussed with regard to women who have somatization disorder.

2:7 Somatization Disorder: Treatment and Help-Seeking

Treatment and help-seeking are an important aspect of dealing with somatization disorder (Dowrick et al., 2004; Mai; 2004; Robbins et al., 1994; Salmon et al., 2004; Quill, 1985). Help-seeking is a term used to refer to:

> "the behaviour of actively seeking help from other people. It is about communicating with other people to obtain help in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience" (Rickwood, Deane, Wilson & Ciarrochi, 2005, p.4).

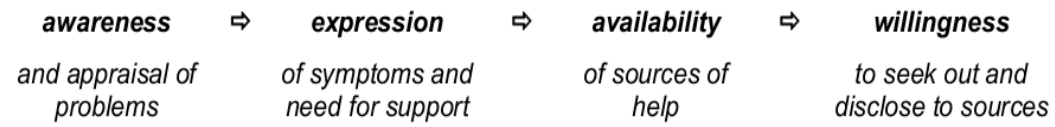
However, help-seeking for the woman with somatization disorder is a complex decision; encompassing many areas of the woman's life. As women from different cultural backgrounds may express their distress differently, their help-seeking behaviours may also differ. Women may often seek help from several physicians or sources concurrently, which may lead to complicated and sometimes hazardous combinations of treatment (DSM-TR-IV, 2002); some may also seek assistance from spiritual sources (for example, the religious leaders) for their symptoms (Becker, Al Zaid & Al Faris, 2002; Kassiram & Maharajh, 2010; Maharajh, 2010).

Rickwood et al., (2005) suggested that even though help-seeking may be an effective way of coping with psychological distress, much more research into help-seeking is required. They argue that a unifying theory of help-seeking is required that integrates existing research in order to help determine the specific factors that may contribute to the help-seeking process. While Rickwood et al., (2005) assert that there are limitations in the lack of unifying theories of help-seeking they also acknowledge that help-seeking itself is not a simple process. That is, there are

numerous factors that can influence whether the individual decides to seek assistance. For instance, if the person decides to seek help, they need to actually carry out this intention, and this may not always be a straightforward process. Factors such as stigma, lack of knowledge of where to seek assistance from, motivation and past help-seeking experiences may hinder the process (Rickwood et al., 2005). However, even with these negative aspects of help-seeking, many still persist and seek out assistance. This is where professionals, such as medical doctors need to encourage relationship building with the patient in order to encourage a sense of comfort in which the woman may feel comfortable to disclose the underlying cause of her distress (Rickwood et al., 2005).

In recognition of the factors commonly acknowledged in the literature as being involved in help-seeking behaviour, Rickwood et al., (2005) proposed a Process Model of Help-Seeking (Figure 1 below). This model proposes that the following sequence of behaviour is involved in help-seeking: the individual has to become aware of the problem; express her symptoms to another person, either a family member or friend. The next step is that the individual, perhaps together with the help of the family or friend, seeks out the various support systems available to her, and, finally, goes to get the desired assistance. As noted in the final step, the individual then seeks out a source of support.

Figure 1: ***Process Model of Help-Seeking***



Source: Rickwood, Deane, Wilson and Ciarrochi (2005, p. 8)

However, critics of this model (e.g. Gulliver, Griffiths, Christensen & Brewer, 2012) argue that it is flawed in that it assumes that all persons will seek assistance in the sequence described. As noted, help-seeking is complex and factors such as culture, fear and stigma may affect the process (Hardin, 2002; Kassiram & Maharajh, 2010). Thus, not all women will follow the suggested sequence. Despite this criticism, the basic principles of the model may be applied to

help-seeking for somatization disorder, as it provides a general overview of the process of help-seeking; however variations in this process will be acknowledged.

Some researchers have stated that in most circumstances women tend to seek assistance from both formal and informal sources (Kress, Eriksen, Rayle & Ford, 2005; Maharajh, 2010; Rickwood et al., 2005). Ethnographic fieldwork has suggested that when Asian women are experiencing emotional distress that they tend to express this as physical and somatic complaints (So, 2008). In biomedicine, somatization disorder is an illness that is stigmatized by primary care physicians and the patient is often said to be "faking" (p.168), and as a result symptoms may be overlooked. The patient's symptoms may therefore not be seriously addressed by the medical doctor. Patients who have been diagnosed with somatization disorder usually represent a major challenge to health care providers, as approximately 10 to 20 percent of patients who present to their primary care physician (USA) with physical symptoms do not have an organic cause. To date, there is no pharmacological or psychotherapeutic intervention that has produced meaningful improvements for patients with somatization disorder (Allen et al., 2006; Salmon et al., 2006). But according to Sharpe and Carson (2001), this pessimistic, anchoring view is not justified, as they suggest effective evidence-based treatments for somatization disorder are now available. Hence, these researchers emphasize that there is a need to educate the public in a non-judgmental manner, by placing emphasis on the integrity of social, physical and psychological factors of somatization disorder. Sharpe and Carson (2001) suggest that medical doctors need to approach the patient with the perceived control as having a functional disturbance that is reversible, rather than one that is solely psychogenic.

Despite these positive advancements in treatment, it has been suggested that physicians do have a significant role in the successful treatment of the patient with somatization disorder (Mai, 2004). Mai (2004) states that many physicians are pessimistic about the treatment of somatization disorder and often describe it as a chronic and stable condition. Epstein et al., (2006) state that patients visit the physician for validation of their symptoms, and to get a meaningful explanation of these symptoms. Nonetheless, it can be argued that physicians themselves often experiences some form of ambivalence with these cases, because of their own

insecurities, and this result in patients feeling discounted and misunderstood (Dowrick et al., 2004; Robbins et al., 1994; Salmon et al., 2004).

It had been suggested that there are four reasons why medical doctors experience challenges in managing patients with somatization disorder because they may be employing step-by-step logic instead of engaging in lateral thinking; these include: their drive to rule out any organic ailments; their ignorance of the condition; the fear of overlooking an organic disease and their discomfort in exploring psychological issues (Mai, 2004 & Quill, 1985). These researchers emphasize the need for the physician to be better educated about somatization disorder, as they are usually the ones who come into first contact with patients presenting with somatic symptoms (Mai, 2004; Quill, 1985). Consequently, as a result of the ineffective communication and the transference of these between the patient and the physician, some patients may report negative experiences. In an effort to resolve this, the physician, in an attempt to also reduce his/her anxiety, may reassure the patient about her symptoms by normalizing them without providing any explanation. Thus, the session may come to a premature close because of the physician's own apprehensions (Dowrick et al., 2004; Robbins et al., 1994; Salmon et al., 2004).

Notwithstanding the medical doctor's own personal inhibitions, Hardin (2002) reported that in many Asian cultures emotional distress is still much stigmatized whereas medical problems are not. As a result of this, some women present to the medical professional with physical symptoms and do not disclose the possible origin of their symptoms (for example, distressing family circumstances). However, it could be argued that this cultural stereotype may not only be confined to Asian cultures, since black women immigrants from Africa and the Caribbean (to USA) were much more likely that their Caucasian counterparts to report stigma-related concerns (Nadeem, Lang & Miranda, 2008). These findings are consistent with inferences which suggest that negative attitudes, stigma and negative cultural stereotypes toward the mentally ill are more prevalent in African cultures than in Western cultures. Additionally, other researchers have reported heightened stigma towards mental illness among Caribbean immigrants to the U.K. and Canada towards mental illness (Bailey, Blackmon & Stevens, 2009; Nadeem, Lange & Miranda, 2008).

As a result, Kress et al., (2005) have suggested that the medical doctors need to be intrinsically motivated and also be aware of their own stereotypes, biases and values and if these inhibit them from enquiring about the underlying cause(s) of the women's symptoms. Consequently, if they are not aware and respond accordingly, this may result in the medical doctor projecting his/her own cultural schemas upon the patient and as a result, the patient may be inaccurately diagnosed, as only the obvious symptoms will be identified and treated (Hardin, 2002).

Kress et al., (2005) suggest that in order to improve the patient's help-seeking experience, consultation with significant others in the patient's life may be beneficial, for example, a folk healer. For some Asian cultures, seeking help for somatic symptoms from formal sources is not commonplace. Kirmayer (2001) states that, in the United States of America, there is great emphasis on opening up about everyday stresses and interpersonal conflict, and daytime television (chat shows, soap operas) offers many examples of people doing so. In contrast, other more collectivist cultures view non-confrontation and social harmony as paramount, and therefore, tend to suppress both interpersonal and internal conflict. As a result, they are less likely to open up to health care providers about their problems, including emotional and social states; instead, emotional issues are viewed from a socio-moral perspective as matters which should be dealt with by a family member, spiritual or community leader.

Therefore, for many Asians, Africans and African-Americans, they may have learnt an acquired response in order to avoid shame and fear of stigmatization and will seek assistance from a family member, indigenous healers or the community, before seeking help from someone outside the family (Bailey, Blackmon & Stevens, 2009; Nadeem, Lang & Miranda, 2008; So, 2008). The trend to seek assistance from non-formal sources for what can be considered a cultural ailment can also be seen in Trinidad. Women who have somatization disorder may feel a sense of shame, and, in turn, may not seek out assistance (Kassiram & Maharajh, 2010). If they do, there is a tendency to seek this help from spiritual sources. Maharajh (2010) notes, that in Trinidad religion and psychiatry have had a long and familial relationship. Supernatural phenomena, demon possession, miracle cures and psychic predictions are almost a weekly occurrence. Two-thirds of all patients presenting to a psychiatric clinic will interpret their symptoms as being caused by

"spiritual wickedness from high places", obeah[10], "spiritual lash[11]" or evil influences (Maharajh, 2010, p. 52). Therefore, cultural, traditional and religious belief systems often delay contact with primary health-care providers and this may have negative outcomes.

Maharajh (2010) also notes that negative attitudes towards mental health and unwillingness to access mental health care remains a problem for the mental health professional in Trinidad, despite the existence of well-structured programmes for general mental health problems (Trinidad is divided into nine catchment areas, each with a "multidisciplinary team of psychiatrists, social workers, mental health officers and auxiliary workers" 2010, p.58). He recommends that a paradigm shift of the population and church leaders is needed with a greater collaboration among these groups. He also states that attempts to work together with the various churches have failed because local religious leaders attribute mental illness to possession of "demon states". This view results in conflict between "the priest and the psychiatrist with opposing views on demons and dopamine" (Maharajh, 2010, p.59). Nonetheless, some sort of spiritual or religious influence, for example, the priest, pundit or imam, remains today as the first contact for the majority of patients in Trinidad (Maharajh, 2010).

Becker, Al Zaid and Al Faris (2002) in their study of 431 primary care patients utilizing the Patient Health Questionnaire and clinical interviews, report that in Saudi Arabia women are more likely to report "nervousness" (p.278), with an emphasis on somatic aspects, than a mental illness to their physician because Saudi patients tend to be cautious when addressing women outside their family group. Mai (2004) suggests that, in addition to the individual seeking help from cultural sources and the physician, it is also important to include the family or spouse of the individual in the treatment process since family members are usually unwittingly involved in the individual's illness and may harbour feelings and reactions that may negatively impact on the individual's recovery. Thus, when addressing somatic symptoms it is important to provide feedback to the family members and/or spouse to help eliminate this negative aspect.

[10] A kind of witchcraft or sorcery in the Caribbean; a survival of African magic rites (Mendes, 2012, p.136).
[11] To harm one physically with necromancy (Mendes, 2012, p. 177).

Summary

From the literature presented, it appears that the some physicians are apprehensive about treating women with somatic symptoms, mainly because of their own anxieties and lack of knowledge about the disorder, as well as ineffective communication (Epstein et al., 2006; Mai, 2004; Quill, 1985). Thus, from a medical point of view somatization disorder is perceived as difficult to treat. But this may not be the case, as there have been some effective treatments, for example, Cognitive Behavioural Therapy (Allen et al., 2006; Sharpe & Carson, 2001). Some women with symptoms of somatization disorder also tend to seek assistance from non-formal sources such as the family or religious leader or other spiritual sources, for example a 'higher being' (Becker, Al Zaid & Al Faris, 2002; Kassiram & Maharajh, 2010; Maharajh, 2010). Therefore, a greater collaborative effort between the medical doctors and religious leaders is needed to fully address the needs of women who present with somatic symptoms. This thesis, in addition to examining Indo- and Afro- Trinidadian women's experiences of somatization disorder, will also seek to explore medical doctors' and religious leaders' resources; willingness to explore these intersecting issues with the women; and the intervention strategies they employ when meeting with women who may have somatization disorder. Women's experiences of help-seeking will also be explored.

2:8 Somatization Disorder and Domestic Violence

Introduction

Many international researchers have reported that somatization disorder is linked to experiences of abuse, specifically domestic violence (e.g. Brown, Schrag & Trimble, 2005; Hegarty et al., 2004; Holloway et al., 2000; McCauley, Kern and Kolodner et al., 1995; Samelius et al., 2007; Samelius, Wijma, Wingren & Wijma, 2008; Righter, 1999). This section explores the research regarding this link and the connection between somatization disorder, domestic violence experiences, and help-seeking. To date, limited research has been conducted on the occurrence of somatization disorder and domestic violence among Afro-Trinidadian women; hence this thesis seeks to address the experiences of these women.

There are very few studies that have been conducted in the Caribbean region with regard to somatization disorder. Literature searches have not yielded any studies on somatization disorder

and domestic violence in the Caribbean, apart from the two conducted by Trinidadian researchers (Kassiram[12] & Maharajh, 2012; Maharaj et al., 2010). It should be acknowledged that much of the discussion to follow will draw heavily on Kassiram and Maharajh (2010) and Maharaj (2010) as these are the only existing studies from this region.

Despite the limited information about somatization disorder and domestic violence in Trinidad, Kassiram and Maharajh (2010) surveyed 200 women (100 Indo-Trinidadian and 100 Indo-Jamaican women) and suggest some reasons why somatization disorder may be linked to domestic violence. They report that when cultural differences were examined between the Caribbean islands of Trinidad and Jamaica, it was revealed that Indo-Trinidadian women had a higher level of somatization disorder and domestic violence experiences than Indo-Jamaican women. According to Kassiram and Maharajh (2010) Indo-Trinidadian women (64.3%) presented with significantly higher levels of somatization disorder and domestic violence than the Indo-Jamaican women (35.7%). It was suggested that some of the reasons for this difference were culture, stigmatization of psychological expression of distress, and not having appropriate avenues to speak about the abuse being experienced; therefore the women may experience much apathy towards their life. However, the researchers did note that a limitation of this study is that there are significantly fewer Indo-Jamaicans than Afro-Jamaicans living in Jamaica. As a result, women who fit the criteria were challenging to access, and this may have limited the sample to women from only certain educational levels or socio-economic statuses.

In another study by Maharaj (2010)[13] conducted in Trinidad, it was reported that 37.8 percent of Indo-Trinidadian women and 44.4 percent of Afro-Trinidadian women had experienced domestic violence. This study did not address the differences in incidence and prevalence rates of somatic symptoms between Afro- and Indo-Trinidadian women, but did state that overall reports of abuse were reported in 48.8 percent of those experiencing somatic symptoms (Maharaj et al., 2010). However, Maharaj et al., (2010) notes that there were several limitations to this study. For instance, women in the study may not have been representative of the entire population, as in Trinidad free health centers (where the sample was obtained) often attract individuals from lower

[12] This research was conducted by the present researcher (Ms. Astra Kassiram)
[13] 432 female participants from 16 randomly selected walk-in clinics in Trinidad, 18 years or older, were surveyed using the WAST-Short and PRIME-MD questionnaires.

socio-economic status band. Therefore, the middle and upper income groups may have been under-represented. Additionally, the assessment instruments used (WAST-Short; Woman Abuse Screening Tool-Short Form and the (PRIME-MD PHQ; Primary Care Evaluation of Mental Disorders-Patient Health Questionnaire) are screening tools rather than confirmatory tests. Thus, conclusions could not be drawn about the causal relationship between mental illness and domestic violence.

However, it may be theorized that the occurrences of somatization disorder may be linked to the ethnic and cultural compositions of these islands' inhabitants. In 1797, Trinidad was captured by the British, and the ongoing slave trade then brought Africans to the island to work on the plantation. When the slavery system was abolished in 1834, Portuguese labourers were introduced, but the cultural diversity was broadened when, in 1845, the first indentured (contract) workers were brought from India to work on the plantations. From 1845 to 1917, approximately 130,000 immigrant workers were brought to Trinidad (Ali, 2006; Brereton, 1996). In Jamaica, between the years 1845 to 1914 approximately 36,400 East Indians were bought to Jamaica under the indentureship program (Coutsoukis, 2001).

With the introduction of approximately 130,000 East Indian immigrants, their culture was also brought to Trinidad. This culture, which still exists, may influence these women's expression of illness (somatization of distress). Kassiram and Maharajh (2010) assert that women of East Indian descent who experienced domestic violence in both Trinidad and Jamaica tend to somatize because they have limited avenues to vent their frustrations; thus, it may be argued that they adopt an 'anger-in' approach. Additionally, since they may not have access to assistance to speak about their difficulties because of the stigma attached to this sort of behavior, they become easily depressed, anxious and distressed and may often experience ancrgia; hence, this is their way of coping with their distress. Also, Maharajh (2010) notes that there is a cultural stereotype that Indo-Trinidadian women are more submissive than Afro-Trinidadian women; according to traditional Indian cultural norms, women are encouraged to believe that they have to submit to their spouse or, in general to the male, otherwise they may not be considered a "good" person (p.323). As a result, if an Indo-Trinidadian woman is being domestically abused she may prefer

to accept this abuse rather than leave; for fear that others will scorn her (Kassiram & Maharajh, 2010).

When researching somatization disorder in abused women not from the Caribbean (for example, in the United States of America), Samelius, Wijma, Wingren and Wijma (2008) surveyed 400 women with a previously reported history of sexual, psychological and physical abuse employing four questionnaires[14]. The researchers found that most of these women reported experiencing abuse mainly in adulthood. Physical and sexual abuse among women has been reported as a risk factor for the eventual development of somatization disorder in adult life (Righter, 1999). However, as noted in the 'aetiology' section, some researchers have argued that somatization disorder is a learnt behaviour, that is, through social learning; they imitate sick behaviour for secondary gain such as, sympathy (De Gucht & Maes, 2006). Despite these findings, McCauley, Kern and Kolodner (1995) surveyed 1952 patients in four community-based primary care internal care medicine practices utilizing a questionnaire and found that women who had experienced domestic violence had higher scores on measures of somatization disorder than women who did not. As a consequence, Holloway et al., (2000) suggested that physicians who diagnose patients with somatization disorder also need to ask about abuse, because traumatized patients will often deny their past because it may be too traumatizing to recount, as a result it may be debated that the person may exhibit alexithymia and not be able to adequately express herself and this could lead to an inaccurate diagnosis. Thus, experiencing sexual, physical and emotional abuse, as well as experiencing or witnessing an act of violence, can be said to be one element that is most predictive of subsequent somatic preoccupation in adulthood (Holloway et al., 2000).

It has been well documented thus far in previous research that abusive experiences are associated with posttraumatic stress disorder (PTSD) as an outcome (Bennice, Resick, Mechanic & Astin, 2003; Briere & Eliott, 1994; Golding, 1999; Woods, 2000). According to Engel (2004) an association between PTSD and somatization has been found but not fully understood. But a major finding was that PTSD seems to increase the risk for somatization symptoms. Samelius et al., (2008) suggest that when investigating somatization in abused women, the expectation was to

[14] Somatization Scale, Traumatic Events Scale, Abuse Inventory, Questionnaire about health

find somatization disorder associated with childhood abuse, but they actually found the majority of abuse occurred in adulthood. The researchers suggested this could be as a result of children reacting differently to abuse than adults. Consequently, it may be further argued that health care personnel and society in general employing avoidance learning may also react differently towards abuse in children than in adults (regarding acknowledgment, support and treatment) and this, in turn, could influence health assistance given and the way psychological problems are presented (Samelius et al., 2008).

Summary

The literature reviewed identifies a link between somatization disorder and domestic violence, but limited literature with regard to ethnicity and this link. What each of these Trinidadian studies did not examine were occurrences of somatization disorder and domestic violence in terms of Indo- and Afro-*Trinidadian* women. Kassiram and Maharajh (2010) did differentiate between Indo-Trinidadian and Indo-Jamaican women but did not investigate the experiences of Afro-Trinidadian women. Since the ethnic composition of Jamaica and Trinidad are vastly different (Jamaica's Afro- population consist of 90 percent and Indo-Jamaican 1.3 percent (Coutsoukis, 2001), whereas Trinidad's Indo population comprises 41 percent and Afro 41 percent (Ali, 2006; Brereton, 1996; Government of Trinidad & Tobago, 2008; Hadeed & El-Bassel, 2006), it is worth investigating if both Indo-Trinidadian and Afro-Trinidadian women express their abusive experiences and somatic symptoms in a similar manner.

2:9 Domestic Violence

Introduction

Somatization disorder seems to have an established association with abuse, especially domestic violence (Brown, Schrag & Trimble, 2005; Hegarty et al., 2004; Holloway et al., 2000; McCauley, Kern & Kolodner et al., 1995; Samelius et al., 2007; Samelius, Wijma, Wingren & Wijma, 2008; Righter, 1999). Therefore, the following section highlights statistics on the prevalence of domestic violence (International, Regional and Trinidad) some reviews proposed theories about the causes of domestic violence; considers the link domestic violence may have with ethnicity, specifically, in Trinidad, West Indies and, finally, the various help-seeking choices made by women who have experienced domestic violence.

2:10 Defining Domestic Violence

Definitions of domestic violence vary considerably between disciplines. For example, legal definitions offer different perspectives than do psychological or gender based definitions. Muehlenhard and Kimes (1999) state that the behaviours that constitute 'violence' are socially constructed. Some argue that the process of deciding what behaviours should be considered as 'violent' and 'non-violent' is not a straightforward matter. The manner in which words may be defined can and does have a powerful influence. This effect can be very subtle that even the professional may overlook the meaning actually attached to the words. Therefore, from a social constructionist viewpoint there is no true definition of domestic violence, rather there seems to be an ongoing struggle regarding how to frame and define this term (Steegh & Dalton, 2008). It should be noted that thirty years ago various terms such as 'wife rape', 'courtship violence' and 'wife beating' did not exist. Violence in general was viewed as behaviour that occurred amongst strangers and not within families (Muehlenhard & Kimes, 1999). Thus, child abuse was the first type of intimate violence spoken about, despite there being evidence to support that throughout history women were being abused by men (Jewkes, 2002; Singh, 2007). In the past, this type of violence was seen as 'normal', that is, the husband was allowed to 'discipline' his wife, given that the husband did so within societal boundaries (for example, hitting his wife with a stick no thicker than his thumb). In 1824, English common law allowed husbands to reprimand their wives but this policy changed in 1894 (Muehlenhard & Kimes, 1999).

In the 1960s and 1970s there was little attention being paid (for example, by sociologists and psychologists) to domestic violence, in so much that it was not addressed, and when it was, the women were often seen as causing the violence (Muehlenhard & Kimes, 1999). However, in the 1970s some changes did occur, when a group of British women who had experienced domestic violence established the first shelter for battered women. Then in 1972, a shelter of this kind was also established in the United States of America. With these advances in the recognition of domestic violence, in 1976, the book "Battered Wives" published in America assisted in highlighting women who had experienced abuse. Then in 1977, The Reader's Digest also published articles regarding domestic violence, stating that it was a terrible problem yet was being significantly overlooked (Jouriles, McDonald, Smith Slep, Heyman, & Garrido, 2008; Muehlenhard & Kimes, 1999). However, since then the public's opinion of domestic violence

has changed, and most definitions of domestic violence now include violence perpetrated by a family member or relative (Muehlenhard & Kimes, 1999).

In 1991, the Government of Trinidad and Tobago recognized a need for legislation, and the Domestic Violence Act No. 10 of 1991 was implemented; prior to this there was no such legislation in Trinidad and Tobago regarding domestic violence, as it was often viewed as a private matter. In seeking to enhance the Trinidad and Tobago legislation on domestic violence between 1996 and 1997, the committee (Community Policing Unit) revealed that there were four major impediments which hindered the effectiveness of the Domestic Violence Act of 1991, and in essence made it very difficult for women who experienced domestic violence to benefit from the protection of the law (Phillips, 2000).

The first impediment was financial considerations. Women who sought assistance under protection orders were often left without financial support. As Borstein (2006) noted, women in financially disadvantaged situations were more likely to experience domestic violence. Thus, if the woman leaves the abusive situation she may return due to financial dependency (Borstein, 2006), therefore, this amendment was important. Secondly, the intervention by the police was not done in a timely manner; moreover their lack of clarity in their roles and functions in domestic violence cases often led to lukewarm responses by the police towards the abused. Flood and Pease (2009) stated that police reactions also influenced the woman's decision to seek help. Most women have either experienced or heard about the police negative reactions, for example, trivializing the situation or failing to arrest the perpetrator. Thus, amending this aspect of the legislation was beneficial, as it would help to counter some of these issues. Thirdly, the definition of domestic violence failed to address financial, psychological, and emotional or sexual abuse. Lastly, the courts did not have enough jurisdiction to enable the legal system to hold the abuser accountable for his action, while at the same time, providing the victim with solutions that would assist with her protection (Phillips, 2000).

With these shortcomings being identified by the committee (Community Policing Unit) the Domestic Violence Act No. 29 of 1999 was introduced. This Act sought to address these

limitations, and allowed the criminal justice system to respond more effectively. The three major objectives of the Act were:

1. To enhance the powers and jurisdictions of the magistrates court
2. To enlarge the ambit of protection orders and
3. To ensure that the response of the police is efficient and effective (Phillips 2000).

Since the Domestic Violence Act No. 29 of 1999 was introduced, no amendments have been made to it, but there has been a steady increase in the number of cases reported (Crime and Problem Analysis Branch, 2011; CSO, 2000; Domestic and Gender-Based Violence, 2003). The behaviours that constitute domestic violence may be defined differently by numerous parties, for example legislators, victims, and perpetrators. Several approaches to recognizing these perspectives in defining domestic violence have been suggested. Firstly, there may be a tendency to rely on a legal definition of domestic violence. Such definitions are considered convincing as they are seen as "official government-approved" (1999, p.237) with the assumption that the local culture may have had an impact in the formulation of particular local legal definitions. These definitions provide the public with the assumption that they are 'objective'; however, the law is not always impartial. Muehlenhard and Kimes (1999) note that on many occasions these laws were or are written by men from upper socioeconomic classes who frame these issues from their own perceptions.

This brings the legal definition given by the Trinidad and Tobago Government at the forefront, as it offers a detailed explanation of domestic violence from a legal standpoint, by addressing all the types of abuse and what each of them are, while at the same time explaining in detail what behaviours constitute each type of violence. The Domestic Violence Act 29 of 1999 states that domestic violence is the "physical, sexual, emotional or psychological or financial abuse committed by a person against a spouse, child, any other person who is a member of the household or dependent" (The Domestic Violence Act 27 of 1999, p.292). The four types of abuse listed in the Act are: firstly, emotional/psychological[15]; secondly, financial[16]; thirdly,

[15] "a pattern of behaviour of any kind, the purpose of which is to undermine the emotional or mental well-being of a person" (Domestic Violence Act 27 of 1999, p.292 – 294)

[16] "a pattern of behaviour of a kind, the purpose of which is to exercise coercive control over, or exploit or limit a person's access to financial resources so as to ensure financial dependence" (Domestic Violence Act 27 of 1999)

physical[17] and finally, sexual[18] abuse. According to Muehlenhard and Kimes (1999) if a violent act does not fit into any one of the groupings, then the case usually does not reach the courts. As a result, the cases that are heard in the courts are usually the ones that reflect the most conventional and narrow definitions.

Another suggested approach to defining domestic violence is to allow the individuals involved to define their experiences of abuse. While this may seem empowering to both the perpetrator and victim there are numerous challenges. Firstly, when the perpetrator defines his/her own behaviour most often they may be hesitant to view or label themselves as 'violent' and may tend to utilize the 'narrow' legal definitions. Additionally, if the victim were to offer a definition of domestic violence, how would one be sure of who is actually the victim? In so doing, it would be assuming who is the victim and who is the perpetrator, when in some cases both persons may claim to be the victim. Therefore, the issue of who should define domestic violence is seen as a controversial one (Coker, 2002; Muehlenhard & Kimes, 1999; Steege & Dalton, 2009).

Nonetheless, there still exist numerous attempts to define domestic violence (Loseke, 1989). Thus, some definitions focus mostly on physical and emotional violence. The Trinidad and Tobago Government has offered a solely legalistic definition whereas, Puchala et al., (2010) define domestic violence as "physical violence carried out with the intention or perceived intention of physically hurting a spouse or intimate partner" (2010, p. 89). While this definition addresses abuse against a spouse or family member, which is important to this thesis, it has a major flaw, as only one form of violence is highlighted: physical violence.

Additionally, approaching some definitions of domestic violence from a gender perspective can also be challenging: gender-specific definitions that include men as the perpetrator ignore the fact that men can sometimes also be victims. As such these definitions promote gender

[17] "act or omission which causes physical injury and includes the commission of or an attempt to commit any of the offences listed in the first schedule" (Domestic Violence Act 27 of 1999, p.292 – 294)

[18] "includes sexual contact of any kind that is coerced by force or threat of force and the commission of or an attempt to commit any of the offences listed under the sexual offences act in the first schedule" (Domestic Violence Act 27 of 1999, p.292 – 294)

stereotypes that men are not subject to violence compared to women who are vulnerable and that women can also be perpetrators (Muehlenhard & Kimes, 1999). Copel (2008) states that domestic violence refers to "acts of violence that could or do result in physical, psychological, or sexual harm and the suffering to women, including threats of such acts, coercion, or the deprivation of freedom in either public or private life" (2008, p.117 cited in United Nations Department of Public Information, 2004). Copel's (2008) definition specifically addresses violence against women. While it may be important to include women in the definition, it is also essential to consider other family members because as noted, domestic violence may include other members of the household and women can also be perpetrators.

However, on the other hand, gender-neutral definitions are also problematic. By ignoring gender there is the possibility of also ignoring the role that culture plays in shaping men and women's beliefs about violence (Muehlenhard & Kimes, 1999). Kurz (1998) identified some gender-neutral terms, such as, "intimate violence" and "family violence" (p. 242) and has stated that by using these terms they hinder the public from really seeing how domestic violence impacts the woman and affects society. Additionally, these terms gives the illusion that the violence is mostly directed or perpetrated by all family members against all other family members. In so doing, it hides the reality of who is actually being violent to whom. Nagassar et al., (2010) defines domestic violence as "any act committed within the family by one of its members, which seriously impairs the life, body, psychological well-being or liberty of another family member" (2010, p.21). This definition can be considered to be more psychologically based, as it addresses the well-being of the person rather than highlighting the forms of abuse that constitute domestic violence. This definition does not provide a detailed understanding of the range of abusive acts that may constitute domestic violence; nor is it gender specific.

Different definitions of domestic violence sometimes reflect the interest of policy makers, or of the perpetrator or the victim. Some of the narrow legal definitions seem to suggest that the issue of domestic violence can be easily categorized, while others that are gender-specific can be said to be biased towards recognizing the violence experienced by women in society, however, at the same time, gender-neutral definitions may mask the experiences of some victims of domestic violence. It seems that there will always be a struggle to validate some domestic violence

definitions over others, and there is no one 'true' definition that could be applied to all cultures or situations (Muehlenhard & Kimes, 1999; Steeg & Dalton, 2009).

Domestic violence is considered to be one of the major causes of injury to women but it is not a new offence committed against women, since for centuries there have been incidences of 'battered women' (Singh, 2007). Historically, domestic violence has been considered to be a personal issue, hence, one of the reasons why little attention was paid to this problem - it was considered of little importance to the rest of society, more frequently referred to as a public versus private debate (Fals-Stewart & Leonard, 2005; Singh, 2007). Domestic violence can be said to be more distressing as it is committed in a situation where the person is supposed to feel and receive love, warmth and reinforcement (Singh, 2007).

Domestic violence is a significant social and medical issue that has a substantial impact on the health of adults, specifically women. Domestic violence tends to be viewed as a family issue, although it should be viewed as a societal problem and a crime (Nagassar et al., 2010). But, in recent times, it has now been acknowledged as a global problem (Bissessar, 2000; Fals-Stewart & Leonard, 2005; Nagassar et al., 2010; Waalen et al., 2000) which in turn has increased the concern for the incidence of domestic violence in the Caribbean (DeShong, 2006).

2:11 Statistics on Domestic Violence

There is now worldwide recognition that domestic violence affects millions of women (Dobash & Dobash, 2011), with international statistics showing that millions of women are assaulted in some manner by their partner every year (Marwick, 1998). A multi-country study by the World Health Organization (Violence Against Women, 2012) found that women between the ages of 15 to 49 years reported 15 to 71 percent of physical and/or sexual violence by their partners. The WHO also reported that women between the ages of 15 to 49 years in ten developing countries[19] who experienced domestic violence also experienced sexual violence (0.3 to 11.4 percent). Additionally, 71 percent of women in Ethiopia and 15 percent in Japan reported physical abuse

[19] Over 24 000 women representing diverse cultural, geographical and urban/ rural settings from 10 countries: Bangladesh; Brazil; Ethiopia; Japan; Namibia; Peru; Samoa; Serbia; Thailand; United Republic of Tanzania

by their partners. In Peru, 24 percent, Bangladesh 30 percent and Tanzania 17 percent of women reported that their first sexual experience was forced (Violence Against Women, 2012).

In the United Kingdom, domestic violence accounts for between 16 percent and one quarter of all recorded crime. One case of domestic violence is reported every minute to the police (Home Office, 2004). The police receive an estimated 1,300 telephone calls per day, and over 570,000 every year, and of these 89 percent are calls by women who are being abused by men (Walby & Allen, 2004). According to the Home Office Bulletin (July 2010), the percentage of domestic violence cases reported to the police for the periods 2001 to 2009/10 was between a low of 35 percent (2001-2003) and a high of 47 percent in 2008-2009. More recent statistics provided by Women's Aid annual survey 2013 reported that approximately 1.2 million women in the UK in 2011/2012 experienced some form of domestic violence. Additionally, The National Domestic Violence Helpline (in partnership with Women's Aid) received on average (per year) 150,000 calls for that period. Also, 82, 517 women with domestic violence experiences utilized outreach services and 9,599 women used refuge services (Howard, Laxton & Musoke, 2013 for Women's Aid).

Similar to the United Kingdom and the rest of the world, in the Caribbean, domestic violence is known to occur regardless of ethnicity or social class (Clarke 2001). Amnesty International (2002), states that in the Caribbean, *"*we experience almost on a daily basis brutal attacks on women by cutlass wielding spouses*"* (2001, p. 22). In the Caribbean, on average one in three women will experience some form of domestic violence in her lifetime (Costs, and Policy Options in the Caribbean, 2007). Studies conducted in Guyana, Suriname, British Virgin Islands and Antigua and Barbuda suggest that between 20 to 69 percent of women in an intimate partner relationship have been the victim of some form of domestic violence (Unifemcar, 2012).

Additionally, according to the Ibero-American Youth Organization (cited in the Trinidad and Tobago Guardian newspaper, 2011), at least one out of three women in the Caribbean under the age of 35 years experienced domestic violence. Regional (Caribbean) statistics show that between the period 2002 and 2008, in Jamaica, 49 percent of girls between the ages of 15-17 years reported some level of coercion (within or out of a relationship was not specified); in St.

Kitts, sexual offences accounted for 24 percent of the assizes[20] list in 2009; in the Bahamas 17 percent of deaths/homicides in 2007 were as a result of domestic violence and 20 percent of homicides in Barbados were domestic, with all female victims but, unfortunately, these statistics just point to a few reported cases of domestic violence and do not come close to the reality of the situation ("Artists United to End Violence Against Women" 2011).

Domestic Violence is a very serious problem for the island of Trinidad and Tobago (Babb, 1997; Ffolkes, 1997; Rawlins, 2000; Zellerer, 2000). It has been suggested that reports of domestic violence have escalated in Trinidad (Nagassar et al., 2010) which will be illustrated by statistics presented below. According to a study by Bissessar (2000), between 1990 and 1995, 80 women were murdered as a result of domestic violence. Then in 1999, male spouses murdered 6 women and between 2000 and 2002, 58 females were killed in domestic violence related situations. The Ibero-American Youth Organization (cited in the Trinidad and Tobago Guardian newspaper, 2012) states that, in Trinidad, for 2009, there were 434 reported cases of rape, with domestic violence matters comprising approximately 19 percent of all matters in the Magistrates' Court.

Table 1 shows that domestic violence is occurring and presents itself in various forms. Recent statistics collected by the Trinidad and Tobago Police Service shows that for the year 2011 (January to July), there was a total of 1276 domestic violence cases reported, ranging from murder to breach of protection order which is only a 20- person difference for the entire year of 2010. Additionally, the number of domestic violence cases decreased between 2001 and 2004 then rose again in 2005 (Crime and Problem Analysis Branch, 2011). The exact reason(s) for this has not been determined, hence, further studies investigating this occurrence are needed.

[20] Court Sittings

Table 1: ***Statistics on Domestic Violence for the period January 01st 2000 to July 31st 2011***

OFFENCE CATEGORY	2000	2001	2001	2003	2004	2005	2006	2007	2008	2009	2010	2011 Jan to July
Murder/Homicides	24	17	17	22	18	26	33	18	37	19	24	16
Sexual Abuse	92	37	24	58	25	53	43	42	67	64	22	24
Wounding	48	42	37	09	29	07	12	34	61	38	44	01
Assault by Beating	775	907	560	406	470	491	421	545	859	568	806	732
Malicious Damage	00	02	00	05	10	01	01	18	24	26	15	17
Threats	214	217	133	227	245	379	498	437	422	405	246	391
Verbal Abuse	94	60	91	40	60	18	15	03	00	00	28	13
Emotional/Psychological Abuse	59	61	55	37	49	33	25	00	00	00	04	00
Financial Abuse	04	00	01	04	12	00	00	00	00	00	00	00
Child Abuse/Abandonment	04	25	09	00	28	31	05	02	03	05	03	00
Breach of Protection Order	16	26	30	38	26	19	13	72	83	127	104	82
TOTAL	**1330**	**1394**	**957**	**846**	**972**	**1058**	**1066**	**1171**	**1556**	**1252**	**1296**	**1276**

Source: Crime and Problem Analysis Branch, Trinidad and Tobago Police Service, 2011

Summary

Domestic violence against women is a global problem (Amnesty International, 2001; British Medical Association, 1998; Marwick, 1998 cited in Nagassar et al., 2010; Watts & Zimmerman, 2003). Statistics presented by the Crime and Problem Analysis Branch of the Trinidad and Tobago Police Service (2011), shows that despite legislation designed to detect, reduce and punish offenders, domestic violence is a growing problem for the islands (Nagassar et al., 2010). Even with this escalation, there is still limited research being conducted in the Caribbean (Le Franc, Samma-Vaughn, Hambleton, Fox & Brown, 2008), and, by extension, in Trinidad

(Hadeed & El Bassel, 2006) with regard to domestic violence, and it is an area in urgent need of research attention.

2:12 Theoretical Perspectives on Domestic Violence

According to le Franc et al., (2008), to date there is still no clear theoretical model or common consensus to aid in the explanation of the root causes that contribute to domestic violence. Still there have been numerous theories suggesting why domestic violence occurs. It should be noted that even though some theoretical structures seem to explain the possible causes of domestic violence there are many limitations to them. Bell and Naugle (2008) state that while some may argue that within specific theories there are flaws; others have argued that all theoretical explanations have limitations. For instance, while feminist theories suggest a link between domestic violence and patriarchal beliefs, other researchers have not found such a connection. Indeed, some findings (Campbell, 1992; Mihalic & Elliott, 1997) indicate that there was actually *less* domestic violence in traditionally male-headed households (Bell & Naugle, 2008).

Furthermore, developing any new theoretical explanation is often very much influenced by established theories. Although it is important to consider and cite these previous frameworks, there may exist many challenges regarding how to incorporate the new literature on domestic violence into existing theoretical frameworks. For example, doing this may constrain the new research findings into fitting a pre-determined set of ideologies (Bell & Naugle, 2008). Therefore, due to the interdisciplinary nature of domestic violence research there still continues to be a divide among researchers regarding how to conceptualize domestic violence (Bell & Naugle, 2008).

A report by UNICEF in 2000[21] drawing on what is domestic violence stated that "Violence against women is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men to the prevention of the full advancement of women" (2000, p.2). According to Jewkes (2002), cross-cultural research suggests that societies that have a stronger ideology for male dominance have more domestic violence. For example, in cultures in which strong traditional gender roles are

[21] not an academic paper

common (for example, male dominance), violence against women is more tolerated by the woman (Flood & Pease, 2009). At a societal level these factors affect the woman's access to political systems, influence in the economy, female autonomy and participation in academic areas. These ideologies also affect the criminal justice system and the police, whether violence against women is criminalized, and the seriousness with which reports of intimate partner violence is viewed. At an individual level, men who hold a more conservative view of women are more likely to abuse them (Jewkes, 2002; Levitt & Ware, 2006).

Therefore, for the purpose of this thesis, culture, religion and physical force will be examined along with the roles to which women are expected to conform. These specific concepts were chosen as, according to Maharajh (2010) opinion, in Trinidad, in many traditional Indian families, the women are expected to be subservient to their husbands. Indian men are characterized as being domineering, possessive and over-protective of their wives and children - particularly their daughters. In Trinidad, in Indian families, the father is viewed as the head of the household, usually the breadwinner, rule-maker and discipliner (Maharajh, 2010). Whereas, within Afro-Trinidadian households the women may be seen as being more assertive and dominant, thus, it has been theorized that as a result of this they may be less likely to experience domestic violence (Maharajh, 2010). This may be challenged since, this suggested cultural stereotype has not been empirically tested; this thesis seeks to explore this notion, by investigating the occurrences of domestic violence among these two ethnic groups.

According to some feminist scholars, such as Millett (1970), Walby (1990) and Oakley (1972) in order to provide an adequate explanation of gender inequalities, the notions of patriarchy need to be considered. Although, patriarchy literally means "rule by the father" (Walby, 1970 p. 109), some radical feminist scholars have chosen to use this term in a broader sense to refer to the male dominance that prevails in society. Therefore, from this perspective, patriarchy is viewed as the exercise of power over women by men (Haralambos & Halborn, 2008), and involves various patriarchal structures which restrict women and aid in the maintenance of male domination. Three of these structures will be discussed with their relevance to this thesis, and hence, Trinidad. These include, first, culture; second, religion and third, physical force.

Culture

Millet (1970, cited in Haralambos & Halborn, 2008) attaches importance to socialization. Millet believed that *"*patriarchy is the most pervasive ideology for our culture, its fundamental concept of power; it is more rigorous than class stratification, more uniform, and certainly more enduring*"* (p. 109). Moreover, Singh (2007) reports that the positions, rights, duties and values of women are all decided by men (for example, India) and dictates that the woman should be relative to the man "To please them, to be useful to them, to make themselves loved and honoured by them" (Singh, 2007, p. 127). These are the duties of women which should be taught to them from infancy. Therefore, it may be argued that for some women, these 'duties' are as a result of culture based on shared values. Consequently, these values may influence how the women react and behave in an abusive situation, thus, indicating that culture is the manifestation of that society's core values. For that reason, it may be reasoned that culture is actually learnt (Sewell, 2005). However, as a result of cultural deprivation for such a long time, women are reared in an atmosphere that positively helps in the development of inferiority. Equally, they become used to the "institutional legitimation" (Singh, 2007, p. 127) of their low status, and find nothing wrong in crimes committed against them, or do not possess the resources to speak about their challenges. In some cultures (e.g. India) males are raised and develop the acquired characteristic that they should be aggressive and violent, and use every means at their disposal to dominate women and girls (Bell & Naugle, 2008; Singh, 2007). Consequently, it may be further argued that these learnt behaviours are stored in memory and were anoetic; as a result the women were able to recall the information without knowing where it came from. Millett (1970) argues that men have enjoyed dominance because of the length of time they were taught to do so, hence women take male dominance for granted.

Again, Maharajh's (2010) opinion that the cultural stereotype that Afro-Caribbean people have traditionally been taught to be strong, independent, assertive and outspoken, whereas their East Indian counterparts have been raised to be passive, obedient and conscientious may be challenged. Maharajh (2010) states this could account for the assumption that, in Trinidad, more Indo-Trinidadian women are subject to domestic violence (Campbell, 1995; Hadeed & El Bassel, 2006). Since it has been asserted that Indo-Trinidadians may still be closely linked to their country of origin (Kassiram & Maharajh, 2010) this notion may be connected to Singh's (2007)

argument. Singh (2007) in his study conducted in India argues that, through culture, men learn to be aggressive and dominant and expect woman to be passive and feminine. However, with a changing social structure in which some women no longer view themselves as subordinate and weak, they participate more in the political structures of society (Singh, 2007).

Alternatively, according to Jewkes (2002) a higher level of female empowerment is seen as a protective factor against domestic violence. Many men would adjust to this change without violence, however, despite this argument some lack apperception and do not (Singh, 2007). Since, when such changes occurs those men who continue to hold traditional sex roles are more likely to become enraged and could result in physical abuse, for example, men with a rigid and traditional gender roles belief system are more likely to practice domestic violence (Flood & Pease, 2009; Singh, 2007). Therefore, it may be argued that for some men this is a form of cultural problem-solving that has been met with success (Cheng, 2001; Na & Kitayama; 2011; Kirmayer & Sartorius, 2007; Sewell, 2005; Straub et al. 2002). As a result, some men may decide to 'solve the problem' of female empowerment with violence because it is seens as an acceptable and socially approved means. Thus, some men may adopt this method (violence) as a means of coping and after some time these abusive behaviours may be seen as a part of their cultural identity (Straub et al., 2002).

Additionally, the position, values and duties of a woman are decided upon by male elements of society and national polices developed worldwide are mostly constructed also by men (Persadie, 2007; Singh, 2007; Steans, 1998). As a result, according to Singh (2007), the teachings of society perpetuate the belief that women's status should be less than men. Women's role in society is to please men, to be useful to men, to educate them when they are young, and to console them a when they are unhappy (Singh, 2007). Patriarchal ideology can be said to be ingrained into women's belief because of these factors (Singh, 2007).

Religion

"Patriarchal religions are said to be formed, governed and made for males in society, thus such religions often have gender inequalities both in membership and leader representation" (Levitt & Ware, 2006, p. 1170). According to Flood and Pease (2009), some Christian religions use the

Bible, and some Muslims use the Koran to select scriptures to justify domestic violence.. In Trinidad, there is ample religious diversity; with this diversity being reflected in the religious mix with Christians 70.3 percent, Hindus 22.5 percent, Muslims 5.8 percent, and a small percentage of Presbyterians, Moravian, Seventh-Day Adventists and Pentecostals (Ali, 2006; Brereton, 1996; CSO, 2000). Thus, from these statistics there is a wide variety of religions in Trinidad, thus the notion of religion as an influence encouraging domestic violence is one worth noting.

Radical feminist theories tend to view religion as a product of patriarchy and religion is seen as only serving the interest of men (Haralambos & Halborn, 2008). Amstrong (1993) argues that "none of the major religions are particularly good to women. They have usually become male affairs and women have been relegated to marginal positions" (p. 402). Despite some women having made noteworthy advances in many areas of life, their accomplishments in most religions have been very limited. Many women continue to be left out of key roles in many religions, for example, within the Roman Catholic faith only men are allowed to become Priests. This is notwithstanding the fact that women often take part in more in organized religion (when allowed to) than men (Amstrong, 1993).

El Saadawi (1980, cited in Haralambos & Halborn, 2008) argues that religion started to become patriarchal through the misinterpretation of religious beliefs by men. She views religion as playing a role in women's oppression; as men twist religious beliefs to serve their own interests and to help rationalize the oppression of women. Millet (1970, cited in Haralambos & Halborn, 2008) also argues that religion is a way of legitimating male supremacy as "Patriarchy has God on its side" (p. 110). For example, Christian religions usually portray Eve as an afterthought produced out of Adam's spare rib, and that human suffering is a direct result of her actions. The secondary and often subordinate role of women in Christian doctrine is also typical of most other religions (Haralambos & Halborn, 2008). However, some women have reported that when religious social support received was positive, this assisted with their recovery. The unconditional love and positive support received from their spiritual community provided them with the hope of restoration needed to overcome their abusive experiences (Giesbrecht & Sevcik, 2000).

However, in some religions, particularly in the Hindu and Muslim religions, the husband is portrayed as the sole owner of his wife's life; he has the authority to discipline her and she is taught to obey and endure the discipline and she may now be forced to adhere and not resist him. This position and role created by religion is very crucial to the subject of domestic violence. This religious outlook can also be considered a reason why the crime of domestic violence is not reported to the police, because it is seen only as a "domestic adjustment problem" (2007, p. 128) and not a serious crime (Singh, 2007). However, Levitt and Ware (2006) in an American study reported that although some view religion as an element used to justify violence against women, others do not. In some faith communities (for example, Christian), religion is said to encourage the wife to be treated as an equal partner and thus, this is expected to decrease the incidences of domestic violence (Levitt & Ware, 2006). Additionally, studies conducted on the general populations "do not appear to suggest that faith groups that endorse hierarchical marital structures report higher rates of domestic violence" (Levitt & Ware, 2006, p. 1170).

Nonetheless, even with this argument Holm (1994) still contends that women are subordinated or exploited in contemporary religions and devalued by different religious beliefs. She argues that, while the classical teachings of many religions have stressed equality between men and women, in reality the compliance to such teachings are not upheld and women have usually been far from equal. She says "women do, of course, have a part to play in many religions, but it is almost always subordinate to the role of men, and it is likely to be in the private rather than public sphere" (Holm, 1994, p. 402). Therefore, it is to be concluded that female oppression is essentially not due to religion, but to the patriarchal system that has long been dominant, and the only way for women to improve their position is to struggle for their own liberation (El Saadawi, 1980, cited in Haralambos & Halborn, 2008).

Physical Force

Millett (1970, believes that patriarchy is ultimately supported by force; for example, dowry related deaths in India (Martin et al., 2002). Walby (1990) states that physical force and violence is a form of power over women, where the use or threat of violence is used to help keep the woman in her place, and is aimed at discouraging her from challenging patriarchy. Even though there have been numerous social and legal polices in place to deal with domestic violence, action

against the violent partner is still infrequent, and therefore, some women continue to be subject to male violence (Haralambos & Halborn, 2008). Oakley (2002) asserts that there is evidence to suggest that men commit approximately 90 percent of all violence, and violence against women is seen as stemming from what men learn about being masculine. For example, men are more likely to become violent if they feel that their sense of masculinity, their authority, is threatened or questioned by others, especially, if the questioning is by women. It can be debated that violence and male identity are linked; Jewkes (2002) and Gelles and Straus (1998) argue that if the man is not able to live up to the ideas that society placed on him, with regards to what constitutes his "manhood" (for example, being the financial provider) this may result in stress within the household and the man expresses this by hitting the woman. Therefore, it may be contested that violence against women is not only an expression of male power but, male vulnerability of not being able to live up to the social expectation. Consequently, the challenge of not being able to adapt their behaviours to meet these social expectation may trigger a "crisis of male identity" and the only avenue the man sees available to resolve this is through the use of physical force (Jewkes, 2002).

Summary

Despite many theories about why domestic violence occurs, the impact of culture, religion and physical force continue to be the most relevant for this thesis. In some cultures men are taught to be dominant women are socialized to be subservient, and resistance to this is seen as a reason for women to be abused (Maharajh, 2010; Singh, 2007). Additionally, deep-seated religious beliefs encourage the domination of women by men, as it has been suggested that men often distort religious doctrines to their benefit, that is, to dominate women (El Saadawi, 1980 & Singh, 2007). Finally, physical force is often used to keep women submissive (Millet, 1970). Thus the next section explores domestic violence in terms of ethnicity, culture and social class.

2:13 Domestic Violence: Ethnicity, Culture and Social Class

It has been suggested that domestic violence may be linked to ethnicity and social class (Campbell, 1995; Ellison, Trinitapoli, Anderson & Johnson, 2007; Grossman & Lundy, 2007; Hadeed & El Bassel, 2006; Nagassar et al., 2010). This association is being explored as this thesis will investigate the possible links between domestic violence and Indo- and Afro-

Trinidadian women in an attempt to add to the limited existing literature on this topic. Therefore, this section examines the possible links between ethnicity, culture, social class and domestic violence.

Domestic violence is known to persist irrespective of place, socio-economic status and ethnicity (Clarke, 2001). Around the world, women suffer harmful and sometimes life-threatening effects of traditional and cultural practices under the guise of social and cultural conformism and religious beliefs (UNICEF, 2000). For example, female genital mutilation in Africa, forced prostitution, trafficking in women (Okemgbo, 2002), dowry-related violence in India (Martin et al., 2002), acid attacks in Pakistan and killing in the name of honour in countries such as, but not limited, to Bangladesh, Egypt, Jordan, Lebanon, Pakistan and Turkey (UNICEF, 2000).

International studies have reported differences in domestic violence rates by ethnicity. Ellison, Trinitapoli, Anderson and Johnson (2007)[22] in their study of domestic violence, ethnicity and religion report that, compared with non-Hispanics, Whites and Latinos, African- Americans have higher levels of domestic violence. Tjaden and Thoennes (2000) investigated the prevalence of intimate partner violence among white, African- American, Asian/Pacific Islander, American-Indian/Alaskan Native, and mixed-race women, as well as women in any of these groups who defined themselves as Hispanic versus non-Hispanic. A sample of 8,000 women and 8,000 men from The United States of America were interviewed via the telephone regarding their experiences of domestic violence. What was revealed was that American Indian/Alaskan Native women experienced a higher amount of crimes such as, physical assault and rape than women from mixed races. Whereas, Asian/Pacific Islander women reported lower occurrences of physical assault and rape than other ethnic groups questioned. African American women only had a slightly higher amount of victimization than White women.

Ethnicity may also influence how different groups view, and, in turn, respond to domestic violence (Campbell, 1995). For example, Sokoloff and Dupont (2005) stated that some African American women may experience ambivalence and hesitate in calling the police, as they are

[22] This study sample of 3,134 men and 3,666 women from National Survey of Families and Households in The United States of America

concerned how the criminal justice system will treat their partner as a result of the anchoring of the stereotype that all blacks are violent. Hadeed and El Bassel (2006) have noted that not much research has been conducted with regard to ethnicity and domestic violence in Trinidad and Tobago. Still, there is the common perception in Trinidad that women of East Indian descent experience more domestic violence than their counterparts belonging to other ethnic groups in Trinidad (Campbell, 1995). However, in a previous study these findings were not echoed, as, Rawlins (2000) research conducted in the Barataria and Chaguanas areas in Trinidad among women of African and East Indian origin; found that 16 percent of the sample of 200 women had experienced domestic violence. With regard to the widely held belief that domestic violence is more prevalent in the East Indian community than in the African community, the results of the study by Rawlins (2000) was contradictory; the East Indian community did not have a higher rate of domestic violence cases against women (Rawlins, 2000). Still, Hadeed and El-Bassel (2006) in their study of 2-hour face-to-face interviews with 17 Trinidadian women reported that 80 percent of women who sought refuge in shelters were of East Indian origin. Therefore, this thesis seeks to address this concern, by investigating both Indo- and Afro-Trinidadians women's experiences of domestic violence.

When socio-economic status was examined, Nagassar et al., (2010)[23] in their study of domestic violence within the various socio-economic classes in Central Trinidad, obtained participants using a two-stage stratified method; this method was chosen to help balance, and then minimize racial, cultural biases, age and confounding factors. They reported that most domestic violence occurred within the working class and lower middle socioeconomic classes, and this was constant regardless of the type of abuse. Verbal abuse represented 49.5 percent, physical abuse 17.7 percent and financial abuse 34.6 percent of the sample. However, Hadeed and El Bassel (2006) in their study reported that domestic violence in Trinidad and Tobago occurred in all socioeconomic and age groups, with loss of life occurring most frequently within the largest

[23] Participants for this study had to be 16 years and older, a resident of that household and female. If more than one female was present in the household at the time of the survey the most senior female was interviewed. Participants were selected using a two-stage stratified sampling method. " Households, each contributing one participant, were stratified into different socioeconomic classes (SES Class) and each stratum size (or its share in the sample) was determined by the portion of its size in the sampling frame to the total sample; then its members were randomly selected" (Nagassar et al., 2010, p. 20).

ethnic groups in Trinidad, Afro-Trinidadian and East Indian population (Hadeed & El-Bassel, 2006).

Summary

In conclusion, the literature reviewed shows that domestic violence occurs regardless of the person's ethnicity or social status (Clarke, 2001). The limited amount of research conducted in Trinidad illustrates conflicting views with regard to East Indian descendants having more experiences of domestic violence than any of the other ethnic groups (Hadeed & El Bassel, 2006; Rawlins, 2000). Since this inconsistency exist in the literature, this thesis investigates whether or not Indo-Trinidadian women experience higher levels of domestic violence than Afro-Trinidadian women. Additionally, the women's domestic violence experiences and how they make sense of their abusive situation will also be explored.

Another important aspect of domestic violence is the help-seeking behaviour women engage in and the assistance they actually receive Gerbert et al., (2002). As help-seeking can be hindered by either stigma of being abused or fear of reporting, thus, resulting in the women staying in the abusive situation and being subject to more abuse. Therefore, the following section focuses on help- seeking behaviours by women who have had experiences of domestic violence. This section will also focus specifically on medical doctors and religious leaders and explore their resources, willingness to explore, and the intervention strategies they employ when meeting with women who may have experienced domestic violence.

2:14 Domestic Violence: Help-Seeking

Liang, Goodman, Tummala-Narra and Weintraub (2005) identified three processes or stages of help-seeking with regard to women who experienced domestic violence. These are: defining the problem; deciding to seek help and selecting the source of help (Liang et al., 2005). Liang et al., (2005) stated that how the woman in the abusive situation defines her problem is important. As discussed above, there are many factors that contribute to this. For instance, if the woman defines her abusive situation through the lens of her culture, she may or may not seek assistance in accordance with the norms of that specific culture. For example, in some Asian cultures it is more acceptable that the women maintains the family unit, as a result she is encouraged to be "a

good woman" or a "strong" (p.76) woman, and not report the abuse; whereas, other women may not be knowledgeable about where to access support from and this deters help-seeking (Kasturirangan, Krishnan & Riger, 2004; Rickwood et al., 2005).

Still, it may be further argued that how the woman defines her situation may be an important factor in terms of the source of help she seeks out. For example, a women who defines her abusive situation as a personal psychological one where she requires emotional support, may choose to seek help from a friend, compared to if she views her situation as one that needs counsel, in which case she may choose a therapist. Whereas others may seek help from a religious leader if she defines her situation as a spiritual battle, or she may seek legal intervention if she defines the abuse as a crime. Thus, Liang et al., (2005) suggest that the definition that the woman applies to her abusive situation determines the source of help she seeks.

While it may be debated that how the woman defines her abusive situation determines the source(s) of help she seeks; it may also be argued that individual influences such as coping and relational styles also impacts upon the woman's choice of assistance. Laing et al., (2005) and Rickwood et al., (2005) both contend that women with a more problem-focused coping style are more likely to seek legal intervention, whereas a woman with emotion-focused coping style is more likely to seek social support from friends or religious leaders. Thus, adopting one particular help-seeking definition for domestic violence could be problematic, as help-seeking varies for each person. Therefore, for the purpose of this thesis, no one definition of help-seeking will be stringently adopted for domestic violence but rather serve to guide the discussion and analysis of the data. Major elements of both Rickwood et al.,'s (2005) more general process model of help-seeking (Rickwood et al., 2005) and Liang et al.,'s (2005) model of help-seeking for women experiencing domestic violence will be incorporated as a framework of discussion here, as these models both address the basic principles of help-seeking, namely recognizing that one has a problem, defining the problems, then deciding to seek assistance and from which source(s).

Help-seeking with regard to domestic violence is a complex decision. Researchers (e.g., Kress, Eriksen, Rayle & Ford, 2005; Maharajh, 2010; Rickwood et al., 2005) have suggested that in

most circumstances women tend to seek assistance from both formal and informal sources, including medical doctors and spiritual sources.

Medical Doctors

Richardson et al., (2002) employing a self-administered questionnaire to 1207 women attending general medical practices in Hackney, London investigated the prevalence of domestic violence among women, and found that one third of the women attending the practice had experienced domestic violence, and that most of these women were not identified by the general practitioner according to data extracted from their medical records. It may be argued that the lack of identification can be linked to latent learning, thus contributing to the hesitation that some medical practitioners felt towards screening for domestic violence (Richardson et al., 2002). As in a study by Gerbert et al., (2002)[24] it was revealed that, despite increasing support and recommendations for physicians to screen for domestic violence, most do not; only one in ten medical practitioners ask their patients about domestic violence experiences, and only one-third of managed care organizations had any sort of policies or guidelines for the screening of domestic violence.

Sugg and Inui (1992) in their analysis of interviews of thirty-eight family physicians revealed that some physicians found exploring domestic violence in the clinical setting analogous to "opening Pandora's Box". As a result, it may be argued that the physicians' reasons for not wanting to explore these issues may be linked to their inability to employ lateral thinking; thereby, contributing to the physician's feelings of lack of comfort, fear of offending the individual, loss of control, time constraints and powerlessness when exploring domestic violence issues with their patients. Additionally, Gerbert et al., (2002) and Elliot, Nerney, Jones and Friedman (2002) also reported on the barriers that physicians faced when screening for domestic violence: together with the above, the most frequent were lack of training and/or resources, inability to be able to "fix" the problem and a belief that the patient's situation would not change; they also reported a sense of feeling overwhelmed.

[24] A mail-in questionnaire was sent to a random sample of 610 primary care physicians from the American Medical Association Physician Masterfile.

But even with these personal restrictions that physicians placed on themselves, when domestic violence was identified some physicians were able to alleviate this belief-bias effect (Gerrig & Philip, 2002) and did intervene as best as possible (Gerbert et al., 2002). In a study by Ramsey et al., (2002)[25] and Sethi et al., (2004)[26], it was reported that respondents felt that routine screening for domestic violence was acceptable, with abused women being one and a half times more likely to favour this screening. However, besides the above mentioned reasons for a lack of screening, Gerbert et al., (2002) have stated that the physician's concern is at least in part on par with the long-standing view that intimate partner violence is a private, taboo topic that will require more time and resources than a physician has to give.

Taket et al., (2003) argued that screening for domestic violence by the practitioner may be beneficial. Whereas Ali (2003) asserts that there is no evidence that routine screening will alter morbidity and mortality levels, but it was suggested that screening may reduce the subsequent psychological and physical abuse to the women. Still, Taket et al., (2003) argue for the benefits of regular screening for domestic violence, and state that it would uncover hidden cases of domestic violence; may change perceived acceptability of violence in the relationship; would make it easier for women to access support services; helps maintain the safely of the woman and change health professionals' knowledge and attitude towards domestic violence and hence reduce the social stigma attached to it.

Spiritual/Religious Leader

Nagassar et al., (2010) conducted a study in Central Trinidad to investigate the prevalence of domestic violence within the various socio-economic classes. They reported that women more likely sought help from a counsellor, psychological counselling, while some sought religious counselling. It has been noted that women who received positive social support when in an abusive relationship tend to cope better with the situation (Hadeed & El Bassel, 2006; Liang et al., 2005). The various sources of social support available to Afro-Trinidadian women who

[25] A systematic review utilizing the data bases: Medline, CINAHL and Embase, in which 20 papers met the inclusion criteria such as, women's attitudes towards health professionals screening for domestic violence.
[26] 198 women in a hospital setting who were not intoxicated, critically ill or confused completed a questionnaire about domestic violence.

experience Intimate Partner Violence (IPV)[27] were also explored by Hadeed and El Bassel (2006) through the use of interviews. The findings were similar to those of Nagassar et al., (2010) however; the majority of women (70%) had social support in the form of a family member. Other forms of social support came from friends and co-workers, employers and supervisors, police and courts, counselling, physicians and nongovernmental agencies (Hadeed & El Bassel, 2006).

Additionally, Hadeed and El Bassel (2006) found that help from the church came in the form of prayers, spiritual songs, and friendships in the church community, talking to their parish priest, or receiving counselling at their place of worship. Despite some church counsellors supporting traditional gender roles, women found the support helpful. Conversely, although positive support from the church community was received, several of the women interviewed believed that a higher power could heal their husbands, whereas other said that prayers helped in diminishing fear of their abusive partners. For a few of the participants, religious beliefs about the sanctity of marriage provided a measure of comfort in knowing they were abiding by the will of a higher power (Hadeed & El Bassel, 2006).

This brings into the discussion the notion of spirituality and religion with regard to domestic violence and help-seeking. Spirituality can be said to play an important role in life satisfaction (Samuel-Hodge et al., 2000). Spirituality tends to influence most domains of some women's lives, and positively impacts on the health of the woman (Hickson & Phelps, 1998; Maloy, 2000; Mattis, 2000). Each individual tends to create a different personal definition of spirituality, and this is greatly influenced by culture, socio-economic class and gender (Wade-Gayles, 1995).

Potter (2007) utilizing in-depth semi structured life-history interviews (40), examined African-American women's use of religious services and spirituality for assistance in leaving abusive relationships. She noted that research in this area is lacking, and a large amount of literature focuses on the responses of women to their abuse. However, Banks- Wallace and Parks (2004) also examined African-American women's perspectives on spirituality when it came to domestic violence. They indicate that women's stories about spirituality were connected to well-being and

[27] Another term for domestic violence

health. The women said they reached new understanding about domestic violence as they continued to seek spiritual guidance, and after consultation with older women and conversations with God or studying spiritual books, the women state that they came to the conclusion that domestic violence was not a part of God's plan for their life, but that spirituality provided a foundation for women's healing journey (Banks-Wallace & Parks, 2004).

Thus, even though spirituality did positively impact some of the women with regard to dealing or coping with their abusive situation Giesbrecht and Sevcik (2000) in their study utilizing a naturalistic methodology, noted that many women who survived abuse turned to religious organizations for support of some kind. Some of the women felt that either their community minimized, enabled the abuse, or denied that the abuse was occurring. Negative religious coping suggested that God was punishing the individual in some manner, or that God had abandoned the women (Fallot & Heckman, 2005). Thus, it may be argued that the women may have experienced transfer-appropriate processing, in which negative emotions elicited negative memories. Whereas, if the social support received was considered to be positive, it proved to be a vital element in the recovery of the individual (women), more specifically in the rebuilding of their lives and family relationships. It was felt by some of the victims that with unconditional love and acceptance from a being higher than themselves (God), a feeling of healing and hope was restored after a distressing period (abusive relationship); (Giesbrecht & Sevcik, 2000). According to Coyle (2001) spirituality may help some women to cope with adversity and may help to promote a positive, calm and harmonious state of mind; and may provide a sense of purpose to one's life (Coyle, 2001).

With spirituality comes the notion of the role that religious leaders' play with women who experienced domestic violence (Copel, 2008). Copel (2008) in her study employing interviews with a convenience sample of 16 women, who were recruited via letters sent to them through an out-patients community mental health clinic they were attended in the United States of America, stated that religious leaders can have an important impact in intervening and preventing domestic violence, as some women with domestic violence experiences may view religious leaders as a source of help to which she can turn to obtain support. But many religious leaders are reluctant to deal with the notion that domestic violence is occurring in their congregations and that sometimes the men practicing the abuse are involved in various community projects (Gillum,

Sullivan & Bybee, 2006; conducted semi-structred interviews with 151 women). Patriarchal religions usually are governed by rules that were formed for, and by, males. Hence, these religions often demonstrate gender imbalances in leader representation and membership status (Johnson, 1997; Stark & Flitcraft, 1996). The traditions that emerged from these religions can greatly influence those congregations' beliefs about marriage and domestic violence. Therefore, interventions for victims of domestic violence may put pressure on the women to adapt and please her husband, leaving the victim open to the notion that the abuse is her fault (Copel, 2008).

In their study of American of religious leaders' perspective on domestic violence Levitt and Ware (2006)[28] found that some leaders appeared to experience loss aversion and thus it may be further reasoned that they experienced approach-avoidance conflict and struggle with the idea of freeing the woman from the abusive relationship and maintaining the marital relationship. Religious leaders described two main approaches they took regarding the advice they gave to the women. First, leaders who argued for equal relationships tended to interpret the scripture on marriage as communicating values that would have been appropriate for that period, but in these cases the traditions were upheld, but in a more modern context. Second, the religious leaders who held strong views regarding the sanctity of marriage emphasized practices instead of values. They believed that the best way in which to help the woman was to place the responsibility on the husband, and that either God wanted the woman to be in this marriage for a reason beyond their intelligibility, or the religious leader sought to find ways of releasing the woman from the marriage (Levitt & Ware, 2006).

Despite some religious leaders trying to find ways to help or release the woman from the abusive marriage (Levitt & Ware, 2006) others have used this to keep the woman in the abusive relationship (Potter, 2007). It has been suggested that some Christian women, who held more traditional beliefs that were grounded in religious teachings such as heterosexual relations and obeying the husband, may find it more challenging to leave the relationship (Knickmeyer et al., 2003). Some religious leaders are often said to make a choice based on their own volition and

[28] Interviews were conducted with 22 religious leaders from the Memphis area in The United States of America. Potential participants were contacted via letters and telephone asking them to participate in a study about faith and domestic violence. Participants estimated congregation size was between 200 to 4,500 members.

provide support to the abuser (Potter, 2007). The Bible is often quoted by religious leaders about the duties of the spouse. The quotation most often used is that from the New Testament, Ephesians (5:21-33) (Potter, 2007). The passage reads as follows:

> *"submit yourselves unto your own husbands, as unto the Lord. For the husband is the head of the wife, even as Christ is the head of the church…. Therefore, as the church is subject unto Christ, so let the wives be to their own husbands in everything"* (2007, p. 266).

Previous research has suggested that many Muslim communities tends to provide inadequate support for victims of domestic violence (Bowker, 1988). Muslim leaders often tried not to become involved in domestic disputes, and tended to blame women for any abuse instead of working through the challenges experienced by the women (Alkhateeb, 1999). African-American Muslim women who sought assistance from members of Muslim communities, who subscribe to the notion that obedience is part of being a good wife, often experience many challenges to leaving the abusive relationship; Muslim abusers will often modify the Quran to suit their needs (Hassouneh-Phillips, 2001)[29].

Hinduism is considered one of the oldest religions in the world, which has no beginning or founder. Hindus believe that there is one creator and that all life should be cherished (Juthani, 2001). Hinduism is another one of the religions existing in Trinidad and Tobago; it is said that Hindus have maintained most of the tradition that was brought to this country by their ancestors, and this can be seen in their dress, food and festivals. But it has been asserted that Hindus in India tend to be more ritualistic that Hindus in the Western world (Juthani, 2001). Still there is some similarity between Hindus in India and those residing in Trinidad and Tobago.

Traditionally, a Hindu family comprises at least three generations living in the same house, the head of the household being the grandfather. Males are usually valued more than females and the woman gains power only after becoming mother-in-law to her son's wife (Juthani, 2001). This

[29] 17 American- Muslim women between the ages of 20 to 59 years old who either previously experienced domestic violence or did not participated in either individual or group interviews and life histories interviews participated.

concept still exists in Trinidad and Tobago today, but the traditional roles of the Hindu woman are fast changing (Maharajh, 2010). One similarity that still very much exists is that most Asian cultures are clearly concentrated in classic religious texts such as the Bhagavad-Gita which may contribute to how Hindu women conceptualize and deal with the notion of domestic violence (Purohit, 2001). Referral to a psychiatrist is only done after religious prayers and rituals have yielded no results (Juthani, 2001). This practice is still commonplace in Trinidad and Tobago, but not only for Hindus, but also for other religious and ethnic groups (Maharajh, 2010).

Summary

From the information presented in this section about domestic violence and help-seeking, medical doctors have an important role in screening and intervention for women, but because of various issues such as culture, time constraints, and fear of offending the women, they usually refrain from asking about domestic violence it (Elliot, Nerney, Jones & Friedman, 2002; Gerbert et al., 2002 & Sugg & Inui, 1992). But despite these self-imposed restrictions, many physicians do intervene to some point, and patients report finding it helpful (Gerbert et al., 2002; Ramsey et al., 2002 & Sethi et al., 2004). Additionally, spirituality and religious leaders' role and intervention in help-seeking for women with experience of domestic violence also seem to be an important one, but as with medical doctors, some are undecided on if and how to intervene (Banks-Wallace & Parks, 2004; Giesbrecht & Sevcik, 2000; Levitt & Ware, 2006). In Trinidad, as noted throughout this chapter, many members of the public usually come into contact with some sort of religious institution prior to attending a psychiatric clinic (Maharajh, 2010). Therefore, this thesis attempts to provide the women's view about their experiences of help-seeking, while also obtaining the medical doctors' and religious leaders' opinion about their views and resources with regard to domestic violence.

2:15 Research Questions

As mentioned previously, limited research exists into somatization disorder and its links to domestic violence in the Caribbean, and specifically, Trinidad. This study seeks to address this void in knowledge. Since both Afro- and Indo-Trinidadians may still practice many of the traditions brought with them to the island over 100 years ago (Maharajh, 2010); this thesis investigates both ethnic groups experiences of domestic violence and somatization disorder

drawing comparisons to international literature on the topic. This will be done in order to further investigate if somatization disorder and domestic violence experiences are indeed more common among Asian descendants living apart from their country of origin; as to date, there is little literature regarding this.

Additionally, as noted throughout this chapter, no attention has been paid to Afro-Trinidadian women with regard to if they also somatize their distress and what links this may have to their domestic violence experiences, because there currently exists no literature on these intersecting issues. Hence, since the ethnic composition of Trinidad and Tobago is approximately 41 percent Indo- and 41 percent Afro- Trinidadian (Government of Trinidad & Tobago, 2008; Hadeed & El-Bassel, 2006), this study will further address this problem and attempt to provide novel research by further studying these two ethnic groups in Trinidad.

Therefore, exploring both Indo- and Afro-Trinidadian women's experiences may shed some light on somatization disorder and domestic violence and determine if there may be some sort of cultural or social link (Affleck et al., 2001; Baron, 1998; De Gucht & Maes, 2006; Mai, 2004 & Prins et al., 2004), that is, if Indo- Trinidadian culture has impacted in any way on Afro-Trinidadian women, thus influencing Afro- Trinidadians ways of coping and expressing distress, or, as some research suggest, that somatic symptoms may be genetically or organically based (DSM-IV-TR, 2002 ; Kristal-Boneh et al., 1998; Nicmi, Portin & Hakala, 2002; Mai, 2002; Reif, Shaw & Fichter, 1998).

Furthermore, as noted, help-seeking for somatization disorder and domestic violence is a very important aspect to both issues (Gerbert et al., 2002; Sharpe & Carson, 2001), and since no research has been conducted in Trinidad on somatization disorder, its links to domestic violence and help-seeking avenues by women of Indo- and Afro- ethnicities, this thesis also seeks to uncover information regarding the various help women sought. Specifically, medical doctors and religious leaders' role in help-seeking for both Indo- and Afro-Trinidadian women who have somatization disorder and experiences of domestic violence, because, as noted, some sort of spiritual or religious influence remain today as the first contact for the majority of patients (both men and women) in Trinidad (Maharajh, 2010). Therefore, Maharajh (2010) has recommended

that a paradigm shift of the population and church leaders is needed with greater collaboration among these groups. It is hoped then that findings from this thesis will help to understand why persons (women in particular) gravitate towards religious sources for help. Through three studies this thesis will therefore, attempt to answer the following research questions:

1. Do Indo-Trinidadian women have a higher occurrence of somatization disorder and domestic violence than Afro-Trinidadian women? (Study one).

2. What sources of help do Indo- and Afro-Trinidadian women seek for their general problems, somatic symptoms and domestic violence experiences? (Study one).

3. Do Indo- and Afro-Trinidadian women find medical doctors and religious leaders supportive when dealing with their somatic symptoms and domestic violence experiences? (Study two).

4. Do medical doctors have better resources, greater willingness to explore and better intervention strategies than religious leaders when meeting with women who may have somatization disorder and domestic violence experiences? (Study three).

Chapter 3
Methodology

3:1 Introduction

This thesis sought to report and compare experiences of domestic violence and somatization disorder amongst Indo- and Afro-Trinidadian women living in Trinidad. Study one (chapter 4; occurrence of somatization disorder, domestic violence and help-seeking) investigates the occurrences of somatization disorder and domestic violence, while study two (chapter 5; Interpretative Phenomenological Analysis (IPA) of help-seeking) maps the routes to help the women took and explores the impact these had on their outcomes. Study three (chapter 6; religious leaders and medical doctors intervention) builds on studies one and two, and focuses on help agencies' knowledge and resources about women with somatization disorder and domestic violence experiences. In order for these studies to have been accomplished a mixed methodological approach was adopted.

This chapter provides an overview and rationale for the research methods adopted throughout this thesis. Mixed methods research is defined in relation to this thesis. This chapter also highlights the strengths and weakness of employing a mixed methods approach in relation to this thesis, and concludes with a section describing the type of mixed method adopted (sequential).

3:2 Different Approaches to Research

According to Leeuw (2005), one of the major challenges that researchers encounter is deciding which method(s) of data collection should be employed for the chosen study. Within the research realm there are various approaches one can adopt (Ivankova, Creswell & Stick, 2006). First, are quantitative research methods. These methods involve enumerating things, and using numbers to describe a relatively large group of people. They concentrate mainly on a positivistic view of the world; the use of science to explain and support findings (Potter, 1996). For example, if one wants to explore the differences between men's and women's earnings this would be a useful approach, but if one wanted to determine the meaning that people place on earnings, quantitative research may not be appropriate (Esterberg, 2002). It would be at this point that a qualitative research method would be more helpful. Qualitative research is concerned with scrutiny of social

phenomena; it examines the subjective nature of human life, where the researcher will try to understand the meaning of the social event in relation to the people experiencing it (Esterberg, 2002). The qualitative tradition is said to have emerged from an idealist argument, that individuals subjectively and creatively construct meaning for themselves and this phenomenon cannot in any way be captured using a scientific approach (Potter, 1996).

Johnson and Onwuegbuzie (2004) assert that those who believe that qualitative and quantitative research are separate have been at odds with those who advocate for a mixed methods approach. They contend that quantitative researchers believe that "social observations should be treated as entities in much the same way that physical scientist treat physical phenomena" (Johnson & Onwuegbuzie, 2004, p. 14). Additionally, the authors also argue that the qualitative researcher (observer) should be completely separate from the phenomena being studied (participants), thus, maintaining objectivity, context and time free generalizations (Johnson & Onwuegbuzie, 2004). Whereas, qualitative traditionalists reject this notion, and instead put forward the argument for the superiority of humanism, constructivism, idealism and hermeneutics (Johnson & Onwuegbuzie, 2004; Sale, Lohfeld & Brazil, 2002). It has been asserted that constructivist research is based on the assumption that there exists more than one reality, which is due to the process of interpretation, where social actors negotiate meaning and understanding from the world around them. Although it can be argued that these methodological and philosophical approaches are oversimplified, still, the underlying assumptions pose challenges for the researcher who would like to adopt a mixed methods approach (Schulenberg, 2007).

Qualitative proponents further argue that "multiple-constructed realities abound" (Johnson & Onwuegbuzie, 2004, p. 14), and that context and time free generalizations are neither possible nor worthwhile (Johnson & Onwuegbuzie, 2004). Furthermore, qualitative researchers often reject the passive and detached writing style that quantitative researchers adopt. Instead they prefer a more descriptive, verbatim and detailed description of the topic being studied (Johnson & Onwuegbuzie, 2004). While these researchers have made well-developed arguments for the non-combination of these methods, this thesis benefitted from adopting a mixed methodological approach for reasons which are discussed further in this chapter.

Johnstone, (2004), Johnston, Onwuegbuzie and Turner (2007) and Sale, Lohfeld and Brazil (2002) have all argued that there are many reasons why qualitative and quantitative methods can and should be combined. Based on the above, several investigative options were considered for this thesis (for example, a strictly quantitative or qualitative approach). However, the methodological stance that was adopted for this thesis is a mixed methods one (specifically a sequential mixed method). It has been further debated that both quantitative and qualitative researchers strive to understand the world in which we live, and are devoted to not only understanding, but also improving for example, the social problem(s) being examined (Sale, Lohfeld & Brazil, 2002). In relation to this thesis, the occurrences of somatization disorder and domestic violence experiences among Indo- and Afro-Trinidadian women are explored. Some research suggests that somatization disorder appears to be more prevalent in Asian populations and in women (Bhui, 2002; Chaturvedi & Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Sarason, 199; Saxena, Nepal & Mohan, 1988). Additionally, the resources available from help agencies and their willingness to intervene with women with these intersecting issues are also explored. As noted above, Esterberg (2002) argues that based on these results, a method that produces statistical representation may be best suited. Therefore, in order to investigate these topics within Trinidad, numerical representation of the data gathered is appropriate, thus, employing a quantitative approach for these aims is appropriate.

However, some researchers have argued that based on the topic being investigated that the use of "a comprehensive range of quantitative and qualitative methods" (Sale, Lohfeld & Brazil, 2002), may be more beneficial than data gleaned only from one perspective (Sale et al.,, 2002). Furthermore, utilizing a qualitative approach also affords the researcher insight into issues that were not pre-determined that the women may have experienced as a result of these interconnecting issues (Schulenberg, 2007). This thesis also sought to obtain insight into the women's lived experiences, that is, what meaning they have attached to their help-seeking experiences for their somatic symptoms and domestic violence behaviour. For that reason, statistical data alone may not have been sufficient; instead a richer explanation using verbatim quotes may achieve this (Brocki & Wearden, 2006; Pringle & Drummond, 2010). Therefore, a qualitative approach, utilizing an Interpretative Phenomenological perspective is employed for

this aspect of this thesis. From the above it is argued that this study benefitted equally from utilizing a combination of questionnaires and interviews.

3:3 Defining mixed methods

Several researchers have sought to define mixed methods research (Johnson, Onwuegbuzie & Turner, 2007), as illustrated by some of these examples: Bergman (2008) defined mixed methods research as the combination of at least one quantitative and one qualitative component in a single research project. Whereas, Creswell defines mixed methods as "a research design (or methodology) in which the researcher collects, analyzes, and mixes (integrates or connects) both quantitative and qualitative data in a single study or a multiphase program or inquiry" (Johnson, Onwuegbuzie & Turner, 2007, p. 119). While Tashakkori and Teddie further contends that "mixed methods research is a type of research design in which qualitative and quantitative approaches are used in type of questions, research methods, data collection and analysis procedures, or in inferences" (Johnson, Onwuegbuzie & Turner, 2007, p. 120).

However, for this thesis the definition provided by Udo Kelle (cited in Johnson, Onwuegbuzie & Turner, 2007, p. 120) was adopted:

> "Mixed methods mean the combination of different qualitative and quantitative methods of data collection and data analysis in one empirical research project. This combination can serve for two different purposes: it can help to discover and to handle threats for validity arising from the use of qualitative or quantitative research by applying methods from the alternative methodological tradition and can thus ensure good scientific practice by enhancing the validity of methods and research findings" (Johnson, Onwuegbuzie & Turner, 2007, p. 120).

Additionally, these researchers argue that mixing methods allows for a deeper understanding and fuller picture of the topic(s) being investigated (Johnson, Onwuegbuzie & Turner, 2007). This definition, as opposed to others (for example, those cited above by Creswell and Bergman) comprehensively incorporates all elements of this thesis. Other definitions lacked this component as they only offer a brief synopsis of what mixed methods are. For example, Kelle's definition

addresses issues of validity that may arise, and how each research tradition deals with such, whereas, others neglect to mention these aspects of mixed methods. Moreover, the chosen definition maintains that mixed methods provide a "fuller" and "deeper understanding" of the topic being explored; this is what this thesis seeks to accomplish regarding Indo- and Afro-Trinidadian women's experiences of somatization disorder, domestic violence and help-seeking. Furthermore, this definition addresses the weakness of adopting only one method. Utilizing both a qualitative and quantitative approach may increase the trustworthiness of the results. For example, the findings gathered from statistical data (occurrences of somatization disorder and domestic violence; religious leaders and medical doctors intervention) is further supported by qualitative interviews and vice versa, by exploring the women's feeling regarding these intersecting issues. At this point it should be noted that there are many different types of mixed methods research. Some of the most common are: concurrent, sequential, conversion, fully integrated and multilevel (Teddie & Yu, 2007; Hanson et al., 2005; Teddie & Tashakkori; 2006). These are further defined and discussed in relation to this thesis later in the chapter.

3:4 Strengths of mixed methods

There are numerous benefits in employing a mixed methods approach. Some of which includes; triangulation, complementary, developmental, expansion and diversity.

Triangulation

It should be noted that there are many forms of triangulation, for example data, investigator and theoretical. Triangulation is "seeking convergence and corroboration of findings from different methods that study the same phenomena" (Onwuegbuzie & Leech, 2004, p. 770). Denzin (1978) and Williamson (2005) spoke about *data* collection in triangulation. Williamson (2005) debates that triangulation utilizes a 'multi-method' approach to collecting data in an effort to avoid biases and errors inherent in using a single methodology. Specific to this thesis, data triangulation (questionnaire and interviews) will enhance the validity of the each research approach by addressing the same topic (somatization disorder, domestic violence and help-seeking) from different data collection perspectives, thus obtaining a comprehensive understanding of these areas.

The second type of triangulation is: *investigator* triangulation, this involves more than one researcher in the research process (Denzin, 1978; Williamson, 2005). Despite this thesis requiring only one principal investigator and according to investigator triangulation this may be a disadvantage. For the purpose of this thesis it may be argued otherwise, as having one investigator actually benefited the research process. For example, when exploring the occurrences of somatization disorder and domestic violence experiences, only one investigator collected data from the women. This was decided upon because of the sensitive nature of the topics, thus, having only one trained investigator ensured that if challenging situations arose these would be dealt with by a professional (e.g. a trained counsellor). Furthermore, employing one investigator during the different phases assisted in building rapport and trust because they already contact with the researcher and may have felt comfortable to disclose confidential information to the same researcher during the second phase of data collection (interviews).

Thirdly, is *theoretical* triangulation. With this form of triangulation the researcher utilizes more than one theory or to analyse and interpret the results (Denzin, 1978; Williamson, 2005). Since this thesis investigated intersecting issues (somatization disorder, domestic violence experiences and help-seeking), it was important to explore the various theories put forward for the occurrences of these intersecting issues. For example, some researchers have reported that Asian women are more likely to have somatic symptoms (Bhui, 2002; Chaturvedi & Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Sarason, 1999; Saxena, Nepal & Mohan, 1988) as a result of domestic violence experiences (Brown, Schrag & Trimble, 2005; Hegarty, Gunn & Small, 2004; Holloway & Zerbe, 2000; McCauley, Kern & Kolodner, 1995; Samelius, Wijma, Wingren & Wijma, 2007 & 2008; Righter, 1999). Thus, several theoretical explanations for these intersecting issues have been proposed regarding this link. Consequently, theoretical triangulation allows for connections to be made between these theoretical proposals, that is, probable explanation for the associations between somatization disorder and domestic violence among Indo- and Afro-Trinidadian women.

Apart from the benefits related to the types of triangulation, that are also numerous advantages associated with employing triangulation itself. Johnston, Onwuegbuzie and Turner (2007) have argued that triangulation enables the researcher to have more confidence in the findings obtained

as it has been argued that triangulation produces richer and thicker data[30], and is comprehensive. Additionally, as opposed to utilizing one research method, a mixed method approach may unearth contradictions in the results through triangulation. This thesis benefits greatly from this, as, combining questionnaires and semi-structured interviews ensures that a comprehensive understanding of help-seeking for somatization disorder and domestic violence experiences is achieved, thereby, providing a more comprehensive representation of each of the components being investigated, while each research method compensates for any short-comings of the other (Bergman, 2008).

Complementary and Diversity

Other strengths of combining methods are that it is complementary and diverse. First, the *complementary* aspect is that "overlapping and different facets of a phenomenon may emerge" (Johnstone, 2004, p. 264). Furthermore, it has been also argued by Bergman (2008) that utilizing a mixed methods approach enables the researcher to obtain a 'complementary' view of the phenomenon being investigated and to gain a better understanding of the relationship between the topics. *Diversity*, another strength of mixed methods, is a very similar aspect to that of complementarity. As also reasoned by Bergman (2008) combining methods allow the researcher to gain divergent views about the same phenomenon, thus allowing for the data to be contrasted and compared. For these reasons, mixing of methods for this thesis allowed the researcher to gain insight into how women with somatic symptoms and domestic violence experiences view their help-seeking experiences, while at the same time gain insight into how the help agencies (religious leader and medical doctors) approach and view these interrelated topics.

Development and Expansion

Bergman (2008) contends that mixing methods is *developmental*, in that questions that emerge from one segment can provide further direction regarding what should be explored next. Furthermore, other researchers Bergman, 2008; Johnstone, 2004; Onwuegbuzie & Leech, 2004) have also argued that combining methods also enables *expansion*. For instance, expansion

[30] Accurately describes and interprets social action within the context in which it took place. It also assigns intentionality and purpose to these actions; capturing the emotions, thoughts and as well as the complex social interaction among the participants in such a manner that the behaviour also becomes meaningful to an outsider (Ponterotto, 2006).

provides the opportunity for the researcher to fully explore an issue that may have emerged from another aspect of the study. Moreover, expansion permits the researcher to compensate for the weakness of one approach by using another (Bergman, 2008). As a result, this thesis utilizes information gathered from one phase to direct which sources of help should be focused on in the second and third phase of data collection. In so doing, the sources of support and reason given by the women for their satisfaction or discontentment with these sources in phase one of data collection enables the researcher to focus and more explore these through interviews in the second data collection phase.

However, despite these advantages seemingly providing this thesis with the direction needed, mixed methods are not without their challenges. Some researchers (e.g. Brannen, 2005; Bryman, 2004; Creswell, Planto & Clark, 2007; Leech & Onwegbuzie, 2007; Mertens, 2010) are opposed to this approach. The disadvantages are critically discussed below and recommendations outlined regarding how this thesis seeks to overcome these.

3:5 Weaknesses of mixed methods

Leech and Onwuegbuzie (2007) and Mertens (2010) have questioned whether the mixed methods approach is in its infancy, adolescence or maturity, or, if mixed methods are at a point where too much convergence may result in many issues related to mixed methods remaining unaddressed, unresolved or even unknown. But still the use of mixed-methods has been hailed as a response to this long lasting, remarkably unproductive debate involving the advantages and disadvantages of qualitative versus quantitative research (Creswell, Planto & Clark, 2007).

However, when considering whether it is feasible to mix methods in research, there are numerous challenges that can arise (Woolley, 2009). There exist well-rehearsed and long standing debates over the issue of whether it is feasible to combine quantitative and qualitative research (May, 2006). Researchers who argue against mixing methods contend that both qualitative and quantitative research approaches are based on different epistemological and ontological commitments that will hinder the combination of both research approaches in any meaningful manner (Brannen, 2005; Bryman, 2004; Onwuebuzie & Leech, 2005). This means that each type of research operates within a different conception of reality, that is, a different set

of assumptions about the definition of reality (ontology) and the acknowledgement of reality (epistemology) and the different ways in which we understand reality (methodology) (Lincoln & Guba, 1985).

Thus, while these researchers (Brannen, 2005; Bryman, 2004; Lincoln & Guba, 1985; Onwuebuzie, 2005) argue that each method operates on different epistemology, ontology and methodology and cannot be combined. Adopting a strict quantitative approach would assume that reality is based on 'numbers', that somatization disorder and domestic violence experiences can be quantified, although this may be accurate on the other hand, a qualitative approach examines how individuals make sense of these experiences; for example, understanding the women's somatic symptoms, domestic violence experience, with regard to help-seeking. From the combining of methods in this thesis, through theoretical and methodological triangulation this allowed for this and other advantages of mixing methods to become evident, such as, it allowed for expansion, diversity and overlapping facets of the phenomenon which were discussed earlier in this chapter.

Still, the decision to mix methods when conducting research is becoming more recognized (Onwuegbuzie & Leech, 2004). However, Sale et al., (2002) argue that the debate about whether one should employ a mixed methods approach is behind us, and thus researchers are free to employ this method to "carry out relevant and valuable research" (p. 44). The researchers' further assert that mixed methods research is now being adopted uncritically by a new a generation of researchers who have overlooked the underlying traditions behind the qualitative-quantitative debate. Sale et al., (2002) further argue that the new generation of researchers has concluded that the differences between the two research traditions are purely technical (Sale et al., 2002). Combining methods may be based on a pragmatic viewpoint, that there exists much similarity between both qualitative and quantitative methods (Brannan, 2005; Bryman, 2004; Onwuegbuzie & Leech, 2005). Furthermore, Tashakkori and Teddie (1998) argue that the pragmatist will embrace both approaches, and embrace the plurality of methods and multiple philosophies. By so doing a broader, richer picture can be obtained about the specific topic being addressed.

However, one can argue that in relation to this thesis, adopting a mixed methods approach may support the researcher in obtaining a broader understanding of the topics being investigated. As noted, some of the studies in this thesis required numerical representation, whereas, other aspects focus on the women's lived experiences, providing a deeper understanding and fuller picture of the topics being explored (Jonhson, Onwuegbuzie & Turner, 2007). It can be said that if a pure quantitative approach was adopted for this thesis then insight into the women's emotions about their help-seeking behaviours may have been overlooked. For example, if the women were asked to write about their feelings they may not have been able to express their experiences, feelings or emotions in the same manner as in an interview. However, on the other hand, if a strict qualitative approach was utilized, then the total number of occurrences of somatization disorder and domestic violence may not have been successfully obtained.

Combining both quantitative and qualitative methods enabled pre-determined data from the questionnaire to be collected, while interviews allowed for the exploration of topics that may not have been foreseen. Thus, data gleaned facilitated stronger conclusions to be drawn. For example, it has been suggested that Indo-Trinidadian women have a higher occurrence of domestic violence experiences (Hadeed & El Bassel, 2006; Kassiram & Maharajh, 2010; Maharaj et al., 2010; Rawlins, 2000), thus, numerical data enabled the research to explore this issue, while at the same time semi-structured interviews permitted the researcher to explore the possible reasons why Indo-Trinidadian women might experience more domestic violence than Afro-Trinidadian women. Therefore, adopting one research method would not have been feasible in achieving addressing the research questions of this thesis. A mixed methods approach provides completeness, as it will provide a fuller understanding of the issues being explored (Bergman, 2008; Johnson & Onwuegbuzie, 2004; Leahey, 2007; Malina, Norreklit & Selto, 2011).

Summary

There are numerous advantages in adopting a mixed methods design, specifically for this thesis. In order for the successful execution of a mixed method design a combination of questionnaires and semi-structured interviews were employed. Within each of these research designs there are several positives as well as negatives. For example, questionnaires provides access to a large

number of participants at a relatively low cost to the researcher (Geinsinger, 2010), while interviews will encourage rapport to be built and evoke empathy, and allow for greater flexibility which will then enable the interviewer to explore novel areas with the interviewee, thus producing richer data (Smith & Osborn, 2007) . The rationale for each of these in relation to the particular study is discussed in-depth at the beginning of each study chapter (chapters four; occurrences of somatization disorder and domestic violence; five, IPA analysis of help-seeking and six, religious leaders and medical doctors intervention).

3:6 Sequential mixed methods

As noted earlier, there exist many mixed methods designs (Ivankova, Creswell & Stick, 2006). Tashakkori and Teddie (2003) have identified approximately forty different mixed methods designs. While Creswell et al., (2003) spoke about six designs that are most often used such as, concurrent and sequential mixed methods. In concurrent mixed methods both qualitative and quantitative research are conducted independently and then inferences made from each strand of the results (Teddie & Tashakkori, 2006). Consequently, with this type of mixed methods the findings from each study do not inform the other, whereas, with sequential mixed methods the results of each strand of data collection inform and direct the second/third phase of data collection. This thesis sought to not only gather statistical data but also understand the women emotions and feelings regarding the intersecting issues. Therefore, it is essential that specific participants be selected, for example, the data gathered from study one seeks to inform selection of participants for study two. That is, for the interview phase of this thesis it is required that the women have somatic symptoms and domestic violence experiences. Furthermore, the information gathered from participants in studies one and two assisted in selecting the sample for study three. For these reasons, a sequential mixed method as opposed to a concurrent mixed method was chosen (Johnson, Onwegbuzie & Turner, 2007; Onwuegbuzie & Leech, 2004; Teddie & Tashakkorie, 2006).

Teddie and Tashakkorie (2006) further defined sequential mixed methods as “designs in which there are at LEAST two strands that occur chronologically (Quantitative⟶Qualitative or Qualitative⟶Quantitative)” (Teddie & Tashakkorie, 2006, p. 21). Thus, the researcher first designs the study, and then collects the data, after which analysis occurs for the quantitative part

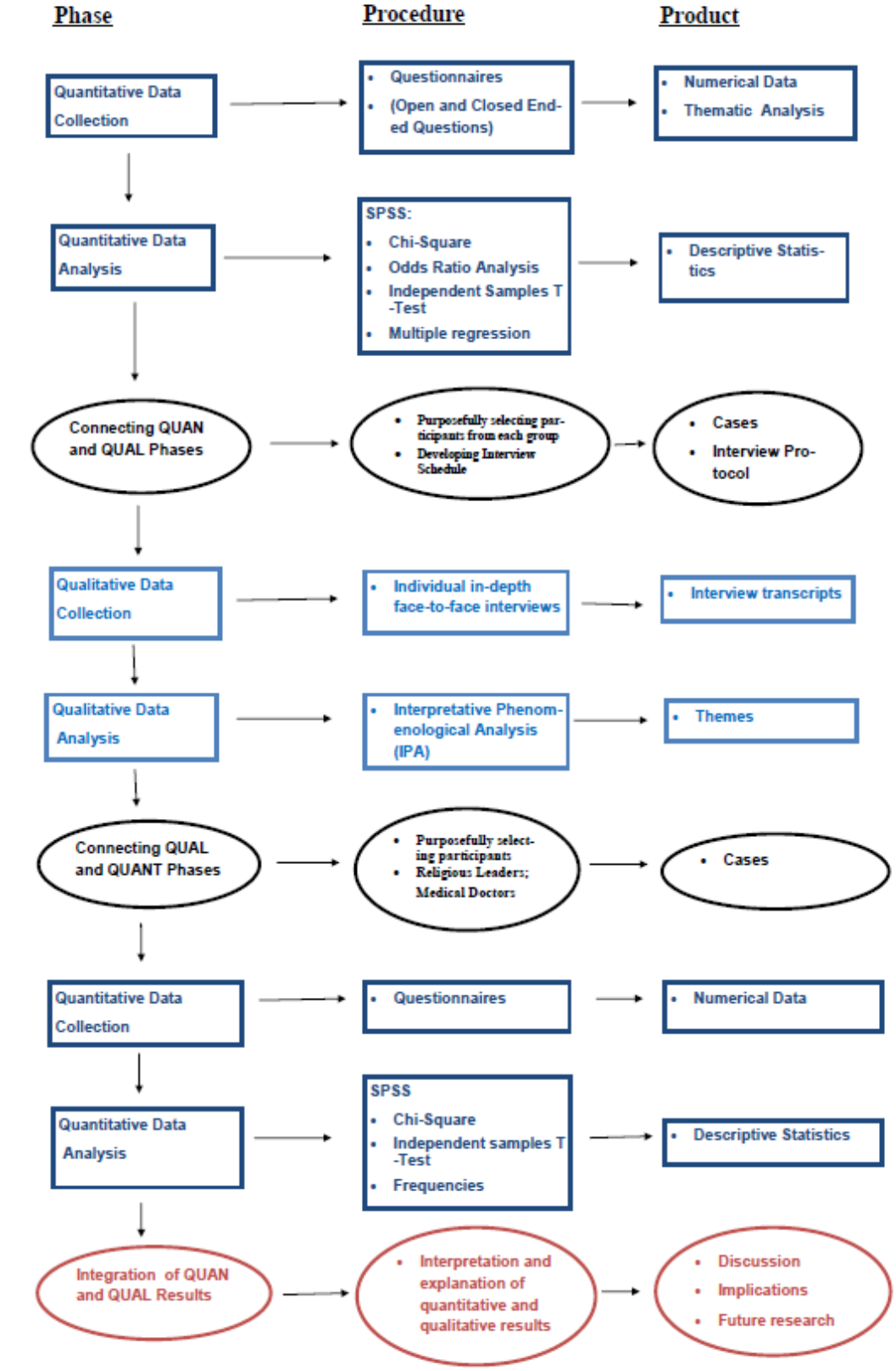
of the study, and then repeats for the qualitative phase. Therefore, by adopting this approach, the findings from the quantitative data collected will be used to provide a general understanding about the topic. The results from the first phase of data collection (occurrences of somatization disorder and domestic violence) provided the researcher with information regarding the overall occurrences of somatization disorder and domestic violence experiences. Additionally, it further directed the researcher to the sources of help most often pursued by the women for these intersecting issues, thereby, providing the sample for studies two and three. This also enabled the researcher to confirm or disconfirm findings from the first phase of data collection (Ivankova et al., 2006; Onweuegbuzie & Leech, 2004; Teddie & Tashakkori, 2006).

However, Ivankova et al., (2006) contends that applying a sequential mixed methods design may be challenging, as this design may take a considerable amount of time to complete, and may also require significant resources to collect and analyse the data. Furthermore, the data collected in the first phase may not yield any significant results (Ivankova et al., 2006). Nonetheless, the researchers noted that while it may be challenging, these designs can be easily conducted by a sole investigator compared to other methods, for example, concurrent mixed methods. The reason being is that it is easier keep each strand of the research separate and the studies usually unfold much slower and in most cases in a predictable manner (Teddie & Tashakkori, 2006).

Additionally, when utilizing sequential mixed methods, data analysis always occurs before all of the data in the overall study are collected (Onwuebuzie & Leech, 2004). Thus, each phase of data collection is completed before the other begins. Also, either all analysis or preliminary results are gleaned from the preceding study in order to inform the succeeding study: this creates a logical sequence for data collection and analysis. Moreover, sequential mixed methods permit the researcher to address some of the issues explored in the literature in one phase of the study and then utilize this information in an exploratory manner in the next phase (Teddie & Tashakkori, 2006). As, noted throughout this chapter, each phase of data collection informs the next. Thus as discussed several times, statistical findings from the first phase of data collection is utilized in this exploratory manner in the second and third phase of data collection and analysis.

Accordingly, this thesis adopted aspects of Teddie and Tashakkori's (2006) framework, while, at the same time, incorporating a modified version of Ivankova et al.,'s (2006) sequential mixed methods design. Their design included only two phases, whereas, this thesis incorporated a third phase, as noted in figure 2 on the following page.

Figure 2: Sequential Mixed Methods for this Thesis



From figure 2 on the previous page it may be noted that data analysis from study one informed and directed study two. That is, study one screened for the occurrences of somatization disorder and domestic violence experiences among Indo- and Afro-Trinidadian women. Thus, study two comprised of women who fit this criterion and these women were then interviewed. The professionals (religious leaders and medical doctors) identified were then surveyed in study three of this thesis. Therefore, the use of sequential mixed methods allows for analysis, data collection and inferences to be completed in a sequential manner (Onwuebuzie & Leech, 2004).

Summary

This chapter discussed the various research approaches (quantitative and qualitative) adopted for this thesis. It outlined the reasons for adopting a mixed methods and specifically, a sequential mixed methods approach. By adopting a mixed methods approach both statistical data and a more descriptive, emotional representation of the intersecting issues was presented. Additionally, the utilization of sequential mixed methods ensured that the appropriate sample and analysis was chosen. As, the previous study accurately informed the direction the proceeding studies should follow; ensuring a precise representation of the findings and discussion. An important aspect of adopting a mixed methods design is triangulation. With regard to this thesis, triangulation assisted in enhancing the validity of the findings, as two approaches to data collection (questionnaires and interviews) were utilized. This ensured that data was both rich statistically while at the same time providing an in-depth analysis of the women's lived experiences of their somatic symptoms, domestic violence experiences and help sought for these intersecting issues.

Chapter 4

Somatization disorder and domestic violence and among Indo- and Afro-Trinidadian women and their help-seeking choices

4:1 Introduction

The intention of this study was to add to our knowledge and understanding of Indo- and Afro-Trinidadian women who somatize their distress and who have experienced domestic violence. This study also investigated the differences and similarities between Indo- and Afro-Trinidadian women with regard to the occurrence of somatization disorder and domestic violence, and if there were any links between these issues. The sources of help the women sought for their general problems, somatic symptoms and domestic violence experiences were also mapped, and the impact these had on their outcomes are also discussed.

This chapter therefore highlights the methodology adopted and the rationale for achieving this. It also outlines in detail the various aspects of this methodology by providing an in-depth account of the participants, research design, sampling method, materials used and procedure to collect and analyse the data. Finally the data is presented in a manner that merges both qualitative and quantitative information, so as to provide a broader picture of the Indo- and Afro-Trinidadian women who somatized their distress, experienced domestic violence and the help that they sought.

4:2 Rationale for adopting a mixed methodological approach for study 1

In order to increase our knowledge with regards to somatization disorder and domestic violence, specifically, in Trinidad among Indo- and Afro-Trinidadian women, a quantitative-driven mixed methods study was conducted. Utilizing this approach, this study addressed the research questions: '*Do Indo -Trinidadian women have a higher occurrence of somatization disorder and domestic violence than Afro -Trinidadian women?'* Secondly, *'what sources of help do Indo- and Afro-Trinidadian women seek for their general problems, somatic symptoms and domestic violence experiences?'* This was achieved by illustrating the differences in somatization disorder and experiences of domestic violence among the ethnicities by drawing statistical comparisons,

while at the same time obtaining a better understanding into help-seeking through the utilization of thematic analysis.

It has been argued that quantitative research methods concentrate mainly on a positivistic view of the world and the use of science to explain and support findings (Potter, 1996) compared to qualitative methods which focus on the participants' own categories of meaning they apply to their experiences (Johnston, Onwuegbuzie, 2004). Thus, a quantitative method was chosen to explore the hypotheses of this study listed below as it enabled the researcher to gain statistical representation (which was required at this stage) of the occurrences of somatization and domestic violence among Indo- and Afro-Trinidadian women.

Hypotheses:

H1: Those Trinidadian women who somatize distress are more likely to have experienced domestic violence than those who do not.

H2: Indo – Trinidadian women will have a higher prevalence of somatization disorder than Afro-Trinidadian women.

H3: Indo – Trinidadian women who have experienced domestic violence will somatize distress more than Afro-Trinidadian women.

However, even though a quantitative approach was best suited for this portion of the study there was also a qualitative element to it. Advocates for qualitative research contend that it is concerned with the scrutiny of social phenomena; it examines the subjective nature of human life, and the researcher tries to understand the meaning of the social event in relation to the people experiencing the event(s) (Esterberg, 2002). As opposed to quantitative researchers who may be only concerned with obtaining statistics (Potter, 1996). Since the aim of this phase of data collection was to gain insight into the women's help-seeking options and the meaning they attached to the assistance received; a qualitative approach was chosen to aid in achieving the following aims:

1. To explore experiences of somatization disorder and domestic violence among a sample of Indo- and Afro-Trinidadian women from the general public.
2. To explore the sources of help that domestic violence victims and women who somatize distress seek.

The qualitative approach taken to achieving the above aims assisted this study to examine the meaning the women held about the help they sought for their general problems, somatic symptoms and domestic violence experiences. This aspect, together with quantitative data, also helped to inform study two (see chapter 5; IPA analysis of help-seeking for Indo- and Afro-Trinidadian women), by identifying places from which the women sought help and how they felt about the help received: this information was the basis for the interviews in study two.

Therefore, a mixed methods approach was the best option as it facilitated in fulfilling the aims of this study. Furthermore, Bergman (2008) and Schulenberg (2007) have both argued that mixed methods are used to gain complementary views about the same phenomenon, and leave room for diversity as they provide a broad representation of the same phenomenon being studied, as oppose to utilizing either a pure qualitative or quantitative approach. Thus, this study was able to accomplish this by incorporating both the lived experiences of the women and statistical data. These two approaches complemented each other, thereby making a stronger case for the findings of this study.

4:3 Method for study one

4:4 Participants

Participants for study one comprised 150 females of East Indian (75) and African descent (75), third and fourth generation over the age of eighteen years, from the general public in Trinidad. Third and fourth generation Indo- and Afro-Trinidadian women were selected to control for cultural differences, as first and second generation Indo- and Afro-Trinidadians may still maintain the culture of their country of origin, and they may not represent the Trinidad culture and way of life. The women were recruited from the eight administrative boundaries (counties) in Trinidad. Individuals were excluded from the study if they were male and/or first or second generation East Indians and Africans. The study recruited women from the general public in an effort to provide an estimation of the occurrences of somatization disorder, experiences of domestic violence, or both, and what type of help they sought; distinctions between ethnicities with regard to the topics were also explored.

The participants were recruited using snowballing[31] through gatekeepers in each of the administrative counties in Trinidad. Gatekeepers were chosen based on their familiarity with each county, that is, if they had spent enough time (either working or living) within that county to be familiar with participants. Initially, there were a total of eight gatekeepers (2 males and 6 females) but as data collection progressed more gatekeepers were necessary; thus this study had a total of 18 gatekeepers (4 males and 14 females) spread across the various counties. Their occupations included; primary and secondary school teachers (currently employed and retired), psychologist, psychiatrist, senior lecturer, clerical, religious leader, police corporal and housewife. The ages of the gatekeepers ranged from 25 years to 71 years; and various ethnicities.

For the purpose of data collection, the number of women who were required from each county was calculated, using the population census information from the Central Statistical Office (CSO) for the year 2000[32] (Ministry of Planning, Housing and the Environment, 2008), in which the total number of women living in Trinidad and the number of women in each county was used (see appendix A).

The population census combined the number of women for some counties: St. Andrew and St. David, and Nariva and Mayaro, because of the low number of persons residing in these counties. Some factors that influence population distribution and density in Trinidad include: physical (mountain, forest, swamps); economic (industrial estates); social (water, entertainment areas) and historical (development of roads, ports and housing) (Wilson, 2005).

Table 2 shows the number of participants surveyed in each of the eight administrative boundaries (counties) in Trinidad.

[31] Identify one person who meets the inclusion criteria and then ask them to recommend other persons who fit the inclusion criteria (Trochim, 2006)

[32] Statistics were used from the year 2000 because it that was the last census population information that was available at the time of data collection.

Table: 2 Number of Women surveyed in each County (Administrative Boundaries) according to Ethnicity

County	***Indo-Trinidadian Women***	***Afro- Trinidadian Women)***	***Entire Sample***
St. David/St. Andrew	4	4	8
Nariva/Mayaro	2	2	4
St. George	34	35	69
Caroni	15	14	29
Victoria	9	9	18
St. Patrick	11	11	22
Total	75	75	150

Table 3 shows the demographic data by ethnicity for the entire sample. The majority of women were aged between 31- 40 years old, with a minority older than 70 years. Overall, more women were married and there were more married Indo-Trinidadian women than Afro-Trinidadian women. The majority of the women had been in their relationships for more than 20 years, with more Indo-Trinidadian women being in this category. The majority of the sample did not have any children, but fewer Afro-Trinidadian women had children than Indo-Trinidadian women in general.

Table 3 also shows that the majority of the women were Roman Catholic (Christian) with more Afro-Trinidadian women belonging to this faith. Afro-Trinidadian women also indicated that

they belonged to the Pentecostal, Anglican and other Christian denominations. More than a quarter of the women from both ethnicities were teachers.

The majority of the women had attained a tertiary level education. More Indo-Trinidadian women had only a primary level of education than Afro-Trinidadian women. The sample was equally divided when it came to secondary level of education. Finally, the majority of the women indicated their sexual orientation as heterosexual (94.7%); only a small percentage (4%) stated they were bisexual.

Table 3: Demographic Data by Ethnicity

Demographics	***Categories***	***Indo-Trinidadian Women (%)***	***Afro-Trinidadian Women (%)***	***Entire Sample (%)***
Age	18 – 12	13.3	25.3	19.3
	26 – 30	8.0	16.0	12.0
	31 – 40	26.7	22.7	24.7
	41- 50	22.7	20.0	21.3
	51- 60	12.0	6.7	9.3
	61-70	10.7	5.3	8.0
	70+	6.7	1.3	4.0
	Missing	0.0	2.7	1.3
Marital Status	Married	45.3	34.7	40.0
	Single	22.7	38.7	30.7
	Divorced	8.0	4.0	6.0
	Widowed	12.0	2.7	7.3
	Common-Law	4.0	4.0	4.0
	*Visiting	6.7	10.7	8.7
	Other	1.3	5.3	3.3

*The partners would stay at each other's home some nights of the week.
**The exchange rate of TT dollars to British Sterling Pounds is approximately TT$10.00 = £1.00

Table 3 con't: Demographic Data by Ethnicity

Demographics Data	***Categories***	***Indo-Trinidadian Women (%)***	***Afro-Trinidadian Women (%)***	***Entire Sample (%)***
	0-6 months	5.3	8.0	6.7
	7 months- 1 year	2.7	9.3	6.0
Length of	1-5 years	17.3	17.3	17.3
Relationship	5-10 years	13.3	13.3	13.3
	11-20 years	18.7	17.3	18.0
	More than 20 years	30.7	18.7	24.7
	Not specified	12.0	16.0	14.0
	None	32.0	49.3	40.7
	One	13.3	14.7	14.0
Number of	Two	24.0	16.0	20.0
Children	Three	18.7	14.7	16.7
	Four	10.7	4.0	7.3
	More than four	1.3	1.3	13
	Hindu	24.0	0.0	12.0
	Muslim	13.3	0.0	6.7
	Presbyterian	30.7	0.0	15.3
Religious	Baptist	9.3	8.0	6.0
Affiliation	Roman Catholic	8.0	32.0	20.0
	Pentecostal	14.7	22.7	18.7
	Anglican	1.3	6.7	4.0
	None	4.0	2.7	3.3
	Other	1.3	26.7	14.0

*The partners would stay at each other's home some nights of the week.
**The exchange rate of TT dollars to British Sterling Pounds is approximately TT$10.00 = £1.00

Table 3 con't: Demographic Data by Ethnicity

Demographic Data	***Categories***	***Indo-Trinidadian Women (%)***	***Afro-Trinidadian Women (%)***	***Entire Sample (%)***
	Teacher	32.0	25.3	28.7
	Retired	1.3	4.0	2.7
Types of	Student	2.7	9.3	6.0
Employment	Unemployed	1.3	0.0	0.7
	Self-employed	8.0	1.3	4.7
	Other	25.3	38.7	32.0
	Not Specified	29.3	21.3	25.3
	Less than $10,000.00	12.0	14.7	13.3
	$10,000 to $20,000	16.0	5.3	10.7
**Income earned	$21,000 to $40,000	8.0	10.7	9.3
per year ($TT)	$41,000 to $60,000	10.7	12.0	11.3
	$61,000 to $80,000	5.3	8.0	6.7
	$81,000 to $100,000	4.0	5.3	4.7
	More than $100,000	10.7	16.0	13.3
	Not Specified	33.3	28.0	30.7
Level of	Primary	18.7	5.3	12.0
Education	Secondary	30.7	30.7	30.7
	Tertiary	50.7	64.0	57.3

*The partners would stay at each other's home some nights of the week.
**The exchange rate of TT dollars to British Sterling Pounds is approximately TT$10.00 = £1.00

4:5 Materials

This study was designed to screen for Indo- and Afro-Trinidadian women who had somatization disorder, domestic violence experiences and their help- seeking choices. Therefore, a questionnaire was used. As argued above this method enabled the data to be gathered in a standardized manner to ensure that there was conformity and that comparisons (Geinsinger, 2010; van Gelder, Bretveld & Roeleveld, 2010; Wright, 2005) could be made between the two

ethnic groups, thereby fulfilling the aims. Additionally, questionnaires allow for data to be collected quickly from a large number of respondents (Geinsinger, 2010). Since this study had a total of 150 participants and the data needed to be collected within a three month period, questionnaires were considered to be the most appropriate tool.

Section A of the questionnaire, designed by the researcher, included demographic information in the form of 12 questions about the women's backgrounds (see appendix Ba) in which the women were asked to tick the appropriate category or write the answer where required. These questions included the women's age and marital status, as these are some of the factors cited in the literature that may contribute to some women having symptoms associated with somatization disorder and domestic violence experiences.

Section B of the questionnaire, also designed by the researcher, consisted of a general help-seeking tool (6 questions), where the respondent was asked either to tick or write as appropriate. Questions focused on where she sought help, for what reason(s) and how satisfied she was with the help provided for her general everyday problems (see appendix Bb). Additionally, this help-seeking information also served to inform study two (IPA analysis of help-seeking) of this thesis, which explored in detail with the women their help-seeking choices.

Section C included an assessment tool for somatization disorder (Brief Symptom Inventory-18, developed by Derogatis, 2001; assessment tool available upon request). The BSI-18 is a highly sensitive and brief self-report symptom inventory that is designed to screen for psychological distress in medical and community populations. This tool consists of 18 statements in which the woman is asked to rate the severity of her symptoms on a Likert scale ranging from "not at all" to 'extremely" over the past 7 days, including the present day. It took approximately 5 to 10 minutes to complete and scoring also took the same time. Scoring entailed summing all the responses; that is, item responses are assigned a value from 0 to 4, and then the values for the six responses for each dimension (somatization, anxiety, and depression) are summed. A participant

who scored 63 or above was considered a "case"[33].Thus, this test assisted in identifying somatization cases for this study and for study two (IPA analysis of help-seeking).

Section E of the questionnaire was an assessment tool designed to gather information about experiences of domestic violence: a modified version of the Coercive Control Measure for Intimate Partner Violence developed by Dutton, Goodman and Scdmidt, (2005). The original tool consisted of 13 scales and over 200 questions, and was extremely thorough as it examined the different types of domestic violence, for example, physical, sexual or verbal. Considering the aims and objectives of this study (stated above), this tool offered the most comprehensive insight into all the forms of domestic violence. For the purpose of this study, a modified version was used which contained 111 statements pertaining to physical, sexual, verbal, and control behaviours the women may have experienced by their partner. These specific questions were chosen by the researcher as these behaviours are consistent with the definition of domestic violence offered by the Trinidad and Tobago Government; that is, the Domestic Violence Act 27 of 1999 which defines domestic violence as, "physical, sexual, emotional or psychological or financial abuse committed by a person against a spouse, child, any other person who is a member of the household or dependent" (1999, p.292). Therefore, this section of the questionnaire, though lengthy, ensured that all these forms of violence were explored to ensure this study covered all aspects of domestic violence the women may have experienced. The women were asked to indicate either "yes" or "no" to these statements by ticking the appropriate box (See appendix Bc).

Sections D and F (10 items each, designed by the researcher) consisted of an assessment questionnaire to determine the sources of help sought for somatic symptoms or domestic violence experienced by the women and whether these sources were helpful or not (see appendices Bd and Be). Again, this also informed study two of this thesis.

Sections A, B, D, and F of the questionnaire (help-seeking) were not piloted before data collection started for three reasons. As Teijlingen and Handley (2001) argue, pilot studies may

[33] As stated by the developer of the BSI-18 Derogatis (2001) – "The rule states that if the respondent has a GSI T score of 63 or higher (on the community norm), or any two dimension T scores are 63 or higher, the individual is considered a positive risk or a "case" (2001, p.23).

have a number of limitations, such as, the possibility of making inaccurate predictions or assumptions on the basis of the pilot data; problems arising from contamination; and problems related to funding. Therefore, completing a pilot study successfully is not a guarantee of success of the full-scale survey. For this study, since the sample consists of Trinidadian women, and the researcher is studying in the United Kingdom (UK), the researcher would had to fly to Trinidad herself to pilot the questionnaire (because of the sensitive nature of the research it would be unwise to delegate other persons to do so, and the 150 questionnaires used in this study were actually administered by the researcher herself). Additionally, a pilot study in the UK may have yielded inaccurate predictions or assumptions as the cultures of the two countries are not the same. Therefore, it was considered appropriate to make adjustments to the questionnaire with the intended sample.

As a result, the first ten participants in the actual study served to guide the researcher to make minor modifications to the questionnaire. Consequently, some modifications were made to the help-seeking sections as the data collection progressed. For example, section B, question 2 where respondents were required to tick the sources of help sought (see appendix Bb), the options of "friend" and "spouse" were not originally included, but when the respondent got to the "other" category the researcher asked if the women had sought help from any other source including the above mentioned categories. The researcher, now in Trinidad was able to confidentially and, in person, administer the questionnaires to participants. Finally, and most importantly, the modifications to the questionnaire were now grounded on that specific culture in which the study was being conducted. With the questionnaire constructed, there were specific procedures that were followed its administration.

4:6 Procedure

The women were recruited via snowballing, in which gatekeepers recruited future participants from among their acquaintances. The gatekeepers contacted women living within each of the eight administrative boundaries (see appendix C for a detailed table) over a period of three months (July to September 2011). The women were then interviewed at either one of the local Primary or Secondary schools located closest to the participants' location. Each of the school

managers were contacted and written confirmation for access to the premises was granted. There were no adverse issues with regard to recruiting.

Each gatekeeper was asked to identify and contact either by telephone or in person, Indo- and Afro-Trinidadian women over the age of 18 years old who resided within specific counties in Trinidad, and ask if they would be willing to participate in a study about somatization disorder, domestic violence and help-seeking. If the woman was interested she was invited to one of the pre-approved interview venues. At the venue, the researcher explained in detail, with the use of the information sheet (see appendix D), what the research entailed. After this, if the women consented to take part, the questionnaire was then administered. For this study, there were no adverse issues with regard to recruiting; the women contacted agreed to participate and came to the pre-arranged venue and time to complete the questionnaire.

Once suitable participants had been identified, a day and time were arranged for them to come to the specified location. They were then greeted and given the information (see appendix D) and informed consent sheet (see appendix E), and, after they had asked any questions and signed the consent form, they were handed a questionnaire. Those women who were willing to participate, but who, for various reasons such as literacy level or poor eye sight, could not read the information sheet or informed consent sheet, had both papers read to them by the researcher, and only when they fully understood what was being asked of them, and had agreed, were they asked to participate.

The entire questionnaire took approximately 30 minutes to one hour to complete, depending on the educational level of the women. That is, women who had at least a secondary school education were able to complete the questionnaire more quickly as they understood the questions and needed less assistance, whereas, women with a primary level education or none needed more help with either reading, understanding or writing their answer where required.

On completion of the questionnaire, each of the women was given a debriefing sheet (see appendix Fa). For those women identified as potential participants for study two of this thesis, an

additional debriefing sheet was given (see appendix Fb), together with verbal protocol on how the researcher would contact them within the following five months (see appendix G).

4:7 Ethical Considerations

All proposals for research using human participants are reviewed by an Ethics Committee at Middlesex University before they can proceed. The Middlesex Psychology Department's Ethics Committee reviewed this proposal and approval was gained prior to the commencement of data collection (please see appendix Ha for approval forms)

The questionnaires administered for this study asked women to divulge information that is considered to be sensitive in nature; therefore, it was of utmost importance that they understood what this study entailed before agreeing to participate. Hence, a detailed information sheet, informed consent and debriefing sheet were given to participants, and they could not participate in this study unless they actively signed the informed consent. Participants were then encouraged to ask any questions concerning this study prior to agreeing to participate. If any of the participants required further explanation beyond the information sheet or informed consent, or if any of the participants felt distressed by taking part, they were offered support initially from the researcher, and then referred to one of the help agencies listed on the debriefing sheet with the knowledge that they were free to withdraw from the study at any point, without any negative consequences.

The women were approached alone without their partner present. This was to ensure that the risk of potential harm to the participant, researcher or gatekeeper was minimized. The researcher conducting this study also has experience counselling victims of domestic violence and individuals with mental health issues. But even with these precautions, it was important to note that some of the women would have experienced some distress about being recruited for a study of this nature (that is, domestic violence and somatization disorder). Therefore, prior to the gatekeepers asking women to participate, they completed a questionnaire themselves in order for them to also fully understand what was being asked of the women. This resulted in the gatekeepers having a better understanding of the study, and therefore, being more sensitive when inviting women to participate; the gatekeepers thus asked the women when they were alone if

they were willing to participate. This then provided the participant the opportunity in private to accept or decline and not feel pressured or obligated to take part.

In addition to this, when the researcher spoke to the women, they were reminded that this study was designed for women from the general public in Trinidad and did not specifically target them. This was in an effort to alleviate any fears or distress they may have had that they were being asked for a specific reason, that is, that someone knew prior that they were/still experiencing domestic violence. For some of the participants whose memories of abuse evoked tearful responses, I was fortunate that I have been trained as a psychologist/counsellor, and at this point I provided an outlet for them to express this distress in a manner in which they felt safe and reassured. This was accomplished by offering the participants the opportunity to just express how they felt and being supportive; I also had to remember at this point that it was not a counselling session, and, at the end, provide them with the debriefing sheet which contained contact information for help agencies.

Some of the women experienced difficulties reading the questionnaire because of their level of literacy. The questions were therefore, read aloud to them by the researcher, and only after they fully understood what was being asked did we proceed with the answer. All efforts were made by the researcher to ensure that those women did not feel embarrassed. This was done through body and verbal language, such as, being relaxed and not adopting a judgmental tone of voice. At the beginning of starting to complete the questionnaire, some of the women expressed that it was lengthy, but when they realized that they had to mostly tick answers they felt more relaxed and completed it without further complaints. Also, some of the women did not want to keep the information and debriefing sheets. This could be as a result of safety concerns for some of the women who were currently in abusive situations. They were reminded of the importance of them and advised to still keep them, if in the future they need to refer to them.

All data collected, together with the informed consent sheet, was coded to protect the identity of participants, and the coded information securely stored in a password protected file on a password protected computer. At this stage in data analysis (data entry) participants were only identified by an assigned code. The primary researcher is the only one with access to the

password; if supervisors need access to the data they are only offered access to the coded data, hence no names can be revealed.

This study took place outside of the United Kingdom, and to ensure that proper guidance was available throughout the data collection period, contact was maintained with all supervisors (Drs. Miranda Horvath, Joanna Adler[34] and Susan Hansen) via email (once per week or more frequently as required), and telephone, where any potential issues arising were dealt with as quickly as possible. Additionally, I kept a reflective journal and recorded my thoughts and feelings each day I had data collection (Please see appendix Hb for an excerpt from the journal).

From the information presented in the methodology section of this chapter for study one; it is clear that all precautions were taken to try and address any issues that may have arisen, and to conduct this study in the most ethical manner to obtain the richest and most informative data possible.

4:8Analysis

Quantitative Data

The quantitative data was then entered into the Statistical Package for the Social Sciences (SPSS) software. A variety of statistical analyses were conducted including, chi-square, odds ratio analysis, independent samples t-tests, hierarchical multiple regression analysis, correlation analysis and frequency distributions in order to compare and explore any relationships between the data; this was done for the entire sample, then the Indo-Trinidadian sample separately and finally the Afro-Trinidadian sample.

More specifically, each test was chosen for a particular purpose in order to support the three hypotheses. Therefore, chi-square analysis was used to examine the similarities between the two populations; for example, with regard to somatization disorder chi-square helped identify any similarities between the Indo- and Afro-Trinidadian women sample. Odds ratio analysis complemented this test, as this test examines the ratio of the odds of an event occurring in one group compared to another (Fields, 2009). This, therefore, served to state how likely it was for

[34] There was a change of supervisor. Dr. Adler was replaced by Dr. de Mornay Davies

Indo-Trinidadian women to either have somatization disorder or to have experienced domestic violence, compared to Afro-Trinidadian women (supporting hypotheses one, two and three).

Additionally, independent samples *t*-tests were used as this test seeks to establish if two means collected from independent samples differ significantly (Fields, 2009). Therefore, this test helped to determine if more Indo- or Afro-Trinidadian women experienced domestic violence or somatization disorder (supporting hypothesis two).

Multiple regression, which is a statistical technique that predicts values of one variable on the basis of two or more other variables (Fields, 2009) was used to determine if somatization disorder may be explained by ethnicity and domestic violence, as well as marital status, number of children and level of education achieved.

Correlation analysis was used, as this test examines associative relationships between naturally-occurring variables, rather than making statements about cause and effect. It also measures the strength of association between two variables (Fields, 2009; Heiman, 1998). Therefore, it was used to examine if there were any relationships between occurrences of somatization disorder, domestic violence and ethnicity (examining all hypotheses in this study).

Coding

In order for quantitative data analysis to be conducted various aspects of the questionnaire needed to be coded in preparation for SPSS. It should be noted that no re-coding of the data was done. Prior to analysis, the responses from Section A, question 1 ("Please state your age") were coded into the following categories: 18 - 25; 26 - 30; 31- 40; 41- 50; 51-60; 61–70 and 71 and over. Also question 9 ("briefly state what kind of job you currently do") responses were coded into the following: teacher, student, retired, unemployed, self-employed and other. Additionally, section B, question 2 ("reasons for seeking help"); responses fell into the following categories: spiritual, emotional/psychological, financial, medical, marital, legal, physical and other. All of these were coded, as this facilitates the organization, retrieval, and interpretation of data, and leads to conclusions on the basis of that interpretation (Lockyer, 2004).

Additionally, in section D, question 3 ("which of these symptoms did you seek help for?"), responses were categorized as follows: somatization, depression, anxiety, somatization and anxiety and depression, somatization and depression, somatization and anxiety and depression and anxiety. For Section B, question 3; section D, question 5 and section F, question 5 which asked "if you sought help from a religious leader please indicate from which religious background the leader was from" the following categories were derived: Christian, Hindu, Muslim, other, Christian and Hindu and Muslim; Christian and Hindu; Christian and Muslim and Hindu and Muslim. This coding was done in order to allow the study to be repeated and validated; it also allows for comparisons with other studies (Shenton, 2004).

The responses to section C (Brief Symptom Inventory-18) of the questionnaire were scored according to the guidelines in the manual, and then entered into SPSS. According to these guidelines on the community norms, an individual is considered a case if they have a GSI T-score of 63 or higher, or if any two dimension T scores are 63 or higher (Derogatis, 2001). There were six items for all the scales (somatization, depression and anxiety) (scoring sheet available on request). This was used to support the hypotheses of the study and also determine "cases" for study two (IPA analysis of help-seeking) of this thesis.

Section E of the questionnaire, which consisted of a modified version of the Coercive Control Measure for Intimate Partner Violence, was then examined (Dutton, Goodman & Scdmidt, 2005). All 111 items were entered individually into SPSS and then each of the following categories were summed into "yes" and "no" according to the number of statements: Personal, Support, Work, Health, Intimate, Legal, Children, Control, Physical, Verbal/Financial and Household (see appendix Bd). This also allows for repetition of this study. In order to generate domestic violence "cases" for study 2 of this thesis, all the "yes" responses on the Coercive Control Measure for Intimate Partner Violence were summed and the women who scored above the mean of 11[35] were then invited to participate in study 2. This score was not used as a criterion

[35] The mean was used: firstly, the mean uses every score, while the median and mode may ignore some scores in the data set. Secondly, the mean tends to be stable in different samples (Fields, 2009). Finally, the mean provides the average score for that sample.

for the selection of domestic violence "cases" in analysis, but was only used to identify women to participate in study two; here the domestic violence scores are treated as a continuous variable.

Qualitative Data

As mentioned earlier in the rationale for adopting a mixed methodology approach, this study also had a qualitative component to it; the procedural issues concerning this will now be discussed. In order to understand the sense that the women made of their help-seeking choices with regard to their general problems, somatic symptoms and domestic violence experiences short, open- ended questions were asked (see appendices Bb, Bd & Bc) with the intention that these questions would help support and add depth to the quantitative aspect of this research and inform studies two and three (religious leader and medical doctors intervention) of this thesis.

Hence some of the questions in this study included: *"From all of the sources of help above, please explain which was the most helpful to you and why?"* and *"From all of the sources of help you sought, which do you think was the least helpful, and why?"* From these questions it should be noted that the participants were not required to elaborate on their answers as with full interviews. They were required to briefly state why, or why not, a source was helpful; this then lent itself to their responses sometimes lacking complexity as some just wrote short responses such as, "*felt better*". Nonetheless, some of the participants did write fairly lengthy and enlightening responses which enabled this research to yield valuable data. This information gathered served to highlight the different help agencies the women sought assistance from, and the benefits or undesirable results of such help; thus, bringing to light various agencies, formal or informal from which the women sought help for their general problems, somatic symptoms and domestic violence experiences .

Therefore, even though it was anticipated that the data from these sections would not be as rich as those from the other sections it still served to support the findings from the quantitative portion of this study and inform studies two and three. For example, with the quantitative sections participants were asked to tick which sources of help they sought, but the qualitative questions asked them to briefly state why it was helpful. This, once again, added to the study by providing what Schulenberg (2004) describes as a complementary view about the same

phenomenon. The data also helped to add complexity to the information collected from the quantitative questions by acquiring information that developed from it that could not have been obtained from a Likert scale, or yes and no answers. These short responses also informed study two of this thesis by providing the direction the study should take and interview questions that should be focused on.

Thematic Analysis

In order to highlight this complementary view, and as mentioned above, the data gathered did not consist of lengthy quotes or responses; a thematic approach was adopted. Thematic analysis was chosen as it "is a method for identifying, analyzing and reporting patterns (themes) within the data. It minimally organizes and describes your data set in (rich) detail" (Braun & Clarke, 2006, p. 97). Additionally, Braun and Clarke (2006) have argued that the benefits that can be derived from this method of analysis are numerous. First, they argued that thematic analysis is flexible, thus, making it best suited for this part of analysis, as with only short quotes it would have been challenging to fit these into another approach of data analysis. Second, the researchers argue that it may generate unanticipated insights into the data gathered; examining these short quotes it was very easy to assume that not much information could be gathered, but with thematic analysis a rich discussion was developed and is presented later in this chapter (Braun & Clarke, 2006). Third, it is reasoned that thematic analysis summarizes the key findings of a large body of data and offers a "thick description"[36] of the data (Braun & Clarke, 2006); this study consisted of 150 women, therefore, there was a large amount of data gathered and adopting this approach enabled the researcher to summarize and report the key findings. Finally, it has been further argued that thematic analysis highlights the similarities and differences that exist within the data, this allowed for the discussion of the benefits and undesirable assessments of seeking assistance from certain sources of help. Hence, this approach aided in examining the women's understanding and knowledge about domestic violence, somatization disorder and help-seeking.

[36] Accurately describes and interprets social action within the context in which it took place. It also assigns intentionality and purpose to these actions; capturing the emotions, thoughts and as well as the complex social interaction among the participants in such a manner that the behaviour also becomes meaningful to an outsider (Ponterotto, 2006).

Transcription

The women's responses to the open ended questions were transcribed. The questionnaire had three sections that required open-ended responses: the first section asked about help-seeking for general problems such as, advice on relationships; the second section was specifically designed to gather information on the women's help-seeking choices for their somatic symptoms, the third section was constructed to obtain information about their help-seeking for their domestic violence experiences. Therefore, the data was transcribed under the headings: general help, somatic symptoms and domestic violence experiences and then each of these categories was further divided into Indo- and Afro-Trinidadian women and then thematically analysed.

After transcription was completed, analysis began, using the sequence described in Braun and Clarke (2006). First, becoming familiarized with the data by reading the responses several times, this then enabled the generation of initial codes, and from these codes themes were identified and reviewed. For example, Table 4 below shows the process whereby one final theme was decided upon. The initial codes which had the word "medication" were grouped together, and then an initial theme was derived, but, upon reflection, it was realized that those responses were more about the treatment or the medication received working than 'proper' diagnosis. Therefore, the final theme of "treatment or medication worked" was decided upon. This process was done for all of the initial codes until all themes were identified. According to Braun and Clarke (2006, p.82), "A theme captures something important about the data in relation to the research question ,and represents some level of patterned response or meaning within the data set". Therefore, the theme highlighted in table 4 sought to help map the source of help the women sought, and the reason why it was helpful. When the relevant codes were grouped and themes were finalized, the end report was then produced.

Table 4: Generating Codes and Themes

INTIAL CODES for medical doctor	SEARCHING FOR THEMES	INITIAL THEMES	FINAL THEME
"*he gave medication and injection for the illness*"	"*he gave medication and injection for the illness*"		
"*learn more about myself and my past and how to deal with my concerns and my health*"			
"*he understood my problem and gave me the right medication to treat it"*	"*he understood my problem and gave me the right medication to treat it"*	"proper diagnosis" or "medication"	"Treatment or medication worked"
"*not as understanding as family and friends and they haven't given me useful advice"*			
"*had me on drips and I was good in a few hours*"	"*had me on drips and I was good in a few hours*"		

Some of the issues that arose when formulating themes were; what quotes should be left out of the discussion. It was decided that codes that had little support, that is, if only one or two persons stated that specific code, then it would be excluded, because it would not be representative of the sample. It must be noted that even though some themes and supporting quotes are used in the discussion of the qualitative results, widespread generalizations about the entire sample cannot be descriptive of the entire sample as some women may not have voiced the same concerns or reasons; these will be discussed in-depth in the qualitative results section of this chapter.

4:9 Results for Study One

This section provides a quantitative analysis of somatization disorder and domestic violence with regard to ethnicity (Indo- and Afro-Trinidadian women). It also highlights the various help-seeking choices that Indo- and Afro-Trinidadian women utilized for dealing with their somatic symptoms, domestic violence experiences and for their general problems, such as: help from a

medical doctor, religious leader, family/relative, government and non-government organization, police and counsellor/psychiatrist. It also offers a brief synopsis of the reasons the women sought help from the various sources for their general problems. Finally, this section also examines the women's knowledge of somatization disorder and domestic violence.

4:10 Somatization Disorder and Ethnicity

This section seeks to illustrate the relationships that exist in the data between somatization disorder and ethnicity. It examines which ethnic group had a higher occurrence of somatization disorder and the strength of that relationship. It also addresses the sources of help the women utilized for their somatic symptoms, and their knowledge of somatization disorder.

The differences in somatization rates among Indo- and Afro-Trinidadian women were examined, using chi-square analysis to explore the similarities between the two populations with regard to somatization disorder. There was a significant association between ethnicity and somatization disorder, with somatization disorder being more common among the Indo-Trinidadian women compared with the Afro-Trinidadian women ($\chi^2(1)=6.32, p=<05$). An odds ratio analysis showed that Indo-Trinidadian women were 3.05 times more likely to have somatization disorder than Afro-Trinidadian women. This finding supports hypothesis two.

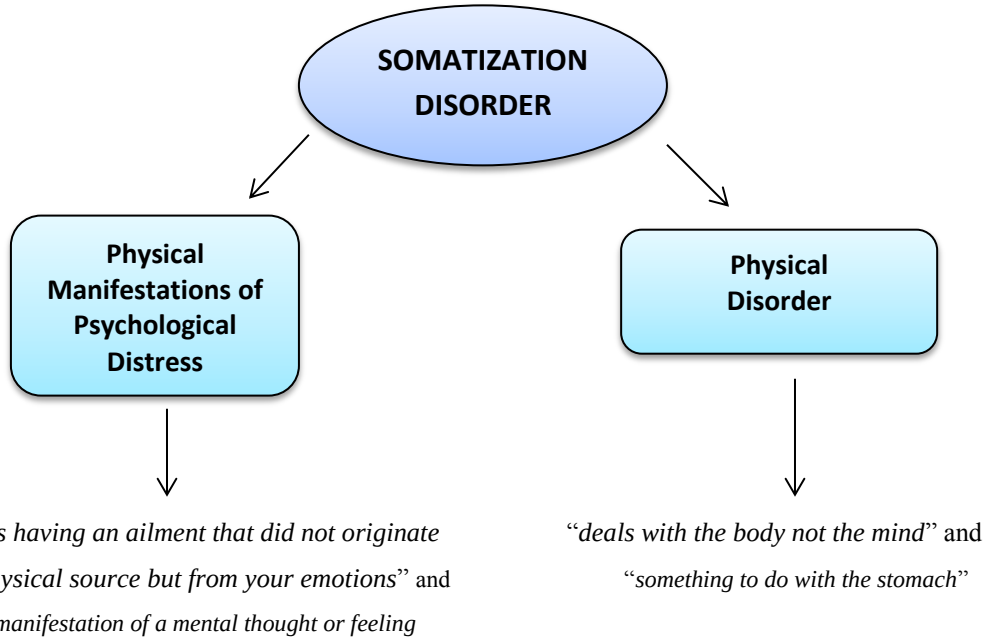
Additionally, an Independent samples *t*-test showed that on average, Afro-Trinidadian women (M= 1.89, SE= .036) experienced more symptoms of somatization disorder than Indo-Trinidadian women in this sample (M=1.73, SE= .051). There was a statistical difference $t\ (148) = -2.552$, $p<.05$ representing a small effect $r = .23$. This suggests that the frequency of somatization disorder is higher for the Indo-Trinidadian women. Whereas, the number of Afro-Trinidadian women who report somatization disorder is higher.

The Women's Knowledge of Somatization Disorder

This section focuses on the women's knowledge about what they thought the term somatization disorder meant. The data revealed that the majority of the women in this study had never heard of the term, and, for the few that indicated they had, only a minority actually knew what it meant. Figure 3 below illustrates some of the explanations the women gave for "what is somatization

disorder". Some of the women stated that it was a physical disorder, having no psychological basis, while some expressed that it was a psychological disorder with a physical basis. These quotes are highlighted in the figure below:

Figure 3: What is Somatization Disorder?



4:11 Domestic Violence and Ethnicity

This section seeks to illustrate the relationships that exist in the data with regard to domestic violence and ethnicity. It examines which ethnic group had a higher occurrence of domestic violence and the strength of that relationship. It also explores the sources of help the women utilized for their domestic violence experiences, and it concludes with their knowledge of, or if they have ever heard of domestic violence. This will be demonstrated through the use of chi-square analysis; independent samples *t*- test; odds ratio analysis and frequencies. First, the occurrence of domestic violence among Indo- and Afro-Trinidadian women will be explored.

Domestic Violence and Ethnicity

Domestic violence was more common among the Indo-Trinidadian women compared with the Afro-Trinidadian women (χ^2 (1) =5.5, p<.05).The odds ratio analysis suggests that Indo-

Trinidadian women were 2.38 times more likely than Afro-Trinidadian women to experience domestic violence.

Additionally, an Independent samples *t*- test showed that on average, Indo-Trinidadian women (M=13.600, SE= 2.038) experienced more behaviours associated with domestic violence than Afro-Trinidadian women (M=9.266, SE=1.595). There was a statistical difference *t* (1.674) =139.939, $p<.05$; which represented a small effect (r = .14).

Sources of help sought by the women for Domestic Violence according to Ethnicity

The sources of help that the women sought for their experiences of domestic violence were also mapped, and the thematic analysis of these findings will now be discussed.

Indo-Trinidadian women were significantly more likely than Afro-Trinidadian women to seek help from medical doctors for DV experiences (χ^2 (1,) =6.7, $p<.05$). There were no other significant differences between women of different ethnicities and the specific sources of help utilized.

The Women's Knowledge of Domestic Violence

This section serves to briefly highlight what some of the women understood by the term "domestic violence". It should be noted that compared with knowledge of somatization disorder, the vast majority of the sample indicated that they had heard the term domestic violence and attempted to apply their definition to what they believed it is. Table 5 below provides a summary of the different themes that were gleaned from the responses and supporting quotes. Six themes were derived, each very distinct from one another. Some of the women stated that domestic violence involved a partner or that it was violence between married persons. Others stated that it was violence within the household among those persons living there. Some of the women offered advice to the person being abused, while some approached the topic from a judgmental point of view. Therefore, some the women in this study seem to have a fairly accurate knowledge of domestic violence.

Table 5: What is Domestic Violence?

WHAT IS DOMESTIC VIOLENCE?	
Themes	**Supporting Quotes**
1. Partner	"*DV refers to situations where one partner exercises dominance over the other physically, mentally and emotionally – moderately - severely*", (IT; teens to 20s)
2. Husband/Wife/Marriage	"*any sort of abusive or aggressive behaviour against a spouse man or woman with whom one is in an intimate relationship*" (AT;40s)
3. Family Members/Same Household	"*any sort of abusive or aggressive behaviour against a spouse man or woman with whom one is in an intimate relationship*" (AT;40s)
4. Abuse in Various Forms	*domestic violence can be any form of abuse – mental, physical, sexual*", (IT;40s)
5. Judgmental	"*I think men or women who exercise domestic violence should be shot*" (AT;30s); "*I think that women need to be educated and get a life*" (AT;20s)
6. Advice	"*if someone beats you, you need to make a report*" (IT;40s)

4:12 Occurrences of Domestic Violence and Somatization Disorder

This section examines the relationships in the data with regard to somatization disorder and domestic violence according to ethnicity by means of chi-square analysis, odds ratio analysis and correlation analyses. The occurrence of somatization disorder and domestic violence according to ethnicity is also examined.

The differences in somatization disorder and domestic violence among the women were examined using chi-square analysis. There was a significant association between somatization disorder and domestic violence (χ^2 (1) =7.8, $p<.05$). According to odds ratio analysis, women were six times more likely to have somatization disorder if they had experienced domestic violence, providing support for hypothesis one. Additionally, correlation analysis found that for the entire sample somatization disorder was significantly correlated with domestic violence ($r = -.32$, $p <.05$).

Therefore, the relationship between somatization disorder and domestic violence was further explored, varying for ethnicity with the use of chi-square, odds ratio analysis and correlation analysis.

There was a significant association between ethnicity, somatization disorder and domestic violence, with somatization disorder and domestic violence being more common among the Indo-Trinidadian women compared to the Afro-Trinidadian women (χ^2 (1) =6.1, $p<.05$). Odds ratio analysis suggests that Indo-Trinidadian women were 3.42 times more likely than Afro-Trinidadian women to have somatization disorder if they had domestic violence experiences. This therefore supports hypothesis three of this study.

Additionally, somatization disorder and domestic violence were significantly correlated for the Indo-Trinidadian sample ($r = -.40$, $p <.05$). For the Afro-Trinidadian sample, however, there was no correlation between somatization disorder and domestic violence
($r = -.16$, $p >.05$).

Table 6 shows a hierarchical multiple regression analysis for somatization disorder (outcome variable) with ethnicity and domestic violence (main predictive variables); marital status; length of relationship; number of children; level of education achieved and age, (predictive variables). It was observed that both models are good predictors of somatization disorder, but the initial model improved the ability to predict somatization disorder F= 13.537. Model 1 suggested that 15.6% of the variation in somatization disorder is accounted for by ethnicity and domestic violence, while model 2 suggest that 16.1% of the variation in somatization disorder is accounted for by other variables. The average VIF = 1.048: this confirms that multi-collinearity is not a problem in this model (Durbin Watson = 1.940).

Table 6: Hierarchical Multiple Regression for Somatization Disorder.

	B	*SEB*	*B*
Step 1			
Constant	1.72	0.10	
Ethnicity	0.12	0.00	0.16*
Domestic Violence	-0.01	0.06	-0.34**
Step 2			
Constant	1.60	0.20	
Marital Status	0.01	0.02	0.04
Number of Children	0.01	0.03	0.04
Level of Education Achieved	0.03	0.05	0.06
Age	0.00	0.00	0.04

R^2=.16 for step 1, ΔR^2=.01 for step 2 ($p<.05$). *$p<.001$ **$p<.05$

4:13 General Help-Seeking Behaviours and Ethnicity

This section focuses on relationships between general help-seeking for everyday problems and ethnicity. It also examines the reasons the women sought help from the various sources identified by them; the "other" sources of help the women sought for their somatic symptoms, domestic violence or general problems. It concludes by examining the religious affiliations of the religious leaders from whom they sought assistance.

4:14 Sources of help sought for general problems according to Ethnicity

Odds ratio analysis suggests that Indo-Trinidadian women were 12.74 times more likely than Afro-Trinidadian women to seek help for a general problem from a medical doctor (χ^2 (1) =10, $p<.05$).

Additionally, even though no significant differences were found with regard to other sources of general help, it was noted, that women also more often sought support for their general problems from the family/relative; government; counsellor; police; religious leader and non-governmental organization (see appendix I). When it came to seeking help from a religious leader for general

problems, the women chose a leader from a Christian, Hindu or Muslim background (see appendix J).

The women also indicated "other" sources of help they used that were not listed as an option on the questionnaire for their general problems. The women sought help from either a friend; or both friend and spouse. Some of the women indicated that they sought help from God through prayer (see appendix K).

All women tended to ask medical doctors or governmental organisations for help with medical needs; family/relatives or counsellors for personal issues; religious leaders for spiritual matters; the police for legal problems and non-governmental organisations for emotional/psychological issues (see Appendix L).

Summary

This section explored the occurrence of somatization disorder and domestic violence with regard to ethnicity. These results also addressed the research question '*Will Indo-Trinidadian women have a higher occurrence of somatization disorder and domestic violence than Afro -Trinidadian women?'* Findings indicated that Indo-Trinidadian women were three times more likely to have somatization disorder; were twice as likely to experience domestic violence and three times more likely to have somatization disorder if they had experienced domestic violence than Afro-Trinidadian women living in Trinidad. It was also revealed that Trinidadian women in general (both Indo and Afro) were more likely to somatize their distress if they had experiences of domestic violence (six times more likely). Additionally, from the data presented above it was noted that the women did seek help for their general problems, somatic symptoms and domestic violence behaviours experienced. The sources of help that both Indo- and Afro-Trinidadian women sought will be further explored in the next section.

4:15 Help-Seeking Behaviours: The sources of help sought by Indo- and Afro-Trinidadian women and outcomes.

4:16 Introduction

This section provides a thematic analysis of the help-seeking behaviours that Indo- and Afro-Trinidadian women sought for their general problems, somatic symptoms and domestic violence behaviours experiences. The sources of help the women sought for these experiences were mapped (Aim 2 and address the research question, *what sources of help do Indo- and Afro-Trinidadian women seek for their general problems, somatic symptoms and domestic violence experiences?*). Therefore, this section focuses on various sources of help the women reported as helpful and those that were not, and also provides an account of the reasons the women cited for their satisfaction or discontentment with the sources of help.

The sources of help will be presented from the most important findings followed by the lesser results (Frost, 2011). The sources of help that emerged include: medical doctor; spiritual leader; counsellor; friend; family/relative; police and government organization. Of note, some of the sources were identified as being both helpful and not helpful by the women; these comparisons will also be explored, all of which will be examined in the context of ethnicity and age of the women.

Medical doctors and religious or spiritual leaders will first be addressed, as these sources informed both studies two and three of this thesis. These sources of help, identified by the women, will also be discussed in the summary sections in relation to the literature presented in chapter two (literature review) of this thesis. The literature advocates that, some physicians are apprehensive about treating persons with somatic symptoms, mainly because of their own anxieties and lack of knowledge about the disorder, as well as ineffective communication (Epstein et al., 2006; Mai, 2004 & Quill, 1985). Additionally, spirituality and religious leaders' role and intervention in help-seeking for women with experiences of domestic violence also seem to be an important one, but similar to medical doctors, some are undecided whether to intervene or not (Banks- Wallace & Parks, 2004; Giesbrecht & Sevcik, 2000 & Levitt & Ware, 2006).

It is also worth recalling that the data collected for this section was completed by asking the women to briefly state where they sought help from and whether it was beneficial or not. Therefore, the data did not yield lengthy answers, but it did produce informative responses. The quotes gleaned from the data will be used to illustrate the points being made, by organizing the quotes in order that they are linked to the data to the story that is being told (Frost, 2011); these will now be discussed. It should also be noted that the following abbreviations will be utilized throughout this section:

AT= Afro-Trinidadian

IT= Indo-Trinidadian

4:17 Findings

In seeking to address the above research question the below themes (super-ordinate and subthemes) were gleaned from the data, illustrated in table 7 below. These themes presented themselves as a result of the women expressing where they sought help from for their somatic symptoms, domestic violence experiences and general challenges.

Table 7: Super-ordinate and sub-themes for the study one

Super-ordinate Themes	**Subthemes**
1. Medical Doctor	a. Treatment worked b. Inadequate diagnosis of the medical problem c. Satisfaction d. Not helpful for non-medical issues e. Other forms of help
2. Spiritual/Religious Leader	a. Encouraging results b. Trust c. Age d. Found peace e. God and the Bible

Table 7: con't: Super-ordinate and sub-themes for the study one

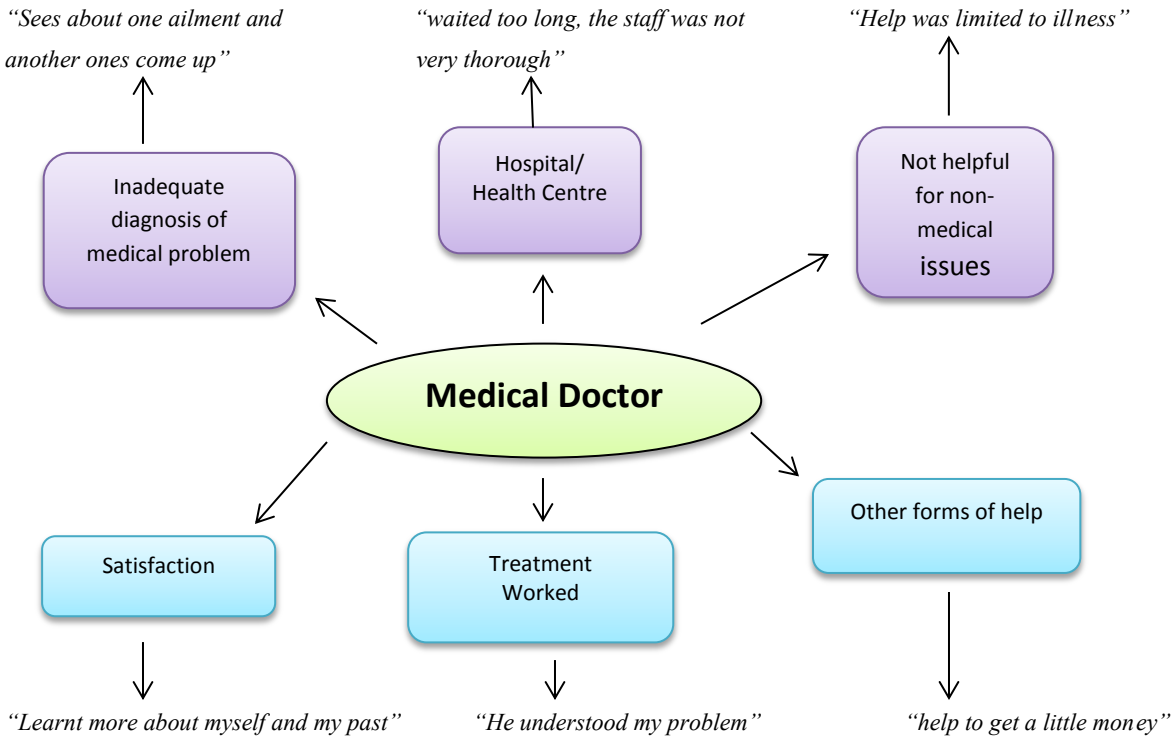
Super-Ordinate Theme	**Sub-Themes**
3. Counsellor	a. Encouraging results
4. Friend	a. Age b. Confidentiality c. No trust
5. Family/Relative	a. Trust b. Support and encouragement c. Not supportive
6.Police/Government Organization	a. No solutions b. Bureaucracy

A closer analysis of each of the super-ordinate themes along with their related sub-themes will now be discussed, starting with the first super-ordinate theme.

1. Medical Doctor

The first theme that developed from the data was **medical doctor**. Figure 4 below illustrates the various sub-themes that emerged from the women identifying medical doctor as a source of help; it also shows some of the reasons why the women felt this source were helpful or not.

Figure 4: Reasons why the medical doctor was helpful or not



Some of the women were of the opinion that the help received from the medical doctor was beneficial, either because they saw encouraging results after treatment; or they were generally satisfied with the approach the medical doctor took; or they received other forms of assistance. However, some of the women did not echo this approval, as some expressed feelings of ambivalence and of being discontented by this source of help, or that their problem was inadequately diagnosed. The reasons offered by the women for their satisfaction or dissatisfaction will be explored in the context of what the women were experiencing when they sought assistance from the medical doctor (e.g. general problems, somatic symptoms, domestic violence).

a. The treatment worked: The first sub-theme that emerged from the data was that some of the women felt or saw encouraging results after treatment, i.e. the treatment worked. When it came to seeking help for their **everyday problems** such as a medical issue, a vast majority of the women stated that the medical doctor was the most helpful because they saw improvements in

their conditions. The women stated that one of the reasons they saw improvements was that the doctor was able to diagnose the problem accurately. As some of the women stated:

"*he understood my problem*" (AT;20s) and

"had understanding and knowledge of diagnosing the problem" (IT;20s).

Therefore, as a result of being accurately diagnosed, the women received the correct medication as indicated by several of their responses:

"*he understood my problem and gave me the right medication to treat it"* (AT;20s) and

"*had me on drips and I was good in a few hours*" (IT;30s).

This encouraging outcome was also supported by some of the women who indicated that they sought help for their **somatic symptoms** from the medical doctor. The reasons stated by some of the women are very similar to the explanations offered for their everyday problems. As several of the women stated that

"*I was given medication*" (IT;70s),

and this seems to have assisted in lessening the problems and thus provided the women with a sense of comfort. This course of treatment also had a beneficial effect on the women's overall health outcomes as they reported that after treatment it

"*made me feel calm with the medication"* (IT;70s) or "*the symptoms decreased"* (AT;30s).

Therefore, some of the women did experience encouraging results from the medical doctor prescribing medication to treat their ailments, and, as a result, were pleased with this choice.

b. Inadequate diagnosis of the medical problem: This is in contrast to what some of the other women stated, that their problems were not properly diagnosed. Therefore, another sub-theme

that was gleaned was inadequate diagnosis of the medical problem. When the women sought help for their **general problems** from the medical doctor some expressed that they were

> "*still sick*" (IT;50s), after treatment or "*because sometimes they miss diagnose the problem*" (AT; teens to 20s)

or that the medical doctor

> "*sees about one ailment but another one comes up*" (AT;50s),

and as a result of not being properly diagnosed some only experienced

> "*temporary relief*" (AT;30s)

for their problem. Consequently, from the above, some of the women felt that the medical issues they sought help for were not readily addressed, and they did not feel any relief.

c. Satisfaction: Another sub-theme that emerged from the data was satisfaction: some of the women stated they were satisfied with the help they received from the medical doctor for their **general problems,** because they were able to

> "*learn more about myself and my past and how to deal with my concerns and my health*" (IT;40s), or "*his words are thoughtful"* (IT;40s), and
> "*very prompt in their response to deal with matters to satisfy my concerns"* (AT;30s)

This satisfaction was also voiced by some of the women who sought help for their **somatic symptoms** from the medical doctor as they stated he/she

> "*spoke my language, did not pretend to prescribe tablets to make extra money but acted as a friend*" (IT;30s) and

> "*was able to tell me about what therapy and what medication I should have*" (IT;70s)

in order to resolve the issue. Some of the women also stated that their somatic symptoms diminished without the use of medication, as the medical doctor was

> "*able to source cause of problem*" (AT;30s), and "*help with some of my childhood and teenage problems*" (IT;40s).

The above quotes suggest that not only prescribing medication was a factor in their outcomes but also the manner in which the medical doctor interacted with the women; interpersonal interaction with the medical doctor was also important. The medical doctor went beyond the diagnosis and treatment of their somatic symptoms by trying to assisting some of the women in uncovering the root cause of their symptoms. Thus, it may be argued that because of the unconditional positive regard shown by the medical doctor, some of the women experienced catharsis, for example, by exploring their childhood or teenage problems. This provided some of the women with a sense of satisfaction that their problem was adequately dealt with, not only from the medical perspective, but more holistically.

d. Not helpful for non-medical issues: However, even though many of the women felt the medical doctor was helpful by providing assistance that was not medically based, others disagreed with this. When it came to seeking help for **general problems,** the theme that arose was that the medical doctor was not helpful for non-medical issues. The most common reasons cited by the women for this lack of approval were that the help received from the medical doctor was

> "*help was limited to illness*" (IT;30s)
> or the help was
> "*only useful for medical concerns*" (IT;30s).

And, as a result, they did not experience any improvements with the medical problem they initially sought help for. One of the women stated that the medical doctor was

> "*not as understanding as family and friends, and they haven't given me useful advice"* (AT; teens to 20s).

This statement also indicates a need for more than just medical care; some of the women would have appreciated a more holistic approach to their medical problem. This therefore may have led to their disappointment with the help received.

The women who sought help for their **somatic symptoms** also specified very similar reasons for their discontentment. They were of the opinion that the medical doctor was not helpful because he/she was unable to solve their problems, as after treatment they were

> "*still having the problem*" (AT;50s)
> and *"because some if the symptoms were more than just physical*" (IT;40s)

or the problem

> "*was psychological and not physical. Spent money for no reason*" (IT; 20s)

and as a result they saw no improvements with their medical complains. Therefore, from the quotes it may be determined that some of the women required more than just medical advice from the doctor for their somatic symptoms. Thus, not being able to obtain satisfactory advice, some of the women may have experienced angst when they were faced with the service received and thus, their expression of a lack of contentment with the treatment they received.

e. Other forms of help: Finally, the sub-theme *other forms of help* was gleaned from the women's responses. Some of the women stated that they sought help from the medical doctor, because they needed assistance with **general issues** such as financial aid,

"*help to get a little money (National Insurance)*" (IT;60s)

or that they wanted

"*to get the tablet free*" (IT;60s).

Therefore, some of the women utilized this source of help to access specific government assisted benefits. This can be attributed to the women's ages, as the women who gave these reasons were in their 60s, and, in Trinidad this is the retirement age and also when individuals become eligible for their National Insurance benefits. As a result, it may be concluded that some of the women adopted selective optimization with compensation, as some were making the most of receiving financial benefits that accompany normal aging.

This may also be linked to some of the women seeking assistance from either the hospital or health center for their **general health concerns,** because usually it is the doctor at the public health centers or public hospitals that provides documentation for the person to receive financial assistance or free medication. However, some of the women expressed that they

"*waited too long*", *the staff was not very thorough*" (AT; 30s) and "*very long wait, sometimes advice conflicting, not very gracious/and in dealing with issues*" (AT; 30s),

and the doctors at the public health center kept

"*giving you the same medication*" (IT;70s).

As a result of this, the women expressed that they

"*did not feel better*" (IT; 30s)

after the treatment. These experiences are similar to those by women who sought help from private practice medical doctors. The experience of having to wait for extended periods of time to speak with the medical doctor seem to have hindered some of the women from full disclosure, and, therefore, underlying issues could have been overlooked. This may have contributed to

inadequate diagnosis, treatment and subsequently leading to some of the women leaving the facility feeling disenchanted with their experience. Thus, their low frustration tolerance became unbearable and hence their dissatisfaction.

Therefore, the women's comments suggest it is not only the medical advice that helps the person, but also the entire process of help seeking and the interactions with the various healthcare providers themselves that also contribute to the women's contentment.

Summary

Overall, it appears that the women were generally satisfied with the service delivery and outcomes they received from their visit to the medical doctor. It is also important to note from the quotes, that some of the women not only stated that it was the medical advice that helped, but also the entire process of help-seeking and the interactions with the various healthcare providers themselves. Even though some of the women indicated that the medical doctor was a helpful source, some of them did not view this option as beneficial, citing various reasons such as: there was no improvement in their condition or the medication did not work. Therefore, it may be concluded that the sample of women was divided on their views about the benefits of seeking help from a medical doctor for their general problems or somatic symptoms.

Additionally, none of the women indicated that they sought help from a medical doctor for their domestic violence experiences. As reported in chapter two (literature review) of this thesis, Gerbert et al., (2002) and Richardson et al., (2002) both maintained that one third of the women attending the general medical practice had experienced domestic violence, and most of these women were not identified by the general practitioner. Physicians exploring domestic violence in the clinical setting analogous to "opening Pandora's Box" (Sugg & Inui, 1992), with reasons such as a lack of comfort; fear of offending the individual; loss of control; time constraints and powerlessness (Elliot, Nerney, Jones & Friedman, 2002; Gerbert et al., 2002 &; Sugg & Inui 1992) most often cited as reasons for being hesitant to explore this issues with women. Therefore, studies two and three of this thesis sought to address these concerns by interviewing women with domestic violence experiences and somatization disorder, and by surveying medical doctors and inquiring about their available resources, knowledge, availability and willingness to discuss this with patients.

2. Spiritual Help

Another source of help the women sought for their general problems, somatic symptoms or domestic violence experiences were spiritual avenues and/or religious leaders. The sources that will be addressed in this section include; the role of the spiritual or religious leaders, God and the Bible. This section highlights these avenues and their outcomes, of either being helpful or not.

Table 8 below provides a brief summary of the women's views regarding whether the religious leaders, God or the Bible was helpful or not. From the quotes it is noted that some of the women either received the motivation to continue by support from the Biblical scriptures, while others stated that it was not helpful as they saw no improvements despite paying money.

Table 8: Spiritual Help

SPIRITUAL HELP	
Helpful Results	**Unhelpful Results**
"*I was given the spiritual support, encouragement and positive outlook*"	"*was not very close and they are younger thereby making it hard for them to understand my problem*"
"*the help he gave allowed me to have closure after a terrible ordeal*"	"*ask to do things and it was not helpful*"
"*guiding me with Biblical principles that forms my foundation today*"	"*went for the children and they still doing the same*"
"*God as my source was the most helpful because he answers all my prayers*"	"*takes your money"*
"*received hope and courage to seek peaceful solutions*"	"*follow-up*"

The first sub-theme that emerged from the data was the spiritual or religious leader's role in help-seeking. This will be examined in terms of help the women sought for their general issues, then somatic symptoms and, finally, for the women's domestic violence experiences.

a. Spiritual or Religious Leader - encouraging results: Some of the women indicated a spiritual or religious leader as a source of help for their **general problems.** They experienced encouraging results and therefore were satisfied because they were offered:

> "*guidance towards making the best decision*"(IT;20s), or "*I was given the spiritual support, encouragement and positive outlook*" (IT;40s) and he/she "*gave us faith and confidence and I was able to draw closer to God*"(IT40s;).

The spiritual or religious leader provided some of the women with encouragement that their situation would improve. Additionally, some of the spiritual leaders also offered the women additional options to resolve the issues, as it was stated that he/she

> "*helped me to find direction or a focus in life*" (AT; teens to 20s)

and this then provided some of the women with the hope for a better future as

> "*the help he gave allowed me to have closure after a terrible ordeal*" (AT;20s).

b. Trust: This then assisted some of the women to cope with their stressful situation. Being able to disclose to the religious/spiritual leader also enabled some of the women to develop rapport and a level of trust between the religious leader and themselves, as they stated that

> "*I knew that I could trust him and I felt a lot better emotionally*" (AT; 40s), or "*I felt comfortable presenting my problems to them*" (AT; teens to 20s).

All of these reasons combined contributed to some of the women reporting that the religious leader as an important source of help when they experienced general problems; as one woman stated

> "*I trust my pastor and thus his advice to me is sound*" (IT;30s).

Therefore, for some of the women trust was an important aspect to their help-seeking, as being able to trust the religious leader encouraged some of the women to disclose their general problems to him/her. As a result, some of the women were able to gain a sense of awareness regarding their experiences, thus assisting them to obtain apperception. Subsequently, because

the religious leader now fully understood the problem, he/she was may be able to successfully advice some of the women with regards to avenues they could employ to either solve or lessen their problem(s). Additionally, it was felt that their problems were not only being dealt with from a spiritual standpoint, but also a more holistic approach as the women stated that the religious leader

> "*addressed both the spiritual and emotional aspect of my problem*" (AT; teens to 20s).

Once again, this provided some of the women with a sense of reassurance that their problems experienced will eventually be resolved. The women were able to receive more than medical advice from the spiritual leader, as he/she also catered to the women's emotional needs. Unfortunately the spiritual or religious leader was not always viewed as helpful for general problems. Some of the women stated that he/she was unsuccessful in providing solutions to their problems, for example, some of the women stated that

> "*went for the children and they still doing the same*" (IT;60s).

Some of the women also reported that the spiritual leader

> "*takes your money"* (IT;60s) and he/she "*ask to do things and it was not helpful*" (IT;40s).

There also seems to be a lack of

> "*follow-up*" (AT;30s)

by the religious leader, and, as a result, the women did not view the help received as beneficial.

c. Age: Another sub-theme was age. Some of the women complained that the spiritual or religious leader

> "*was not very close and they are younger thereby making it hard for them to understand my problem*" (AT; teens to 20s)

Here the woman is in her late teens to early 20s (up to 25 years), and the spiritual leader seems to be younger than her. Therefore, it may be argued that this young woman displayed ageism since she viewed the religious leader as not having enough experience to assist with her challenges solely based on age. Therefore, the woman was not reassured that her issue would be resolved, as no relationships were formed from their interactions.

d. Peace: However, this discontentment with the religious or spiritual leader could be said to be confined to help offered for only general problems, as some of the women who sought help for their somatic symptoms and domestic violence experiences stated that he/she was indeed helpful. The women who sought help for their **somatic symptoms** from the religious or spiritual leaders stated that they

> "*found peace*" (IT; 50s) and that "*he spoke about faith in a powerful being*" (IT;30s), or "*guiding me with Biblical principles that forms my foundation today*" (AT;30s)

this enabled some of the women to better deal and cope with the somatic symptoms and aided in their recovery.

Additionally, some the women who experienced **domestic violence** and sought help from the religious leader also specified very similar reasons why this source of help was beneficial. They stated that they were provided with a

> "*listening ear*" (IT;40s) or the "*advice given was helpful*" (IT;40s) and that they learnt "*how to deal with the situation from the perspective of an adult*" (AT; teens to 20s).

From the quote by this woman in her late teens to early 20s it would appear that she experienced domestic violence at a younger age and benefitted from having a knowledgeable person providing advice to her. One of the women stated that the pastor offered

> "*prayer and speaks to the person*" (IT;50s), while another stated that her *"faith in God was strengthening and I was able to overcome the situation*" (AT;50s).

Therefore, it may be argued that the pastor catered to the affiliative need of the woman in this case as he provided the support that a counsellor or medical doctor may not have offered, as he/she chose to contact the perpetrator and speak with him. The women who sought help from the spiritual or religious leader for their general problems, somatic symptoms and domestic violence experiences seem to have had a reassuring experience, because the leader was able to fill the gap that the women spoke about when seeking help from the medical doctor. That is, they desired a more holistic approach from the medical doctor for their problems. The women seem to have received this from the religious leader in various forms such as trust, a listening ear, and hope and encouragement.

e. God and The Bible: Another sub-theme that emerged from the data with regard to spirituality was <u>God and the Bible</u>**.** The women saw this source of help as only helpful. In addition to turning to their religious leader, some of the women revealed that when they experienced **general problems** they also turned to God, through prayers or the Bible for answers. Some of the women stated that they had learnt

> "*how to live a life pleasing to God*" (AT;20s) or "*God as my source was the most helpful because*
> *he answers all my prayers*" (AT; teens to 20s).

As a result of their faith in God, the women indicated that they often turned to the Bible for assistance regarding how to

> "*clarify the problem*" (AT;40s) and were able to obtain "*Biblical support for any concerns faced*" (AT; missing) and hence a "*deeper faith*" (AT; teens to 20s) was obtained.

Some of the women also expressed employed active learning and searched the Bible for supportive verses which helped them to cope and that they

> "*receive spiritual solace, peace and courage. Gives me hope to press on*" (IT;40s)

from this source of help. The women who sought help from Biblical scriptures for their general problems felt that they were provided with solutions and avenues that they could adopt to resolve their challenges.

Some of the women chose to seek help for their **domestic violence** experiences from the Bible. It was reported that they

> "*received hope and courage to seek peaceful solutions*" (IT;40s).

Therefore, the belief that a higher being would be able to provide them with solutions to their problems was important in the help seeking process, as; once again, it provided the women with a sense of encouragement that their problems would be resolved. For most, it equipped them with answers and the coping skills needed to resolve the situation and as a result they were able to obtain some form of self-actualization.

Summary

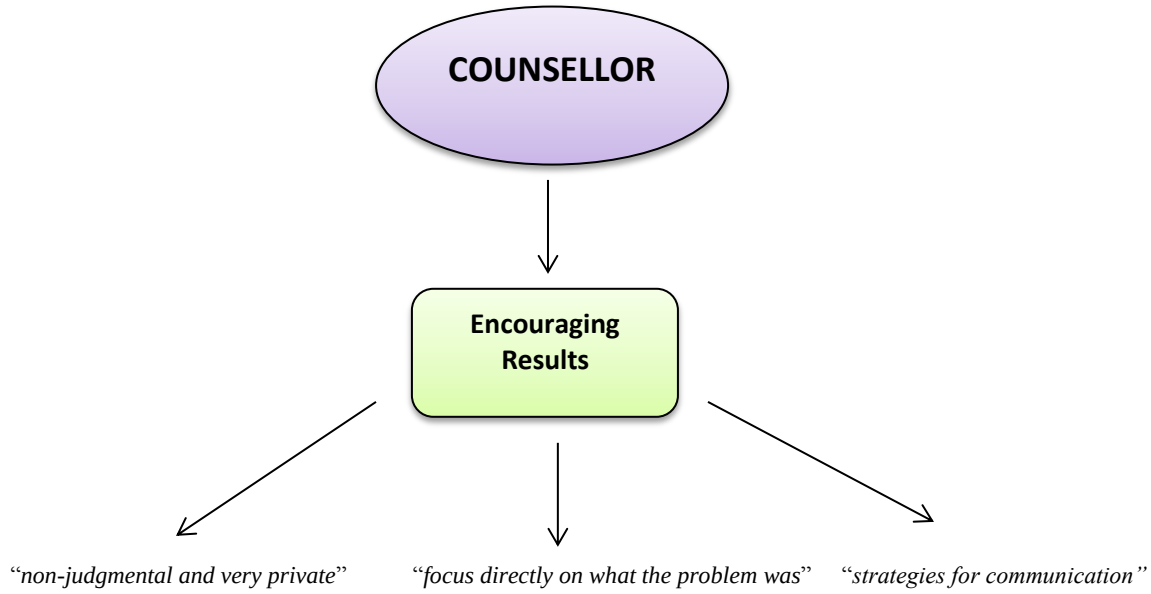
In conclusion, the spiritual or religious leader was a very helpful source of assistance to some of the women, but not everyone was of this opinion, as others stated they did not experiences any resolution to their problems from this source. Both Indo- and Afro-Trinidadian women sought support from a spiritual perspective, with God and the Bible only being viewed by some of the women as helpful sources. Therefore, this thesis seeks to provide information about the various help agencies and the women's views about them. Again, studies two (IPA analysis of help-

seeking for Indo- and Afro- Trinidadian women) and three (religious leaders and medical doctors intervention for somatization disorder and domestic violence experiences discussed in chapters five (IPA analysis of help-seeking) and six (religious leader and medical doctors intervention) sought to address these issues by interviewing and surveying women, medical doctors and religious/spiritual leaders.

3. Counsellor

A third source of help that emerged from the data was counsellor. This section highlights the reasons why the women sought help from this source. It is noted that all the women who cited counsellor as a source of support stated that the counsellor was indeed helpful because they were able to communicate comfortably, logically examine their situations and find solutions. Figure 5 below illustrates the reasons some of the women felt the counsellor was helpful; such as, he/she listened in an unbiased manner; they were able to focus on the problem, and, as a result develop solutions to these challenges.

Figure 5: Counsellor as a source of encouragement



a. Encouraging results: As mentioned the women felt that only encouraging results were gained from their interaction with the counsellor. From the quote below, some of the women stated that when they sought help for their **general problems** (such as, relationships) the counsellor offered

the appropriate advice as he/she was able to deal with their issues in a non-judgmental manner and he/she was very thorough.

> "*non-judgmental and very private*" (AT;30s) and that he/she "*dealt with the situation more in-depth*" (IT;40s).

These quotes illustrate that some of the women may have felt a sense of comfort that they were speaking to someone whom they could trust and who would not reprimand them for their beliefs or past actions. It also appears that because the counsellor was able to address their issue(s) in a very detailed manner, this enabled some of the women state that they were heard and the counsellor was listening to them, as stated by one woman

> "*I talk they listen*" (AT;20s).

As a result of some of the women being able to express themselves to the counsellor, their challenges was addressed and dealt with in a private and in-depth manner. Therefore, it may be argued that this assisted some of the women with changing their disruptive behaviours for more constructive ones. Therefore, some of the women felt that they received solutions to their general problems, and were advised by the counsellor how they could use their own innate qualities to overcome their problems. As one woman stated the counsellor helped her to

> "*identify my worth and strengths and weaknesses*" (AT;30s)

With her coping skills now identified some of the women felt that their general problems were being heard and solutions found. Similar sentiments were also stated by some of the women who sought assistance from the counsellor for their **somatic symptoms**.

Some of the women expressed that the counsellor was able to help them focus on the symptoms they were experiencing in a manner that helped them to find ways of coping. This is illustrated by the quotes listed below.

> "*focus directly on what the problem was*" (IT;40s) and '*was able to clarify issues which seemed overwhelming*" (IT;40s)

From the above quotes, it seems that when some of the women felt they were able to openly speak, employing algorithm[37] (Gerrig & Philip, 2002) and then were they able to find solutions to their somatic symptoms. They identified their problems and thus received the encouragement that their symptoms would be addressed.

> "*communicate feelings and verbalize my situations which helped when thinking of solutions or my next step*" (AT;40s)

Thus far, it seems that what is contributing to the women expressing fulfilment with this source of help is that they were able to openly communicate and not feel judged, and that solutions were being considered.

Again, this satisfactory communication was also voiced by some of the women who sought help from a counsellor for their **domestic violence** experiences. Though not many of the women seem to have sought assistance from this source for their domestic violence experiences, the ones who did stated that the counsellor was able to find solutions to their problems, and that someone was interested and willing to listen to their difficulties. This was expressed by some women when they stated that the counsellor was

> "*able to resolve the problems and clear up any misconceptions I or he may have had*" (IT40s;) or that the counsellor "*helped me conceptualized my situation and gave me a sense of understanding of my feelings*" (AT;40s).

The above quotes demonstrate that some of the women through apperception were able to gain insight into their domestic violence experiences. Additionally, from this new awareness some of

[37] "A step-by-step procedure that always provides the right answer for a particular type of problem" (Gerrrig & Philp, 2002).

the women were able to find ways of coping with their domestic violence experiences, as some stated that they found

> "*strategies for communication"* (IT;40s) and "*helped me to identify where he stands vs where I stand and how to make choices you can accept in a relationship*" (IT;30s).

From these quotes it is apparent that some of the women gained a better understanding of their domestic violence experiences. They also developed approaches for dealing with and coping with these intersecting issues, and as a result they were able to make more informed choices about their relationships. All of these seem to have contributed to some of the women having a positive experience of help seeking from the counsellor.

Summary

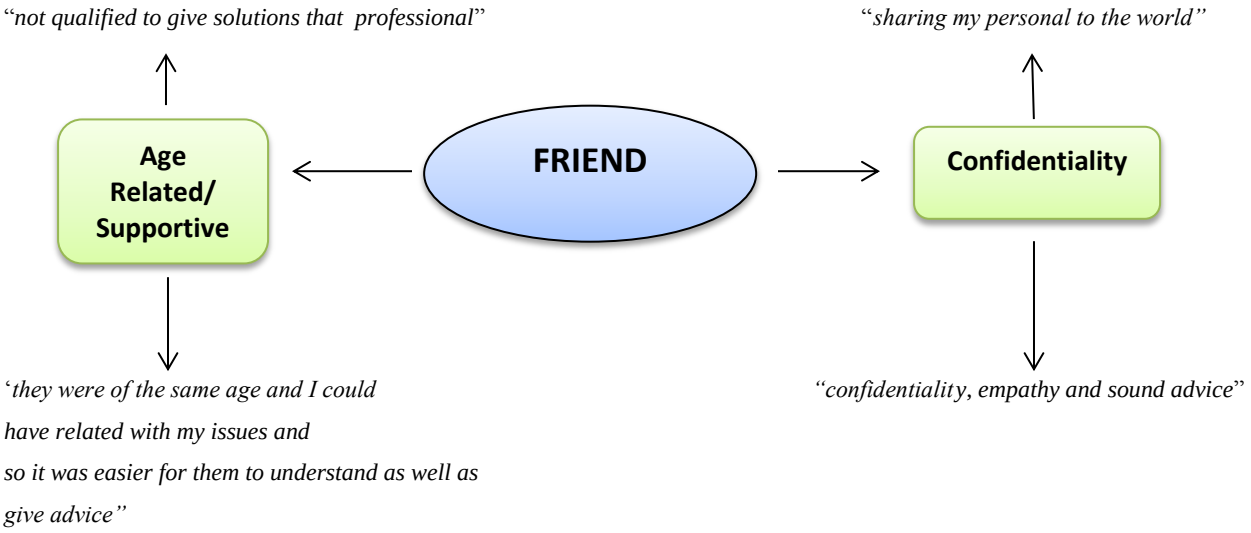
The quotes utilized throughout this section help to represent the view of support sought from the counsellor, that is, some of the women felt they were being heard in a non-judgmental manner, they were able to speak openly, and solutions were being found for their general problems, somatic symptoms or domestic violence experiences. Women from both ethnic groups sought help from the counsellor for these intersecting problems. The women were mostly in their 20s, 30s, 40s or 50s; for the women in their 70s (especially Indo-Trinidadian women), the counsellor was seen as inappropriate, as according to Maharajh (2010) her culture and upbringing would not have encouraged her to discuss her problems with someone who was not a family member, as this would have been viewed as "scandalous" (Maharajh, 2010). However, even though some of the women sought assistance form these formal sources (medical doctors, counsellors), many chose to seek assistance from informal sources, for example, a friend or family or relative.

4. Friend

When the women were asked to state any other sources of help that were most helpful and why, some indicated friend. This section seeks to explore the various reasons cited by the women for friend being helpful or not helpful. Additionally, from the responses it seems that the friend had more of a supportive role than actually providing solutions to their problems.

Figure 6 below illustrates the various reasons some of the women were of the opinion that a friend was a valuable source of help to them. From the quotes, age was regarded as both helpful and not helpful; some of the women stated that because of the similarities in their ages they felt the advice was more suited to their needs. Whereas, others felt because of age (being younger) the advice was not specialized. Secondly, confidentiality, for some of the women was a problem; however, others felt that the friend was able to provide privacy for them to express themselves.

Figure 6: Friend as a source of help



a. Age: The first sub-theme that was gleaned from the data was age related/supportive. Some of the women stated that when they sought help for their **general problems** from a friend, he/she was supportive. Some of the women expressed that they were able to speak with the friend, and as a result were of the opinion that the advice received was genuine. This is illustrated by some of the quotes taken from the women

> "*always been supportive and encouraging and even inspiring for me*" (AT30s)
>
> and gave an "*unbiased perspective even though she was my friend*" (AT;20s)

Therefore, since of some of the women felt that they could openly communicate with their friend; it became easier for them to express their feelings and the difficulties they were experiencing. Additionally, it may be argued that the concept of selective optimization with

compliance was seen here again as one of the women stated below, being of similar ages was reassuring to her as the advice received catered to her needs

> "*they were of the same age and I could have related with my issues and so it was easier for them to understand as well as gain advice"* (AT; teens to 20s).

Therefore, age seem to have encouraged some of the women to divulge information to the friend with the hope that it would provide them with some sort of solution to their general problems. Similar sentiments were echoed by some of the women who sought help from a friend for their **somatic symptoms**. These women stated that their friend listened to their issues, and understood what they were experiencing, and as a result, they experienced some relief from their somatic symptoms. This is illustrated by some of the quotes from the women:

> "*good listener*" (IT;30s);
> "*able to communicate and have discussions about feelings, thus getting relief from symptoms*" (IT;30s) and
> "*understood feelings and shares advice*" (IT;20s)

This in turn may have helped reduce some of their somatic distress, as some of the women now had an avenue to vent their feelings without being judged. Being able to openly communicate with their friend seems to have contributed to some of the women feeling reassured that their symptoms would improve.

However, this level of contentment was not voiced by all the women, when assistance was sought for domestic violence experiences, as age now became a negative component. Some women were of the opinion that the friend was either not trained (educated) enough on the subject matter to offer advice, or because of their age he/she could not relate to what they were experiencing. The following quotes are taken from some of the women:

> "*not qualified to give solutions that are professional*" (IT;40s), or

> "*they themselves haven't gone through the situation and had almost no experience in dealing with it*"(AT; teens to 20s) and
> same "*age and may not have much experience in life changing decisions*" (AT; teens to 20s).

Therefore, it seems that even though some of the women were pleased that their friend was of similar age, for some their schemas did not permit them to view the friend as not possessing enough life experiences to offer advice regarding their experiences of domestic violence.

b. Confidentiality: The second sub-theme that emerged was the friend as a confidant; someone whom they could communicate with. The women who sought help from a friend for their **domestic violence experiences** stated that the friend was able to provide them with an atmosphere where they could privately discuss their experiences. As some of the women stated:

> "*I felt as though I had someone whom I can trust and I know will be there for me rather than going to a complete stranger*" (AT; teens to 20s).
> *"confidentiality, empathy and sound advice*" (AT;40s)
> "*more confidential and less political*" (AT;40s) or
> "*confident advisors and the freedom to vent*" (AT;50s)

From these quotes it appears that the friend did not need to provide solutions to their problems as with the other sources of help (medical doctor or counsellor), but rather that their role was more supportive, by providing a confidential atmosphere. This assertion may be linked to the religious leader, as similarly some of the women stated they were comfortable in disclosing their challenges to him/her. Accordingly, being able to confidentially explore challenges with a friend seems to have positively impacted on the women's help-seeking experiences. As with the previous sources of help discussed (medical doctor, religious or spiritual leader and counsellor) it gives the impression that what women most appreciated was being heard.

Some of the women revealed that their interactions with their friends provided them with a sense of comfort and this, in turn, helped them feel better:

"*give encouragement and makes you feel better*" (IT;50s) and
"*assisted in comforting me at that time and still does*" (IT;40s)

Therefore, it may be argued that even though the friend did not provide them with any solutions to their general problems, somatic symptoms or domestic violence situation, but through listening to their problems the women felt hopeful about their situation thus, they experienced anticipatory coping; which in turn assisted them with reducing the stressful situation by implementing advanced efforts.

c. No trust: However, once again, as with most sources of help stated by the women, even though there was a positive aspect, there was also an undesirable one. Some of the women cited the friend as a negative source of help for their **general problems**, stating that the friend could not always be trusted and that confidentiality was not always a priority for the friend. As two women reported, their friends would discuss their challenges with other persons:

"sharing my personal to the world" (IT;30s) and
"*tell your secrets or say some bad things about you*" (IT;30s).

Therefore, there seems to be a lack of confidentiality expressed by some of the women, and this may have hindered some from seeking additional support from this source.

Summary

For some of the women, the friend was not always reassuring because they could not openly communicate their experiences. Consequently, it may be noted that the friend was viewed as both helpful and not-so-helpful source of support to the women for their general problems, somatic symptoms and domestic violence experience. The women in their late teens to early 20s seem to have conflicting views regarding issues associated to age related advice. Some stated that age was a positive influence, as they were able to discuss their challenges with someone who may have a similar perspective. However, age was also viewed as a hindrance for some women

were of the opinion that their peers lacked the understanding and experience needed to advise them. This leads into the family or relative as another source of informal support for the women.

5. Family/Relative

The family served an important role in the helping process for some of the women. This section of the findings highlights the reasons cited for why family/relative was helpful or not. The helpful themes that emerged were trust, support and encouragement and listening. The undesirable themes were not supportive or biased, or a lack of close relationship existing between the women and the family or relative.

Table 9 below provides a summary of the findings about the family/relative as a source of help to some of the women for their general problems, their somatic symptoms and domestic violence experiences. As shown in table 9, many of the women felt that the family member or relative was able to provide them with trust, encouragement, and a listening ear. Whereas some women voiced this was not possible, as they never had a close relationship, therefore, could not confide in them.

Table 9: Family/Relative's role in help-seeking

FAMILY/RELATIVE	
Supportive	**Not Supportive**
"*I believe it to be more confidential, they know my situation and me as an individual. I am more trusting of them*"	"*wasn't all that easy to tell them all my problems. Wasn't comfortable talking to them*"
"*source of support and encouragement; never lets you down*"	"*lack of empathy*", *confidentiality and occasionally gave poor advice*"
"*good person to talk to and gives good advice*"	"*never grew up with close relatives*"
"*emotional support given"*	"*not supportive enough*"
"*were able to listen with care and attention no matter how stupid you are sounding/behaving. They help put the problem into perspective*" (IT40s)	"*I feel like I am being judged and at times they act too emotional towards certain situations*"

a. Trust: One of the sub-themes that emerged from the data with regard to family/relative was trust. Some of the women stated that the family was a trusted source of help when it came to managing their **general problems**; as they were familiar with the person and therefore a sense of

trust already existed, as a result they were able express themselves. For example, some of the women stated:

> "*I trust the person*" (IT30s) or
> "*I believe it to be more confidential, they know my situation and me as an individual. I am more trusting of them*" (AT; 30s).

Subsequently, when some of the women felt they could express their feelings or discuss their challenging situations with the family or relative, this provided them a sense of encouragement. This may be related to the cultural traditions of the family. According to Maharajh (2010) Trinidad is still viewed as a fairly traditional society with regard to the family, therefore, when women sought help from family members because of obligation and not wanting to be viewed as "bad" and "uncaring" (Maharajh, 2010) this may have offered assistance to some the women.

b. Support and encouragement: Another sub-theme derived from the data with regard to satisfactory assistance received from a family/relative was support and encouragement. In addition to some of the women stating that they could trust the family/relatives with their challenges, the women also reported that when they sought help for their **general problems** they also received "support and encouragement". This presented itself in the form of emotional support, and offering advice.

> "s*ource of support and encouragement; never lets you down*" (IT;30s) or
> "*emotional support given"* (IT;40s)
> *"usually provide sound advice based on their experience*" (IT;30s).
> "*not only educate me on the specific problem, but also encourage me with the situation*" (AT;40s)

The above quotes convey the message that some of the women may have also needed to the reassurance and unconditional positive regard that there were others would support them no matter what their challenges were.

Similarly, when some of the women sought help for their **somatic symptoms** from a family member or relative, they stated they also received support that encouraged them

> *"were able to understand my situation and give great words of encouragement*" (AT; teens to 20s) and "*family gives me the support and encouragement to continue*" (AT;30s).

These sentiments were also expressed by some of the women who sought help for their **domestic violence experiences**. Additionally, it may be argued that some of these women's relatives were intrinsically motivated as they provided practical support in the form of monetary gifts that would help. Additionally, some of the relatives expressed support by listening:

> "*financial*" (IT;60s) and
> "*good person to talk to and gives good advice*" (AT;20s).

For that reason, the women appreciated the comfort and support received, as having someone to speak with when encountering challenges may have provided them with emotional support.

c. Not supportive: However, even though the family/relative seems to have had a positive influence for some of the women, others were not in agreement. Some of the women stated that the family/relative was not supportive, or that they were biased when providing assistance to them for their **general problems:**

> "*not supportive enough*" (IT;30s)
> "*biased at times*" (IT;30s)
> "*advice was prejudicial*" (IT;40s)
> "*take sides*" (IT;20s & AT; teens to 20s)

when the problem was presented, or that there was a

> "*skewed point of view*" (AT;30s).

As a result of this, some of the women were of the opinion that the help received was not beneficial, as no positive outcomes were accomplished. The women who sought help from a family member or relative for their **somatic symptoms** echoed similar experiences, as they stated the family or relative were unsupportive; lacked sympathy and apathy; or were not knowledgeable about mental health issues. This, in turn, encouraged some of the women to not disclose these somatic symptoms to the family/relative. These are illustrated by some of the quotes:

> "*lack of empathy*", *confidentiality and occasionally gave poor advice*" (AT;40s),
> "*not tend to be open minded about emotional/mental issues*" (IT;30s) and
> "*always available and at times could be difficult voicing certain feelings to them*" (AT; teens to 20s).

The lack of support that some of the women received for their somatic symptoms may be linked to individuals not being well-informed about what is somatization disorder. The findings presented in the quantitative results section, indicated that most of the sample were not aware about what somatization disorder was. In addition to a lack of knowledge regarding somatization disorder, a communication barrier seems to have existed for the women who sourced help for their **domestic violence** experiences for a family/relative. Some of the women stated that the family/relative appeared to be uninterested, and, as a result, a sense of comfort was not experienced:

> "*ignore you*" (IT;40s) and
> "*wasn't all that easy to tell them all my problems. Wasn't comfortable talking to them*" (IT; teens to 20s)

For some of the women, help-seeking for domestic violence experiences appeared to be a challenging and unsatisfying one. Domestic violence is still considered a taboo topic for many societies and cultures, and, therefore, this may have contributed to some of the reactions from the family/relative. Furthermore, because of culture and social influence, the family member may choose to ignore the woman, as domestic violence is seen by some as a "domestic adjustment

problem" that should be dealt with by both parties involved and not outside sources (Singh, 2007, p.128). Therefore, the family/relative may "ignore" the woman in an effort to not get involved in what they term as an immediate family problem (Maharajh, 2010; Nagassar et al., 2010; Nashaz, 2000). As quoted by one of the women:

> "*seeking further professional help was not in the culture of my upbringing. May lead to feelings of embarrassment*" (IT;40s).

Overall, there seems to be a lack of understanding from the family/relative with regard to domestic violence. As a result, some of the woman felt that this source was not beneficial.

Summary

In conclusion, the role of family member or relative in help-seeking may be viewed as an important one. The family may provide individuals with a sense of comfort and trust, and this may encourage them that their challenges will be resolved. Even though many of the women indicated the support received from the family or relative was beneficial, some disagreed. For those women, they stated that the family/relative was not interested in offering assistance, they were biased, or were not in a close relationship with them.

6. Police and Government Organizations

Two sources of help that were identified by some of the women were the police and government organizations. It should be noted that none of the women in this study cited these sources as a potential help avenue for their domestic violence experiences, but only sought help for their **general problems** (such as, legal matters). These sources were also only viewed as negative.

a. No solutions: Some of the women stated that seeking help from the police did not provide them with any solutions, and the time taken to seek assistance from this source was not being constructively utilized. This is illustrated by a quote by one of the women:

> "*waste of time*" (IT;40s)

This woman was of the opinion that seeking assistance from the police for general challenges was not productive, and, her time was misused. Some of the other reasons cited for why the police was not helpful were: the level of attention received and the style of communication by the police was not acceptable. As stated by some of the women, the police

> "*ignore you*" (IT;50s) or
> "*issue in delivery of effective and efficient service*" (AT;30s).

These issues may have also contributed to some of the women feeling unsupported by the police, and thus, giving the impression that the advice offered was insufficient. As some of the women stated the police

> "*did not support me"* (IT;30s) and they were given
> *"poor advice"* (IT;50s).

The above quotes suggest that some of the women who sought help from the police were not pleased with the assistance. As one woman stated that the police have

> "*only book sense and no common sense and wanting government money"*
> (IT;30s)

b. Bureaucracy: Additionally, help received from government organizations was also only deemed unhelpful for some of the women's **general problems**. One woman expressed that when she sought assistance for her problems there was no one available to answer her questions, as illustrated by the following quote:

> "*gives you the run around*" (IT;30s)

In addition, to not receiving accurate information regarding her matter, some of the women stated that, there were negative issues regarding the system itself, as one women stated:

"*to many red tape*" (IT;30s)

The above quotes convey the message that some of the women were of the opinion that their issues were not being heard and thus, not dealt with accordingly as a result of personnel being viewed as uncaring. As one of the women stated:

"*they know the least about you, hence may not genuinely care about you problems"* (AT; teens to 20s)

Thus, all of these may have contributed to some of the women's discontentment with their help-seeking experiences from a government organization.

Summary

This study surveyed 150 Indo- and Afro-Trinidadian women: some of the women report experiences of domestic violence, however, none of them chose to seek assistance from the police for this matter. Flood and Pease (2009) debated that police reactions may also influence the woman's decision to seek help. This may be linked to some of the women expressing that when they sought assistance from the police they felt they were not being heard, their time was being wasted, the mode of delivery was not efficient, they were being offered poor advice, and, as a result felt unsupported. As a result, a sense of mistrust may have developed between the police and the some of the women, hereby deterring some from disclosing their domestic violence experiences to them. This poses a problem for the detection and prevention of domestic violence. Statistics may not be as accurate ("Artists United to End Violence against Women" 2011) and therefore policy makers may not be aware of the extent of the issues and would not have the necessary tools to implement amendments to the existing domestic violence legislation.

Some of the women's experience of bureaucracy was a negative one; and this may have tainted their view of government organizations. However, what seems to be an over-arching theme expressed by some of the women was that they believed some of the individuals working at the government organizations were not motivated to care enough about their needs. From all the sources of help discussed (medical doctor, religious leader, counsellor, friend or family or

relative), what seems to have contributed to the women being satisfied with the help received was 'being heard'. When the women felt that their opinions were being ignored, this appears to have contributed significantly to their dissatisfaction with their help seeking choices.

4:18 Discussion

This chapter through quantitative findings suggests that Trinidadian women, in general, were more likely to experience somatic symptoms if they had experiences of domestic violence. This finding is consistent with international and local (Trinidad) research, which suggests that some women who experience domestic violence will also have somatization disorder (Brown, Schrag & Trimble, 2005; Hegarty et al., 2004; Holloway et al., 2000; Kassiram & Maharajh, 2010; Maharaj et al., 2010; McCauley, Kern & Kolodner et al., 1995; Samelius et al., 2007; Righter, 1999). However, it also suggests that Indo-Trinidadian women living in a western culture, seems to express illness in a manner similar to their ancestors from India (Kassiram & Maharajh, 2010) and other Asian cultures. It may be further argued that as a result of accelerated interaction between Indo-Trinidadians because of culture based on problem solving that this form of expression of illness may be based on 'traditional' problem solving that have been met with success (Cheng, 2001; Na & Kitayama; 2011; Kirmayer & Sartorius, 2007; Sewell, 2005; Straub et al. 2002). The implication of this finding is discussed in chapter 7 (discussion).

Indo-Trinidadian women are also more likely to have somatization disorder and to have experienced domestic violence than Afro-Trinidadian women. Additionally, the Indo-Trinidadian women were also more likely to somatize their distress if they had experiences of domestic violence. These findings support previous local (Trinidad) research (Kassiram & Maharajh, 2010; Maharaj et al., 2010). These findings suggest that the expression of somatic symptoms and help-seeking for domestic violence may be culturally linked. Additionally, that not only is culture linked but may also be learnt, as discussed in Chapter 2 (Literature Review). This possible link will be further discussed in chapter 7 (Discussion Chapter). Moreover, the finding that the majority of Indo-Trinidadian women have more somatic symptoms and domestic violence experiences than Afro-Trinidadian women has provided some insight into the differences in expression of illness with regards to ethnicity, which was initially absent from previous research on this topic (as noted earlier, no studies to date have been conducted to

investigate Afro-Trinidadian women's experiences of these intersecting issues). The implications of this finding will be discussed in detail in chapter 7. Furthermore, this study revealed that more Indo-Trinidadian women had experienced domestic violence. Local (Trinidad) research states that there is the 'perception' that East Indian women in Trinidad experience more domestic violence than their counterparts belonging to other ethnic groups (Hadeed & El-Bassel, 2006; Rawlins, 2000). This research has provided the empirical data missing to support this 'perception'. Possible explanations for this are also critically discussed in the discussion chapter (chapter 7).

Seeking assistance for somatization disorder and domestic violence is a multifaceted decision (Gerbert et al., 2002; Sharpe & Carson, 2001). International (Cheung, 1995; Hardin, 2002; Jabinsky, Satorius & Gulbinat, 1981; Kirmayer & Sartorius, 2007; Maharajh, 2010; So, 2008; Tseng, 2005) and local (Trinidad) research have emphasized that many women who present with somatic symptoms would rather be considered as having physical complaints instead of a psychological problem. Kassiram and Maharajh (2010) suggest that this could be as a result of cultural restrictions; some women would not seek help for psychological ailments but rather physical ones. This can be noted by the finding that the more Indo-Trinidadian women sought assistance for their challenges from the medical doctor. Therefore, it may be argued that the Indo-Trinidadian women in this study were trying to manage the impression others may have of them (impression management). As, Maharajh (2010) further suggested that Indo-Trinidadian women seem to still place a lot of emphasis on "looking good" (p. 322) to their fellow neighbours. They would rather seek support from a less stigmatized source of help, such as a medical doctor as opposed to a psychologist.

This finding feeds into the qualitative results gathered from this study. The findings suggest that some of the women were pleased with the help they had received from the medical doctor, religious or spiritual leader, counsellor, friend and family/relative. This sense of contentment seems to be as a result of the women feeling that they were being heard and the person giving the help cared. Additionally, when the women did not receive an avenue to vent and/or discuss their challenges, they felt unimportant, and this contributed to some not being satisfied with the help, for example, in the case of seeking assistance from the police and government organizations.

This supports research by Epstein et al., (2006) which states that patients visit the physician for validation of their symptoms, and to get a meaningful explanation of these symptoms. Also, women who received positive social support when in an abusive relationship, tend to cope better with the situation, and significantly helped in rebuilding their lives and relationships (Giesbrecht & Sevcik, 2000; Hadeed & El Bassel, 2006; Liang et al., 2005).

Therefore, it is important that help agencies seek to promote an atmosphere where individuals seeking help feel comfortable and able to frame and ask questions in a manner that may assist in transfer-appropriate processing. That is, positive/negative memories are evoked and retrieved and dealt with accordingly. This is especially so for persons who have somatic symptoms and experience of domestic violence, as these are very sensitive issues. By providing a safe and conducive environment, women may be more encouraged to seek the appropriate help and find solutions to their problems. All of these finding are critically discussed in relation to international research in chapter 7 of this thesis.

Findings from this study informed studies two and three of this thesis. Study two sought to explore with both Indo- and Afro-Trinidadian women, more in-depth, their experiences of help-seeking for their somatic symptoms and domestic violence experiences, specifically from medical doctors and religious leaders; this is discussed in chapters 5 (IPA analysis of help-seeking) and 6 (religious leaders' and medical doctors' intervention). Study three focuses on the professionals that women sought help from for either their domestic violence experiences or somatic symptoms. Study three also focuses on medical doctors and religious leaders and explored their resources, willingness to explore and intervention strategies they employed when meeting with women who may have domestic violence experiences and somatization disorder; this is discussed in chapter 6 (religious leaders and medical doctors intervention).

Chapter 5

An Interpretative Phenomenological Analysis of Indo- and Afro-Trinidadian women's experiences of help-seeking for domestic violence and somatization disorder.

5:1 Introduction

This study aims to increase our understanding of Indo- and Afro-Trinidadian women's experiences of domestic violence, their somatic symptoms, and the help they sought for these problems. Utilizing an Interpretative Phenomenological Perspective (IPA) (Smith, Flowers & Larkin, 2012) this study examines how the women interviewed manage and make sense of these issues when they intersect. This chapter also highlights the methodology and the rationale for adopting an IPA perspective, while discussing the various aspects of this methodology by considering the participants, research design, sampling method, and materials used and procedure to collect and analyse data. Finally, this chapter attempts to present the data gathered in a manner that highlights the women's experiences with their choice(s) of help sought for either their somatic symptoms, domestic violence experiences, or both.

5:2Rationale for adopting qualitative research for study two

Qualitative Research

"Drawing from a long tradition in anthropology, sociology, and clinical psychology, qualitative research has, in the last twenty years, achieved status and visibility in the social sciences" (Merriam, 2002, p. 3), as it has been argued that it enables the researcher to obtain a "thick description"[38] of the phenomena being investigated (Whitley & Crawford, 2005). Since this study sought to gain insight into Indo- and Afro-Trinidadian women's help-seeking experiences for their somatic symptoms and domestic violence experiences, a qualitative approach was adopted. Compared to a quantitative approach which seeks to measure by means of statistical analyses the extent or size of a phenomenon, and where the ability to predict the outcome is desired (Kitto, Chesters & Grbich, 2008; Whitley & Crawford, 2005), qualitative research is

[38] Accurately describes and interprets social action within the context in which it took place. It also assigns intentionality and purpose to these actions; capturing the emotions, thoughts and as well as the complex social interaction among the participants in such a manner that the behaviour also becomes meaningful to an outsider (Ponterotto, 2006).

concerned with gaining insight into how individuals interact and experience the world in which they live in, and thus the meaning they attach to these experiences (Merriam, 2002). Some researchers (Kitto, Chesters & Grbich, 2008; Merriam, 2002) have argued that one of the major objectives of the qualitative approach is "to explore the behavior, processes of interaction, and the meanings, values and experiences of purposefully sampled individuals" (Kitto, Chesters & Grbich, 2008 p. 243), thus, capturing and recording the "multiplicity" and "complexity" of that experience (Merriam, 2002). Therefore, in order to achieve the aims of study two listed below, a qualitative approach best captured the women's experiences of domestic violence, the impact their somatic symptoms had on their lives and their overall experiences with help-seeking for these issues.

1. *To investigate in depth with the women their experiences of their somatic symptoms and their experience of help-seeking, and support from others, in relation to this.*
2. *To explore with the women their experiences of domestic violence and their experience of help-seeking, and support from others, in relation to this.*
3. *To explore the ways in which the women manage, and make sense of, these issues when they intersect.*

By addressing the above aims through a qualitative approach, it is hoped that the research question *"Do Indo- and Afro-Trinidadian women find medical doctors and religious leaders supportive when dealing with their somatic symptoms and domestic violence experiences?"* would be addressed. Thus, semi-structured interviews are the best method, as they provide appropriate data for the chosen method of analysis (Interpretative Phenomenological Analysis), which will allow the research question to be addressed.

Qualitative Interviewing (Semi-Structured Interviews)

One of the methods qualitative researchers utilize to gather data is interviews (Orb, Eisenhauer & Wynaden, 2001). DiCicco-Bloom and Crabtree (2006) have contended that the interview method is one of the most "familiar" approaches used for collecting data of a qualitative nature. Thus, in order to address the above aims and obtain information that reflects the women's behaviours,

meaning, interactions and values they place on their domestic violence experiences, somatic symptoms and the help sought for these, semi-structured interviews were used to collect data from a predetermined sample (sampling is discussed in the following section).

There are different types of interviews, for example, the unstructured, the structured and the semi-structured interview. For the purpose of this study semi-structured interviews were utilized. Compared with structured interviews where there are fixed questions, or unstructured interviews, which may be conducted in conjunction with observational data, it has been argued that semi-structured interviews enable the researcher to facilitate more of a dialogue between the researcher and interviewee, thus allowing questions to emerge from other questions; encouraging more personal experiences being expressed and allowing richer data to be gathered (DiCicco-Bloom & Crabtree, 2006; Roulston, 2010). Semi-structured interviews may also be done either individually or in a group (DiCicco-Bloom & Crabtree, 2006). For this study, interviews were conducted on an individual basis, because of the sensitive nature of the topics being investigated. This allowed for the confidentiality of the participant to be maintained (this is further discussed in the ethics section of this chapter), compared with a group setting in which the participants may have felt they did not have the privacy to be able to discuss their experiences in-depth. Smith and Osborn (2008) also argue that semi-structured interviews encourage rapport to be built and evoke empathy, and allow for greater flexibility which then enables the interviewer to explore novel areas with the interviewee, thus producing richer data.

Additionally, interviews can last anywhere from 30 minutes to several hours (DiCicco-Bloom & Crabtree, 2006). For this study, each individual interview lasted between 45 minutes and one hour, enabling the researcher to delve deeply into the personal experiences of the women (further discussed in length in this chapter). This method therefore, allowed in-depth information to be gathered, thus, capturing the experiences of the women with regard to their help-seeking options for their domestic violence experiences and somatic symptoms.

But even with these rationales for the use of qualitative interviewing, there are some researchers who disagree with this approach. Roulston (2010) argues that authors across disciplines advocate that interviewing is fraught with problems. Douglas, 1976, cited in Walford, (2007) states that:

> [there is an] epistemological question of whether or not there is any ultimate 'reality' to be communicated, the interviewee may have incomplete knowledge and faulty memory. They will always have subjective perceptions that will be related to their own past experiences and current conditions. At best, interviewees will only give what they are prepared to reveal about their subjective perceptions of events and opinions. These perceptions and opinions will change over time, and according to circumstance. They may be at some considerable distance from 'reality' as others might see it (Walford, 2007, p.147).

Additionally, Smith and Osborn (2008) state that interviewing takes longer to carry out than some questionnaires, is seen as more difficult to interpret, and reduces the amount of control the interviewer has over the situation. However, despite these arguments, interviewing still allows the researcher to be transparent in order to "elicit data that will inform understandings of the meanings that participants make of their lived experiences" (Roulston, 2010, p. 203). Thus, utilizing this form of data collection for study two allowed the researcher to obtain data that reflected the women's experiences of domestic violence, somatic symptoms and how these impacted on their help-seeking. Further noted, according to Kvale (1996, p. 145) cited in Roulston (2010), there are six criteria for judging the quality of an interview:

1. Spontaneous, rich, specific and relevant answers from the interviewee.
2. Shorter interviewer questions and longer interviewee answers.
3. The degree the interviewer follows up and clarifies the meaning of relevant aspects of answers.
4. The ideal interview is, to a large extent, is continuously interpreted throughout the interview.
5. The interviewer attempts to verify his/her interpretation of the interviewees answers during the interview.
6. The interview is self-communicating – a story contained in itself that does not require much extra description.

Throughout the data analysis in the results section of this chapter, these six criteria are demonstrated with the help of excerpts from the various interviews.

5:3 Interpretative Phenomenological Analysis

An interpretative phenomenological approach (IPA) was adopted for this study. It has been suggested that IPA is "a qualitative approach committed to the examination of how people make sense of their major life experiences" (Smith, Flowers & Larkin, 2012, p. 1). Additionally, IPA is also "concerned with the detailed examination of human lived experiences" (Smith, Flowers & Larkin, 2012, p. 32). It has been further debated that it "aims to conduct this examination in a way which as far as possible enables that experience to be expressed in its own terms, rather than according to predefined category systems" (Smith et al., 2012, p. 32). For these reasons, this approach assisted in the understanding of the women's insight about their experiences and the meanings they have attached to them, specifically their help-seeking behaviours for their somatic symptoms and domestic violence experiences that another approach may not have been able to capture.

In the past 10 to 15 years it has been argued that IPA has gained both in momentum and popularity (Pringle & Drummond, 2010). Additionally, IPA is said to be rooted in the underpinnings of psychology and pinpoints the important role the researcher has in the understanding of, and making sense of the participants' experiences (Pringle & Drummond, 2010; Smith, 2004). Similar to thematic analysis, which is used for identifying, analysing and reporting themes, Braun and Clarke (2006) also contend that IPA is inhibited by its theoretical origins (Pringle & Drummond, 2010). However, according to Pringle and Drummond (2010, these roots can be said to add a "sense of depth and purpose that thematic analysis lack" (2010, p.24). Discourse analysis, while similar to IPA in that they both share a commitment to the significance of qualitative analysis and language, does differ from IPA "in its perception of the status of cognition" (Chapman & Smith, 2002, p.88). Discourse analysis is skeptical of mapping verbal reports, whereas IPA is concerned with the participants' understanding of their lived experiences and the meaning(s) they assign to these (Brocki & Wearden, 2006; Chapman & Smith, 2002). Thus, IPA allows the participant to be more creative than any other approach (Willig, 2001). Therefore, for the purpose of study two IPA helped the participants to 'tell their

stories', and engaged with the various meanings the women placed on their somatic symptoms, domestic violence experiences or both, and their reactions to the help they sought and received for them.

Furthermore, it has been argued that IPA encourages the participant to interpret their own experiences in a manner that is understandable to them (Brocki & Wearden, 2006). Moreover, in addition to the participant trying to make sense of her world, the researcher is also trying to understand how the participant understands her world (Smith & Osborn, 2008). Thus, by asking questions, the researcher is trying to understand the participant's view of her challenges and get closer to her "personal world" (Smith & Osborn, 2008). For this study then, IPA facilitated the understanding, interpretation and meaning the participants attached to their experiences of domestic violence, somatic symptoms or both, and their encounter with the various help agencies from which they sought assistance for these.

5:4 Method

5:5 Participants

A purposive sampling method[39] was utilized, where the participants shared critical similarities that are related to the research questions. This method also aids in maximizing the richness and depth of the data collected (Brocki & Wearden, 2006; DiCicco-Bloom & Crabtree, 2006). According to Kitto, Chesters and Grbich (2008) by "constantly comparing the experiences and responses of participants against each other, subtle differences can be uncovered" (p. 244) which helps to increase the richness and depth of the data collected in order to fully address the research questions of the study (DiCicco-Bloom & Crabtree, 2006). Therefore, twelve interviews were conducted, with Indo (n=7) and Afro (n=5) Trinidadian women who were screened for somatization disorder, who had experienced domestic violence. The women were over the age of eighteen years who took part in study one (conducted in 2011). Table 10 below provides a summary of the participants' characteristics with regards to their ethnicity, age and whether they had domestic violence experience, symptoms associated with somatization disorder or both.

[39] "A process that deliberately recruits individuals or groups with the requisite demographic or clinical characteristics into the research, allowing the study to be grounded in a local context" (Whitley & Crawford, 2005, p. 117).

Table 10: Participants Characteristics

Name	Approximate Age	Ethnicity	Somatization Disorder (SD)/Domestic Violence (DV)
Anna	30s	Indo-Trinidadian	SD & DV
Betty	30s	Indo-Trinidadian	SD & DV
Nana	Late Teens	Indo-Trinidadian	SD & DV
Reshma	30s	Indo-Trinidadian	SD
Charmain	50s	Afro-Trinidadian	DV
Rahni	40s	Indo-Trinidadian	DV
Lola	20s	Afro-Trinidadian	SD
Charlie	30s	Indo-Trinidadian	DV
Lee	30s	Indo-Trinidadian	SD
Cecelia	40s	Afro-Trinidadian	DV
Cassie	40s	Afro-Trinidadian	SD & DV
Classic	30s	Afro-Trinidadian	SD

The age ranges of the women were between 20s to 50s; with Indo-Trinidadian women between 20s to 40s and Afro-Trinidadian women within the 20s to 50s age range. These women scored significantly on the Brief Symptom Inventory-18[40] (BSI-18, developed by Derogates, 2001) for somatization disorder, and over the mean score of 11[41] on the Coercive Control Measure for Intimate Violence (Dutton, Goodman & Schmidt, 2005). Eight Indo-and four Afro-Trinidadians fit the criteria for somatization disorder, from which two Indo- and two Afro-women were interviewed. Twelve Indo- and twelve Afro-Trinidadian women were identified as having a

[40] As stated by the developer of the BSI-18 Derogatis (2001) – "The rule states that if the respondent has a GSI T score of 63 or higher (on the community norm), or any two dimension T scores are 63 or higher, the individual is considered a positive risk or a "case" (p.2)

[41] The mean was used: firstly, the mean uses every score, while the median and mode may ignore some scores in the data set. Secondly, the mean tends to be stable in different samples (Fields, 2009). Finally, the mean provides the average score for that sample.

mean score of 11 or above on the Coercive Control Measure for Intimate Partner Violence, from these twelve, two Indo and two Afro women were interviewed. Also, twelve Indo- and four Afro-Trinidadian women were identified as having both somatization disorder and domestic violence experiences. From this, one Afro- and three Indo-Trinidadian women were interviewed. In order to ensure that twelve women would participate, fifteen women were contacted. Three women declined to participate.

The gatekeepers from study one were also used for this study. Assistance was sought from five gatekeepers (4 females and 1 male) who were also used in study one, and were, therefore, familiar with the aims of the thesis, and, in turn, the women. Their occupations included secondary school teacher, university lecturer, pastor, retired primary school teacher and clerical worker. The gatekeepers assisted in gaining access to various sites approved by the Ethics Committee to conduct the interviews; only two gatekeepers were used to gain access to the women. The male gatekeeper (pastor) tried to gain access to one of the women as the telephone number I had for her was no longer in service, but he was unsuccessful. Therefore, another one of the women who fit the criteria for somatization disorder and domestic violence was contacted. For the female gatekeeper (clerical) I did not have a contact number for the participant, and the gatekeeper provided this. For the majority of the women I already had contact details, and I was therefore able to contact them directly.

5:6 Materials

Study two was designed to gather information regarding the experiences of help-seeking by Indo- and Afro-Trinidadian women for either their somatic symptoms, domestic violence experiences or both. This study sought to obtain insight into the women's lived experiences, that is, what meaning they attached to their experience. In order to access this information three separate interview schedules were designed for somatization disorder (appendix Ma), domestic violence (see appendix Mb) and both (see appendix Mc). The various interview schedules were constructed prior to the interviews in order to allow the researcher to consider the contents of the interview and to foresee possible challenges with wording and give some thought as to how these could be resolved (Smith & Osborn, 2008). Thus, questions for this study served to guide the interviews.

According to Smith, Flowers and Larkin (2012) one of the aims of formulating an interview schedule is to help the interviewee to express her experiences, thus assisting her to feel comfortable in providing a detailed account of these experiences. The interview questions should also encourage the participant to speak at length and be as open as possible. For example, questions such as *what else was going on for you in your life when your partner acted like this?* Or *did you speak to anyone about what you were feeling?* were posed to the women and their responses then assisted in leading the interviews. Various prompts were also decided upon prior to the actual interviews, in order to also help encourage the participant to elaborate on a response given. For example: *"what about your family, what was happening?"* Each interview schedule comprised four to nine main questions and various prompts (please see appendices Ma, Mb and Mc for the detailed interview schedules).

Additionally, all (interview) schedules were constructed with discussion focusing on 4 areas:

1. The women's experiences of help-seeking for their domestic violence experiences
2. The women's somatic symptoms
3. The women's experiences of help-seeking for their somatic symptoms
4. The women's experiences of domestic violence

All interviews were audio recorded and transcribed; detailed explanations of these are discussed in subsequent sections of this chapter.

5:7 Procedure

Data collection took place over a period of two months (June to July 2012). Initially, when the women were selected from study one, they gave their contact details to the researcher and verbal protocol was agreed upon (see appendix G). Therefore, some of the participants were contacted while the researcher was still in the United Kingdom. For example, the researcher would telephone and ask, *"Hello, I am Astra Kassiram, the PhD student you had your interview with last July/August/September 2011at the community center; is this a good time to speak with you?"*. Each woman was then asked if she was still willing to participate in the study. If she was, then a time was arranged for the researcher to contact her again to finalize details of when and where the interview would take place. If the participant was no longer willing to participate,

then she was thanked for her time. When the researcher arrived in Trinidad the willing participants were contacted again and asked if they were still willing to participate, but also reminded that they were free to withdraw without any consequences. If they were still willing at this point a date, time and place were agreed upon for the interview to be conducted. For the women contacted for the first time, when the researcher arrived in Trinidad, the above was done with the exception that, if the women agreed, a date, time and place were decided upon within that initial contact.

At the pre-approved interview site, the researcher explained in detail, with the use of the information sheet (appendix N), what the research entailed. All interviews were audio-recorded and the women were reminded that they could stop recording at any time without any negative consequences. Also, the women were asked to give an alias by which they would like to be referred to throughout the interview. Once the women understood, they were then presented with a consent form to sign (see appendix O). The entire interview took between 45 minutes to one hour to complete, depending on the experiences of the women. On completion of the interview, each of the women was given a debriefing sheet (see appendix P). Additionally, each of the women was given TT$100.00 dollars (approx. £10.00) for transportation to and from the interview site. The women were also given some light refreshment at the end of the interview. In order to gain a better understanding of this procedure, the actual interview process will now be examined.

Interview Procedure

This section attempts to highlight the steps taken in the actual interviewing process to ensure that rapport was established. When good rapport is built, it encourages the participant to divulge information that is beneficial to the topic under investigation (DiCicco-Bloom & Crabtree, 2006). Thus, qualitative interviews usually employ questions that are open and more loosely structured where the interviewee is as much in control of the agenda as the interviewer (Whitley & Crawford, 2005). Additionally, it is also important that rapport be established; where a sense of trust and respect is developed to enable the participant to share her experiences more freely. Also, it is important that the participant feels safe and that the environment promotes this sense of safety (DiCicco-Bloom & Crabtree, 2006). This was partly accomplished when the researcher

initially met the participants when data was collected from them in study one. Thus, the participants had already met the researcher and trust and respect were established from then. This aided in facilitating the interviews and encouraged participants to share many personal details about their lives.

But even so, some participants needed more time with the researcher to develop this sense of trust and security. Even though Spradley (1979) could be considered to be rather dated, it does identify stages of rapport that can be seen as relevant today and more so to this research. Thus, Spradley's (1979) basic outline is used together with more recent research by Brochi and Wearden (2006), DiCicco-Bloom and Crabtree (2006), Orb, Eisenhauer and Wynaden, 2001and Roulston (2010). Spradley (1979) stated that building rapport usually includes stages such as 'apprehension', 'exploration', 'co-operation' and 'participation'.

First, 'apprehension'. Here the participant is uncertain about the researcher, because of the "strangeness of a context" in which they may be new to the situation (Spradley, 1979). Thus, it is recommended that the first question in the interview be open ended, broad and non-threatening (Brochi & Wearden, 2006). Therefore, for this study the first questions for each interview schedule were designed to capture this, for example, "*last time we spoke you mentioned that you were experiencing some problems in your relationship; can you tell me some more about this?"* In response to the answer given by the participant, the follow-up question can either be unplanned or carefully considered. Thus, the next question should be as non- directive as the researcher can make it, for example, *"how do you feel about the way he acted towards you?"*

The use of prompts (by repeating the words used by the participant in the interview) is also very helpful, as it encourages the participant to speak and clarify information (DiCicco-Bloom & Crabtree, 2006; Spradley, 1979). This can be seen from an example where the participant used the expression 'food card'. The researcher then repeated only these words, thus encouraging the participant to elaborate on this topic.

By encouraging the participant to fully describe what he/she has experienced, the 'exploration' can begin. In addition to 'exploration', this phase also encourages listening, and learning, and

thus a sense of sharing and bonding is developed. The next stage, 'co-operation' is developed where the participant is now comfortable to share without being afraid and finds satisfaction in the interview process. At this stage the researcher may want to clarify any issues, and may use this opportunity to ask any sensitive questions (Roulston, 2010; Spradley, 1979). For example, the researcher in this study asked a participant what kind of violent behaviours she had experienced. This enabled the researcher to clarify what the violent behaviours were, while, at the same time exploring a sensitive topic.

Finally, the 'participation' stage occurs during the time of the interview, that is, the participant now guides and educates the researcher, and this is where the greatest sense of rapport is demonstrated (Spradley, 1979; Orb, Eisenhauer & Wynaden, 2001). For example, in the present study, one of the participants described her 'shortness of breath' and the home remedies her mother would give to her.

Therefore, by incorporating the above stages into this phase of data collection rapport, a sense of trust and of comfort was developed, and participants divulged information that was rich and enlightening, while at the same time maintaining confidentiality which are discussed further in subsequent sections.

5:8 Transcription and Analytic Process

Transcription

All interviews were audio recorded and transcribed verbatim (please see appendix Qa for an anonymised transcript of one of the interviews). Each interview took approximately three hours to complete, and the researcher re-read the interview transcripts to correct any initial mistakes. Additionally, since this research was conducted in Trinidad, some of the women used the local dialect to explain their experiences. In the results section, these terms will be explained to the reader with the use of footnotes.

Analytic Process

As mentioned previously, IPA helped to formulate, guide and direct this study, thus and was used to analyse the data gathered. Smith, Flowers and Larkin (2010) outlined 6 steps that can be

used to interpret data from an IPA perspective; these steps were adopted for this study, while also incorporating suggestions presented by Smith and Osborn (2008) and Touroni and Coyle (2002).

After the interviews were transcribed, I read and re-read each of the interviews (step 1), thereby immersing myself in the original data. This was done in an attempt to re-familiarize myself with the interviews and assist with the second step by creating initial notes. The second step involved 'initial noting', where I recorded anything of interest. This was done in order to help understand the way in which the participant thought about, understood and spoke about the issues being discussed. I also examined any descriptive, linguistic and conceptual comments that were made by the participant, for example, any key words the participant may have used to describe her help-seeking experiences.

During the third stage 'emergent themes' were developed where I examined the initial noting and looked for the most consistent themes. After this, I searched for connections across the emergent themes (step 4) which involved examining the rest of the interview and searching for similar extracts. This process was done for the entire interview, and when themes were found throughout one of the interviews, I then moved onto the next interview (step 5) where steps 1 through 4 were repeated. This was done for all 12 interviews and I then looked for 'patterns across cases' (interviews) (step 6). After this, a list of themes was formulated and actual interpretation and write-up was done using excerpts from the various interviews to support the themes (Please see appendices Qb and Qc for tables illustrating the process whereby one final super-ordinate theme and a final sub-theme was decided upon).

Also, as noted previously, the interview schedules were constructed to elicit information about the types of abuse the women are or were experiencing and their somatic symptoms. Thus, the following are some examples illustrating the data gleaned from these interviews. According to Betty's (IT; 20s; SD&DV) account of the abuse she experienced:

> *He, he used to kick! He used to hold me… this man actually hold me on a room on the wall and lift me off the wall with his hand around my neck,*

> *right? He used to cuff*[42] *me up on my head… I don't know. He never really used to hit me in my face so people couldn't see it. But he used to… my head, he used to really cuff it. He used to pound my head, he used to cuff it, my head. He used to kick me, he used to, he used to choke me. A time this man lift me up choking me, holding me by my neck, like that was his behaviour.*

Additionally, the women who had symptoms of somatization disorder recounted their symptoms. The following is an excerpt from Cassie's (AT; 40s; SD&DV) interview:

> *Umm it started manifesting itself like headaches. Umm and umm gastric problems, problems with my stomach. Umm and it kind of went on to problems in my muscles, in my umm in my hips and-and you know and it was basically stuff that was appearing all over my body. Umm I didn't know what to make of it initially. The stomach problems, umm it got worse and worse and I went to the doctor and they diagnosed me with Irritable Bowel Syndrome. Umm and why I know that it was… I felt that it was directly related to that issue with my… you know, with the, the stresses I was having at home, is when I left and divorced him, it almost stopped entirely.*

Thus far, it is to be noted that interviews involved the participants expressing very personal, and, in this case, traumatizing details about their lives to the researcher (as noted in the extracts above). But IPA is also concerned with the researcher trying to interpret the participants "trying to make sense of their world" (Smith & Flowers, 2007). For example, how the researcher interprets the above extracts in relation to the participant's experiences of domestic violence or somatic symptoms. Therefore, it is essential that the researcher acknowledges her role in this process; the next section attempts to do so by addressing the issue of reflexivity.

[42] "beaten with the fist" (Mendes, 2012, p. 53)

5:9 Reflexivity

Reflexivity within qualitative research is very important (Kuper, Lingard & Levinson, 2008). The participants were asked to speak about either their somatic symptoms, domestic violence experiences or both. Being reflexive also acknowledges the influence the researcher has on the research process (Kuper, Lingard & Levinson, 2008). Therefore, as with study one, the impact the researcher had on data collection, the position I took regarding the participants and how my previous knowledge and assumptions may have impacted on the research process will now be discussed.

Similar to study one (chapter four; occurrences of somatization disorder and domestic violence experiences), I had to remind myself that I was now in the role of researcher and not psychologist or counsellor, especially when some of the women became emotional while relating their domestic violence experiences. Fortunately, I was now better equipped to do this as I had practice from collecting data for study one. With this experience, I was able to subdue my desire to help participants from a counselling point of view and provide them with the necessary emotional support, and then refer them to the appropriate help agencies. As with study one, I was able to collect the necessary data without any challenges; I admired the women for sharing such personal information with me. I believed that it was because, for study one, I collected data from each participant personally therefore the participants for study two may have felt a sense of comfort speaking to me on an individual basis, and now felt they could share their experiences.

Again, as with study one, I kept a reflective journal and recorded my thoughts and feelings about each day I had interviews. This helped me to prepare for other interviews, as I was able to express my experiences of having to speak with each participant and to listen to their sometimes very challenging experiences. Reflection at this phase of data collection helped me as the researcher to express my own feelings, sometimes of sorrow, for the participants and their experiences. Reflecting also provided me with an avenue to think about my past experiences as a psychologist and how previous clients' experiences help me to cope with hearing the participants' stories in this data collection. I drew on some of the advice I gave to my then clients, while also remembering I was no longer in the role of counsellor.

Firstly, I have to admit (without sounding insensitive) that listening to the women tell their stories were not disturbing to me. I was sympathetic to the women's abusive situations and their somatic symptoms but because I have many years of counselling experience, I have heard and dealt with cases of domestic violence. Therefore, in transcribing the interviews and writing up the analysis I thought about some of the women I meet when practicing as a full-time counsellor and how very similar their stories were. All of these experiences are discussed in detail in chapter 8 (Reflexivity).

In hindsight, I believed that with the participants already being familiar with me from study one, together with my own experiences of collecting data for study one and my past experiences of being a psychologist contributed to this phase of the research process being as successful as it was. For example, previously interacting with women who had experienced domestic violence from my past job equipped me with the knowledge of how to approach women with such experiences. A detailed reflective account of the research process for this study is discussed in chapter eight (reflexivity) of this thesis. As with study one, this study also dealt with very sensitive topics; therefore, it is important to address ethical issues that arose in data collection; the next section attempts to do so.

5:10 Ethical Considerations

Similar to study one, all proposals for research using human participants are reviewed by an Ethics Committee at Middlesex University before they can proceed. The Middlesex Psychology Department's Ethics Committee reviewed this proposal and approval was granted prior to the commencement of data collection (please see appendix R for approval forms). As mentioned, this phase of data collection was even more sensitive than study one, as it required the participants to actually speak about their somatic symptoms and domestic violence experiences. The protocol described in the procedure section was followed to ensure the confidentiality and safety of each participant. Participants who had an emotional reaction to speaking about their experiences were offered initial support by the researcher, and then referred to one of the help agencies listed on the debriefing sheet.

Additionally, in order to ensure the safety and confidentiality of the participants, a verbal protocol was agreed upon after data collection for study one for contacting them to participate in study two:

> *Hello, I am Astra Kassiram, the PhD student you had your interview with last July/August/September 2011at the community center/church hall, is this a good time to speak with you?"*

If the participant stated it was not an appropriate time, then the researcher followed the agreed protocol below:

> ***How will the researcher keep in contact with the participant?***
> *It will be agreed upon during the initial data collection phase that the researcher will call the participant during the month of March 2012 on her personal mobile. If the participant does not answer no voice message will be left, and the researcher will try again at a later date within the same month. If the participant answers the phone but indicates she is unable to speak at this time the researcher will contact her again the following day.*

By following the above, both participants and researcher were protected from any potential danger by an abusive partner. This procedure proved to be very effective, as throughout the process of contacting participants and conducting interviews no negative situations arose that I was made aware of.

As with study one, the data gathered is highly confidential; therefore, all data collected, together with the informed consent sheet, was coded to protect the identity of participants (participants are only identified by their pseudonym), and the coded information, together with all transcribed interviews, securely stored in a password protected file on a password protected computer. The primary researcher, Ms. Astra Kassiram is the only one with access to the password; if supervisors need access to the data they are only given access to the coded data; hence no names will be revealed. This study, as with study one, also took place outside of the United Kingdom, and to ensure that proper guidance was available throughout the data collection period, contact

was maintained with all supervisors (Drs. Miranda Horvath, Susan Hansen and Paul de Mornay Davies) via email (once per week or more frequently as required).

Therefore, again all precautions were taken to ensure the confidentiality and safety of both participants and researcher, while still obtaining valuable information. Thus, the findings of study two will now be presented.

5:11 Results

Introduction

Help-seeking is an important aspect of somatization disorder and domestic violence as noted by several researchers (Becker, Al Zaid & Al Faris, 2002; Hadeed et al., 2006; Mai, 2004; Walton & Takeuchi, 2009). Help-seeking is the process whereby the individual actively seeks out and utilizes social relations which can either be formal or informal to help him/her with personal problems in order to obtain advice, understanding, general support or treatment (Rickwood, Deane, Wilson & Ciarrochi, 2005). Therefore, this section through the use of IPA will attempt to illustrate Indo- and Afro-Trinidadian women's experiences of their somatic symptoms, domestic violence experiences, and the help they sought for these and how the women made sense of their experiences and the meaning(s) they attached to them. Therefore, by adopting an IPA perspective the following section will seek to address the research question *'do Indo- and Afro - Trinidadian women find medical doctors and religious leaders supportive when dealing with their somatic symptoms and domestic violence experiences?'*

5:12 Findings

Before delving into an in-depth analysis it is important to gain an understanding of what all 12 interviews revealed in order to ascertain what elements contributed to the development of the themes. The interview schedules were constructed to elicit general information about help-seeking for somatic symptoms and domestic violence experiences but at the same time also sought to uncover the women's experiences of help-seeking from either a medical doctor or religious leader. This was done because study one of this thesis identified both these agencies as a major source of help that the women approached. Thus, when writing the analysis these two

agencies presented themselves in a variety of forms. A summary of the findings is presented below:

Summary of Findings

From the interviews, it appeared that both Indo- and Afro-Trinidadian women internalized their distress as a means of coping, and thus, their self-identities were being affected by either their abusive situations, somatic symptoms or both. Since they felt that in order to maintain a sense of calm and reduce the risk of future abuse they had to suppress their feelings, and adopt a personality that they felt was not their own. Additionally, many of the women in this study made sense of their experiences by turning to a "higher power" when faced with challenges and stressful situations. They sought guidance and support from God, and this provided them with strength to cope with their situations. This avenue also seems to have enabled some of the women to disclose their situations to another (Jesus Christ) and not fear that there would be repercussions from either an abusive partner or society. Whereas, for some of the women, they rationalized that if they disclosed to a medical doctor that he/she might be obligated to report the abuse to the police. As a result, their partner may become more abusive in the future; thus, hindering them from disclosing. Consequently, many of the women shared a fear of revealing the abuse, minimized their symptoms and feared the implications of disclosing. Also, all of the women seem to have manifested their experiences of abuse as somatic symptoms, as they may not have had other avenue(s) to express themselves or did not know what other means were available to seek help from. Despite this, many of the women found the strength to leave their abusive situations or seek help for their somatic symptoms and in so doing experienced restoration of self and strive for happiness.

One over-arching theme did emerge from the data, that is, many of the women were afraid to disclose their abusive situation because they felt their partner would find out they told and abuse them further. This theme is depicted throughout several of the super-ordinate and sub-themes themes and will be discussed within that specific theme. In seeking to address the above research question the super-ordinate and subthemes that were gleaned from the data are illustrated in table 11 below. These themes presented themselves as a result of the women expressing their own frustrations, coping skills and fears about the situation(s) they were or are still in. Also, central to

this thesis, many of the women stated that they felt either their somatic or physical symptoms were associated with the abuse they experienced or a stressful situation. This theme is significant and enlightening to this study and as a result will also be discussed.

Table 11: Super-ordinate and sub-themes of the study

Super-ordinate Themes	Subthemes
1. Internalization of abuse and symptoms: 'My self-identity was being lost'	a. Traditional Values b. Losing oneself c. Feeling betrayed d. Lost identity e. Police failures f. On my own
2. The Relationship between Spirituality and Help-Seeking: 'My faith helped'	a. The church/pastor helped b. I felt disappointed c. Spiritual forces d. Who should I trust? e. God/higher being was a source of strength
3. Rationalizing disclosure to the medical doctor: 'I was afraid to tell because I might get hurt'	a. The medical doctor provided support b. Afraid to disclose c. No close bond d. Trivialization of symptoms
4. The manifestation of abuse as physical symptoms as a means of coping: 'My physical symptoms are linked to my abuse'	a. Past abusive experiences caused symptoms b. Relief from symptoms
5. The restoration of self after abuse and somatic symptoms: 'I can plan for the future'	a. Inner strength b. Re-gaining control c. Still coping

A closer analysis of each of the super-ordinate themes along with their related sub-themes will now be presented, starting with the first super-ordinate theme.

1. Internalization of abuse and symptoms: 'My self-identity was being lost'

This theme explores how the women felt as a result of not being able to disclose, and express their experiences and emotions, and how this affected their self-identity. It also looks at how the

women felt about not being able to disclose their abusive situations, and the impact this had on their relationships and help-seeking.

a. Traditional Values:

Not being able to tell anyone what was happening in either their relationship or health seems to have adversely impacted on many of the women. Some of the women suppressed their feelings in order to keep a sense of calm within the household. This may have also been done in an effort to minimize both their anticipatory anxiety and the risk of further violence from the partner, and avoid any future confrontations. By doing this, the woman could be said to be losing who she is. That is, she is unable to deal with challenging situations by discussing and finding solutions, instead she has to keep her feelings inside. This is noted in the extract from Cecelia's (AT; 40s; DV) interview:

> *"Okay one of the other things that I've had to endure which are corrected umm many times, let's say the person he-he… a bottle fell with water and it broke. 'Get the mop.' It's like in my mind… or you know, because the person has this temper… and my grandmother told me this lifelong lesson: 'sometimes you have to stay quiet or be calm because it could explode', you know? Out of proportion. So instead of saying well 'why you don't get the mop for yourself?' or you tell them 'get the so and so mop". You know, so they… because you could get to… after going thr–,*

Here, Cecelia is unable to express her anger, she is experiencing what is termed 'anger-in' thus, chooses to supress her feelings, and instead has to give the impression that she is calm, when she is actually very frustrated and would prefer that her partner 'get the mop' for himself. Therefore, Cecelia is rationalizing that if she chooses to stay quiet because her partner has a 'temper' then a potentially violent situation may be avoided. Thus, she chooses to not express how she really feels about the situation. Cecelia seems to have internalized 'what her grandmother told her' that she should not share her problems. Cecelia's decision seems to be inter-subjectively anchored in the advice given to her by her grandmother. As a result Cecelia is encouraged by this advice not to express what she is really feeling, as she now has to suppress her emotions, in an effort to

conform to traditional norms. Sisley et al., (2011) examined how Afro-Caribbean women (living in the United Kingdom) managed emotional distress. They reported that some of the women felt that older generations were not as tolerant of seeking help from persons outside the family circle. Thus, they were also taught to not express their challenges to others. However, despite these findings bearing similarities to the Afro-Trinidadian women in this study Sisley et al.,'s (2011) findings can also be related to Indo-Trinidadian women's experiences, as will be discussed below.

Cecelia also appears to be trying to distance herself from her partner, as on many occasions she refers to him as 'the person'. This can be a coping mechanism that Cecelia is employing, that is, since she may now view him as an ambiguous figure in her life, if she feels disconnected from her partner, then she can view him as the 'perfect partner', one who will not cause her harm. On the other hand, by distancing herself from him she is ignoring the situation and justifies her partner's behaviour by 'not being involved'. In this way Cecelia is able to live in the same dwelling and accept her partner's abusive behaviour towards her.

These findings reflect what some traditional societies (for example, Trinidad) teach their children, that, women need to present a demeanour of being calm and that expressing oneself is not appropriate. Therefore, women grow up with the impression that they should not express their feelings and challenges and if they did tell someone they may be seen as inconveniencing others (Maharajh, 2010, Millett, 1979, Singh, 2007). In further support of these findings, Hadeed and El-Bassel (2006) in their study of social support for Afro-Trinidadian women in abusive relationships further highlight this inter-subjective familial barrier to the disclosure of feelings and thoughts, as a way of managing the potential 'dangerous' situation. They reported that some of the women's mothers advised them to "*keep quiet and that things would eventually cool down*" (p. 745-746). Additionally, some of the mothers advised their daughters not to be 'aggressive' and this would subdue the abusive situation. This inhibited many of the women from disclosing their abusive situations and seeking help.

In terms of ethnicity, Hadeed et al., (2006) findings are similar to what Cecelia described as her 'grandmother's advice'. Cecleia is Afro-Trinidadian, but Rahni (IT;40s;DV), an Indo-

Trinidadian reported a similar experience. She stated the advice given by her now ex-partner's mother was not beneficial:

> *His mother's advice. Whatever he is doing, once he don't bring it in the home you shouldn't have a problem. So I never back to her for any ad–*

From this extract, Rahni's ex-mother-in-law (who can be seen as a mother figure since Ranhi's own mother had died) advised her not to worry about her ex-partner's behaviour, as long as his extra marital activities are not brought into the family dynamics. Here Rahni is also being advised not to express her emotions regarding her ex-partner's extra martial affairs. Consequently, this also serves to erode her sense of self and reinforces the traditional roles women in patriarchal cultures are supposed to abide by, for example, that women should be quiet and not 'make trouble' (Maharajh, 2010, Millett, 1979, Singh, 2007).

b. Losing Oneself:

Some of the women kept their experiences of domestic violence and somatic symptoms hidden from society and as a result suffered in silence. They were socialized to deal with difficulties on their own, and were scared about the consequences of disclosing. As a result of not being able to express what was happening in her life and that domestic violence is still seen as a 'private' problem Anna (IT; 30s; SD & DV) stated that she became scared to tell others about her domestic violence experiences because she feared that no one would believe her:

> *I was afraid that nobody would believe me when I tell them what happened to me so I just keep everything and I went on with my life.*

Here Anna appears to have kept all her challenges to herself and pretended that everything in her life was satisfactory and she was not experiencing any distress. Anna and Cecelia had to manage their abusive situations by not disclosing to anyone what was happening, they both altered their ways of coping in order to maintain calm. For example, Anna feared that if she told others about the abuse they would not believe her, and that this may further exacerbate an already volatile situation.

Additionally, some of the women with somatic symptoms also chose to deal with their symptoms alone. As Lola (AT;20s;SD) stated:

> *Mummy and I… okay yes Mummy wasn't always someone that I can go to……I always felt like she took everyone else's side before she took mine. So I didn't feel like I could talk to her because I felt like she couldn't relate to me per se. So umm yes. yes so umm she wasn't the best person to talk to at the time when… I felt [inaudible]. So I felt like I internalized everything and I sort of tried to deal with everything by myself.*

From this extract, the phenomenological experience for Lola is a loss of self-identity and self-worth. Lola actually stated that she had to 'internalize' her feelings, and cope on her own because of a lack of support from her mother. Lola's identity as a daughter as well as her mother's identity as a parent was also being challenged, as Lola saw her mother as not fulfilling her parental duties. That is, the expectation that a parent would be supportive, and help her cope with her difficulties was now missing. Therefore, Lola was not able to disclose to her mother her symptoms and receive the support she desired. Additionally, Lola seems to be feeling a sense of betrayal by her mother, as she stated that her mother would always take 'everyone else's side'.

Once again this contributed to the displacement of Lola's identity, and challenges her sense of self and self-worth as a daughter. She was now confronted with the possibility that her mother favoured and valued others more than her. Also, Lola stated that as a result of her feeling her mother was not supportive she was unable to express how she was truly feeling to her. Again, Lola seems to have felt that the person that is supposed to be the closest to her was not there, thus creating the impression that she now had to cope with her somatic symptoms on her own and inhibiting her from disclosing these symptoms.

c. Feeling Betrayed:

Similar to Lola, Anna's (IT;30s;SD&DV) identity as a daughter/sibling was also challenged. According to Anna's account of her experience of help-seeking from family members, she was left feeling isolated, and that her family had abandoned her, and chose to believe, and

accommodate her ex abusive partner; she felt that she was being displaced and replaced by a stranger:

> *P: Because I find if it's a… if you go to parents for help in that kind of case, they should've at least, well… they know that you… no matter what they know you and the person was together, they not supposed to be encouraging the person to be coming home by them. And my… my parents used to make Robert come home still.*
> *I: Tell me some more about that.*
> *P: Because when I was there even self I'm coming and going, I never stay by them. But coming home by them and going sometimes I come there I bounce up*[43] *Robert there. He have things to tell me so I used to just leave and walk out. And I find for my parents, they not supposed to allow that because I is their daughter. They could… they put a stranger in front their child. That's how I feel it was.*
> *I: Okay. How did that make you feel?*
> *P: It did make me feel really uncomfortable.*

Anna's comment also conveys that she felt a sense of betrayal as her parents would still allow her ex-partner to visit her family home. Anna is trying to make sense of the identity that is now being imposed on her, that is, she is not fully valued as a daughter or sibling. Anna does not refer to her ex-partner as 'ex-boyfriend', 'ex-husband' or 'estranged', but places him into the category of 'stranger' (perhaps in an effort to distance herself from him). Here Anna seems emotionally upset that her parents put a 'stranger' in front of her needs and safety. Thus, this makes her feel she is like a 'stranger' in a place where she was supposed to find solace and assurance that her situation would improve. This could have contributed to her not disclosing to anyone her abusive situation or somatic symptoms; as she felt the people closest to her could not be trusted. Similar findings were reported by Hadeed et al., (2006), as one of the participants mother "sympathized with the abuser and welcomed him into her home" (2006, p. 745).

[43] "To suddenly come face to face with; to meet unexpectedly" (Mendes, 2012, p. 27)

Moreover, Anna referred to her ex-partner as 'stranger', and similar to Cecelia, also called him 'the person'. Anna is also trying to distance herself from her ex-partner in an effort to cope with the betrayal she feels from her parents and siblings. This serves to illuminate the complicated relationship that has developed for Anna with her family, as a result of their involvement with her ex-partner. Anna's parents' refusal to stop associating with her ex-partner also seems to have spilled into her siblings' interaction with her. Consequently, Anna's self-identity as a sister was also questioned, as noted in the following excerpt:

> *Because I never know who to trust. Because anything that I talk or I… sometimes I used to tell my sister and them. Sometimes if he hit me I would tell my sister and them and he used to get to know it back and he used to come home and really get on*[44]*. What I going and tell my sister and them and everything. Although I never used to tell them anything, sometimes when I say I could trust them and tell them something and [pauses] he get to hear it back.*[45]

Thus, Anna eventually felt that she could not trust her sister. Her sister would inform her ex-partner about what she said, and this would cause him to 'really get on[46]". Therefore, in an effort to minimize or manage the risk of potential violence, Anna chose not to disclose further details about her abusive situation. Hence, Anna is concluding that if she does not divulge information about the abuse the risk of her ex-partner 'hearing back' would be minimized, and perhaps an abusive situation could be avoided. Similar to Cecelia and Lola, she internalized her experiences and chose to cope on her own. From the above extract it also seems that Anna wanted help or an avenue to discuss her situation but could not find one. This contributed to her having to alter her ways of coping and thus, internalizing her frustrations, and adversely affecting her sense of self. That is, she now had to pretend to be able to cope with her situation when in fact she needed help. Therefore, from Anna's account, fear and a lack of trust contributed to her not disclosing her experiences to anyone, and as a result she did not receive assistance for either somatic symptoms or domestic violence experiences. Similar to Bull (2010) she stated that some of the women in her study expressed that they felt like "an outsider within their own families" (p.608).

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[44] Behave inappropriately; quarrel or argue; react violently
[45] Hear what occurred/transpired from a third party
[46] Behave in an angry manner

As a result, the interaction between the women and their families were sparse and did not provide them with much support.

d. Lost Identity:

The women in this study talked about their identity as a daughter or sibling being adversely impacted upon, and their identity as a person in general. For Charmain (AT; 50s; DV), her family minimized her abusive situation, as noted in the following extract:

> *Well to tell you the truth, my family doesn't really get involved too much you know? As long as there's no hitting and thing, they don't get in−too much involved because they does always tell themselves allyuh*[47] *go make up back,* [48]*you know this kind of way? But as long as you hitting and thing maybe they might get involved but as long as you ain't hitting and… they don't really…*

In the extract above, Charmain's relatives are conveying the message that even though she is experiencing abuse (other than physical) she is not worth defending. Here Charmain is made to feel that as a person is it acceptable for her partner to abuse her as long as it is not physical. Thus, her self-worth is not being recognized, and Charmain's identity as a valuable person is now being questioned. She now suppresses her emotions regarding the abuse because she assumes that if she discloses to relatives, they will not defend her. Charmain's situation is viewed by her family as a 'private' matter because she will 'make back up' with him. Thus, she justifies, and makes sense of the abuse as being only temporary, and that eventually she will resume the relationship because there is no physical abuse. This affects how Charmain copes and internalizes her abusive experiences.

e. Police Failures:

Rahni's (IT; 40s; DV) sense of self (who she views herself as) was also challenged. When she did manage to disclose her situation to the Police; she received negative, belittling and highly

[47] "All of you people; a group" (Mendes, 2012, p. 8)
[48] "To resume a broken relationship" (Mendes, 2012, p. 121)

sexualized comments. Rahni stated that when she went to the police station to report her ex-husband's abusive behaviour, a police officer said:

> *Umm "he didn't have a big penis and I like big prick" and those were the nasty comments. And I got very offended because I don't speak to people like that. I'm not that person. Umm I didn't get any help at all. One even tried to get my number and tried to meet me. Umm I end up… some friend, I spoke to a friend who knew the relationship, another police officer, and he put me on to an inspector in the Police Station. And he was the one that helped me. He umm… it wasn't his district but because he was an inspector he called the inspector in the Police Station.*

Initially Rahni did not receive any assistance and was sexually harassed. It was only after telling a friend and having 'contacts' that anything productive arose from her reporting. This experience evoked some inner turmoil for Rahni as her identity as a woman was being threatened by police who were contributing to Rahni feeling abused and unimportant. Rahni's self-identity as a person was already being eroded by the abuse she was experiencing from her partner, and now it was being further undermined by the comments by the police officers. This could have contributed to Rahni further internalizing that she is only viewed as a sexual object to be used and discarded (Rahni noted in her interview that she was sexually abused by her ex-partner) and inhibiting her from seeking further assistance and leading to a her experiencing a lack of trust in others. Hadeed et al., (2006) also stated that some of the Afro-Trinidadian women in their study reported that the police either minimized or "*downplayed the seriousness of her situation*" (p. 752), as also seen with Rahni. Although, Hadeed et al., (2006) did note that some of the women's experiences of help-seeking from the police was positive, and they received beneficial assistance (for example, when the police responded appropriately they felt 'empowered' and 'validated').

f. Feeling Alone:

As a result of not being able to seek assistance (for example, from the police) for either their somatic symptoms or domestic violence experiences some of the women stated that they felt disconnected and alienated from their surroundings, relationships and a sense of social isolation developed, as expressed here by Cassie (AT; 40s; SD & DV):

Okay yes I felt very alone. I felt very, very alone. I felt very isolated.

Thus, all of the key experiences discussed as part of this super-ordinate theme could have contributed too many of the women feeling that they were unable to disclose to others what was happening either with their relationship or their health.

Summary

As noted by other researchers, such as Dunhan and Senn (2000) women tend to minimize their experiences of domestic violence. From the data presented throughout this theme it appears that many of the women internalized their distress as a means of coping with their somatic symptoms or domestic violence experiences. Additionally, some of the women internalized their abuse as a means of reducing any realistic and anticipatory anxiety thus, also reducing the risk of further violence by their partner. As a result, many of the women appeared to have had their self-identity challenged, and their self-worth questioned. This inhibited some of the women from disclosing and seeking assistance for their somatic symptoms and domestic violence experiences. Some of the women felt isolated and angry as a result of not having an appropriate avenue to speak about their experiences, while others were left with feelings of betrayal, isolation and lack of trust.

Therefore, if the women received the appropriate support they then felt comfortable in relating their experiences. Additionally, in Trinidad, like some other countries (India), women are often socialized to internalize their emotions when it comes to abuse and domestic violence is not to be spoken about (Maharajh, 2010; Singh, 2007). The expression of illness when related to violence may also be viewed as unacceptable. Thus, the only suitable way the women can express their illness is if they avoid disclosing their domestic violence experiences. It appears that this behaviour is taught to women as a protective measure against the escalation of conflict.

Despite having to internalize their somatic symptoms and domestic violence experiences, many of the women did state they sought help from a religious leader or comfort from a higher being (for example, through prayer or reading the Bible). This second super-ordinate theme will now be explored.

2. The Relationship between Spirituality and Help-Seeking: 'My faith helped'

This super-ordinate theme illustrates the women's experiences of help-seeking from this source. The results of this study support findings in study one of this thesis: that some religious leaders were either instrumental in assisting women in gaining better insight into their experiences, while others were not. What the present IPA study brought to light were the in-depth experiences that influenced the women's perceptions of the help received from the religious leader; these will now be discussed. Also, many of the women expressed the view that it was their faith in God or a higher being that truly helped. According to Maharajh (2010), in Trinidad, psychiatry and religion have always had a long and familial relationship, with many persons seeking help from spiritual sources before speaking to a medical professional. Therefore, Maharajh (2010) suggested that it is essential that religious leaders and the medical groups work together for the benefit of the population.

a. The Church/Pastor Helped

This study supported the notion that some persons in Trinidad tend to first seek assistance for various issues from a spiritual source instead of from a medical professional (Hadeed & El Bassel, 2006; Maharajh, 2010; Nagassar et al., 2010). Lola (AT; 20s; SD) stated that she found attending church helped her overcome her challenges, as she explained:

> *Church well, it provided an avenue for me to participate in other activities so I didn't have to be home as much during the day because Mummy was working a lot. So it was like my little escape, my little my time to be with God yes.*

Lola seems to have felt that because her mother (as noted in theme one) was not available, church helped fill this void. Lola was able to 'escape' her home and find a sense of peace with her church activities. Lola's involvement in various church activities provided her with a 'distraction' from her somatic symptoms, and from her mother's lack of ability to provide her with the support she needed. Also, Lola's mother seems to have worked outside of the home, and did not spend much time with her. This could have contributed to Lola feeling a sense of abandonment by her mother, and illuminates what seems to be a complicated relationship between them. As noted in theme one, Lola's sense of identity of being a daughter was being

eroded by her suggesting that her mother was neglecting her parental duties and her mother's absence in the home may have added to this. However, for some of the women, attending church alone was not the only aspect that helped. Reshma (IT; 30s; SD) went to her local pastor for assistance for her somatic symptoms and describes the meeting:

> *I: So how do you feel about the help you received from the pastor….?*
> *P: Umm well it's, it's nothing negative. It's very positive for me because it buoyed my-my feelings of depression and my feelings of worthlessness. It, it lifted me up, it brought me out from where I was at because I felt pretty low, pretty, pretty low and umm you know, what they had to tell me, it made me feel a little better about myself. It gave me a sense of hope that I am a capable person and even if it comes to the worst, I can take care of myself. I don't necessarily need these people around me to survive.*

Reshma appears to have internalized her distress as a means of managing her symptoms, and it was being expressed as somatic symptoms (for example, physical pains, feeling sad). Prior to her encounter with the religious leader she felt demotivated, and was questioning her self-worth. Her somatic symptoms contributed to her feeling that she was worth less than others. Thus, before visiting the pastor she appears to have made sense of her symptoms by associating them with her self-esteem. Reshma's account of her experience with help-seeking from her pastor indicated that he was instrumental in her re-gaining a sense of confidence in herself, and, as a result, she was able to overcome her challenges. Thus, her interaction with her pastor provided her with faith and courage to overcome her problems and continue with daily living. The pastor helped her to realize that her symptoms were not her identity, and she was valuable despite them, and thus, also obtain some level of self-actualization. Thus, by making sense of her symptoms Reshma was now able to understand her situation and receive appropriate help; therefore, reducing any inhibitions she may have had about seeking help for her symptoms. Reshma's comment that she 'can take care' of herself also suggests a temporal link between regaining her self-confidence and the future. By re-building her self-confidence, this gives her the assurance that in time, she will be able to manage and take control of her life without depending on others.

Betty (IT; 30s; SD&DV) reported a similar experience to Reshma. Betty sought assistance from an Imam (Muslim Priest), and also described her experience as a beneficial one as noted in the extract below:

> *P:……. The people from the mosque start to come and help me out until eventually today I out of it and standing then.*
> *I: Okay so you felt… do you feel that the help you got from the members of the mosque was positive?*
> *P: Yes, they were positive. They were, they were helpful.*

The assistance Betty received from the Mosque seems to have given her confidence in others. That is, she did not have to cope with her challenges alone. She did not have to keep silent about her difficulties and there were people who cared about her. This helped her to disclose her abusive situation and somatic symptoms. Similar to Reshma, Betty's self-esteem and faith in herself was now being restored, and how she viewed herself was now changing. Thus, women's encounters with religious leaders helped them to manage their symptoms and see improvements with their health and relationships.

b. I felt disappointed:

Some of the other women in this study did not echo this sentiment however. Anna (IT; 30s; SD&DV) stated that she sought assistance for her somatic symptoms and domestic violence experiences from a pastor and was not satisfied, as illustrated in the excerpt below:

> *P: Actually I did speak to a pastor.*
> *I: Yes. What did they tell you? How did they respond, you know?*
> *P: Well actually the response wasn't good because what they was trying to do was to go back with Robert and I didn't to do that.*
> *I: What about the health issues? Did the pastor address that?*
> *P: No.*

Anna complained that the pastor's goal was to encourage her to return to her abusive ex-partner and this is not what she wanted, thus, supporting research by Potter (2007) that some religious leaders are often said to provide support to the abuser, in this case, by encouraging Anna to return to her abusive partner. The pastor was trying to manage the abuse by making Anna think that if she returned to the relationship the situation would improve. Anna's self-concept is being eroded as she is now being told that she is not worthy of being treated with respect. That is, it is acceptable for her partner to abuse her. Consequently, in subsequent discussions she revealed that she did not return to the pastor for help, possibly providing a barrier to further help-seeking. Anna also stated that her somatic symptoms were not addressed by the pastor as he/she focused on trying to get Anna to resume the relationship. Therefore, by minimizing her symptoms, the pastor is contributing to Anna feelings that she is not important. That is, her symptoms do not need to be addressed; her emotions and ways of coping are secondary, when they are linked to the abuse.

But Anna was not the only one dissatisfied with her religious help-seeking. Betty (IT; 30s; SD&DV) who sought assistance for her physical symptoms from a Pundit (Hindu Priest) stated that she was not satisfied with the help received:

> *P: My boyfriend know. He know something was going wrong with me but I don't know. Two, three time we went, he carry me by a pundit, he gone and carry me by a lady to rub my belly.*
> *I: Why did he carry you to the pundit?*
> *P: Because I was getting sick. They say a time I had umm jaundice, that's what they say.*
> *I: He carried you to the pundit for the physical ailments?*
> *P: Yes what he was seeing. Then the bellyache he carry me… Because a time I get up, I couldn't, I just couldn't walk because of the belly. I don't know. And he carry me for the belly to rub* [49] *by a lady and like that. That was the treatment I [laughs] got for those things.*
> *I: So what was the experience at the pundit and stuff for you?*

[49] To rub (apply pressure) the stomach because of various ailments

P: Me, that time I was just frustrated. I myself didn't know what was going on at that time so whatever they were doing with me I just let them do.
I: What did they do?
P: Well the pundit ….. me with some kind of oil thing and say it's jaundice. Umm the lady who rub my belly tell him to give me Guinness to drink. [Laughs] so that was the treatment. She rub my belly, she balm it like them kind of thing.

In the above excerpt the Pundit prescribed a 'local remedy' for her health problems, such as, 'rubbing her belly', 'drinking oil' and 'Guinness'. Here Betty also stated that she agreed with the course of treatment that her now ex-boyfriend sought for her only because she may have been experiencing avolition and thus, was frustrated, and at that point she did not care about her own well-being. Betty appeared to have given up hope that her situation would be resolved, she was distressed, and chose to cope with her situation by not taking an active role in her recovery. It should be noted that Betty did not meet the criteria for somatization disorder on the BSI-18, but still reported many physical symptoms as illustrated by the above extract. It can be said that Betty may have been internalizing the abuse and she was expressing it as physical symptoms. Betty's experience of help-seeking would have encouraged her to think that there was something wrong with her, hence the reason she experienced physical symptoms, thus, deterring her from seeking assistance for the abuse. Therefore, she continued to self-manage the abuse by expressing her distress through somatic symptoms. Additionally, from Betty's extract she was unable to walk and her ex-partner had to carry her. Thus, the ex-partner gave the impression that he was helping when in reality he was contributing to her somatic symptoms that more rendered her in need of help.

c. Spiritual Forces:

Nonetheless religious leaders' recommending 'local' remedies for either physical symptoms or domestic violence experiences are not uncommon for many Trinidadians, as noted by Maharajh (2010). Anna (IT; 30s: SD&DV) also stated that the pastor from whom she sought help for her abusive relationship told her that she needed to 'drink oil,' and her challenges were because of spiritual forces:

P: When I go all she tell me I have to come back, I have to come back. She always telling me that something bothering me, something umm… I say 'you see this?[50] *I not going back.'*
I: When you say something bothering you, what, what…?
P: She's always say like you know, somebody do me something, somebody have a hand on me, have me like that. So I… I get fed up [51] *of it and I didn't go back.*
I: Okay so you…
P: Because whole time when I go she will tell me bring a bottle of annoint−of sweet oil [52]*and she will bless it and I will drink it and… I got fed up of it. [Laughs] I find that wasn't helping.*
I: Okay so you didn't go back?
P: No.

In this extract, Anna stated that the pastor (female) told her that "somebody have a hand on me". In Trinidad, this means someone has 'done the person witchcraft' and hence the reason he/she is ill. From this extract it seems that the pastor made Anna think and feel that the abusive situation was a result of spiritual forces attacking her, thus, shifting responsibility from the abuser to Anna. This would have affected how Anna manages and copes with the abuse; she was now left with the responsibility of believing that the abuse was her fault. When internalized, this may have contributed to Anna's somatic symptoms, as this would be the only way of coping and making sense of the abuse. Additionally, adopting the 'sick role' may have helped Anna to obtain her secondary gain of managing the risk of future abuse. That is, if she presents as being ill, then the abuse may lessen or stop. Anna did not succumb to what the pastor was suggesting, as she realized that the 'remedies' were not working and did not follow the advice. This illustrates that despite being abused, internalizing and expressing it as somatic symptoms she was still able to make sense of the situation and not return to the pastor.

However, religious leaders are not the only people who allude to spiritual origins for the cause of an illness or problem. Individuals also attribute their difficulties to this source. For example, in

[50] "You're too much; I can't keep up with you" (Mendes, 2012, p. 216).
[51] "State of being bored; tired (emotionally, mentally); frustrated; irritated; annoyed" (Mendes, 2012, p. 73)
[52] "Olive oil" (Mendes, 2012, p. 182)

Classic's (AT; 30s; SD) case, she stated that for her somatic symptoms she sought help through prayer, and attributed her symptoms to a 'spirit of depression' as noted in the excerpt below:

> *If I feel depressed at some point in time I would pray. I would pray and as I said I think it's just a spirit of depression that would just come up on me and I would pray about it and ask the Lord Jesus to remove this spirit of depression. At some point in time I do feel it move.*

Here Classic is attributing her somatic symptoms to an external force that she has no control over. She is making sense of her symptoms by believing that they are as a result of spiritual forces and not associated with her. Classic is coping with her symptoms by placing the responsibility on another person, in this case, her faith in God. By so doing, she does not have to cope with the situation; she is depending on another that she views as unable to fail her, thereby reducing the risk of being disappointed and having to cope with another setback in her life. Both Anna and Classic's interviews support research cited in chapter two of this thesis that two-thirds of all patients presenting at a psychiatric clinic will interpret their symptoms as being caused by "spiritual wickedness from high places", "obeah"[53], "spiritual lash"[54] or other evil influences (Maharajh, 2010, p. 52).

d. Who should I trust?:

For Cassie (AT; 40s; SD&DV), it was her involvement in Ministry that discouraged her from going to her church for help. She was concerned about her image and trying to maintain her looking-glass self (Cooley, 1902) that others may have created of her as she and her now ex-husband were prominent figures in their religious community, and she was concerned about what others would think and say about her domestic challenges:

> *…….The church that I worked with as well, I didn't feel I could talk to anybody there about…… Because you think you are the pastor−this was our situation−and they are the parishioners and you really can't share things.*

[53] A kind of witchcraft or sorcery in the Caribbean; a survival of African magic rites (Mendes, 2012, p.136).
[54] To harm one physically with necromancy (Mendes, 2012, p. 177).

> *You know, you are supposed to be there to be the sounding board for them and none of them the sounding board for you, you know what I mean?*

It seems that Cassie felt she was unable to speak to other members of the church. She felt that the church members wanted her to be their ear and not the other way around. Cassie because she was the Pastor's wife felt she was unable to speak with the parishioners about the abuse she was experiencing. This seems to be as a result of the 'image' that the Pastors' family is supposed to be 'perfect', and they can help other member with their problems. The Pastor and his family are usually seen as not having challenges, especially those of abuse. As a result of this, she had to present herself in a manner that would be acceptable to the congregation (impression management). Therefore, Cassie may have also been feeling a sense of shame and that she would be judged by the congregation, or even blamed for the abusive situation. Additionally, because congregational members view her as a person who is supposed to solve their problems, Cassie is now left with not being able to disclose to others that she is now in need of assistance.

It seems that many of the women were not pleased with the help they received from religious leaders for various reasons, such as, feeling they were given poor advice; or were told to engage in activities with which they were not comfortable, or were themselves in a position of authority, and thus could not share their experiences with others in the community.

e. God/higher being was a source of strength:

However, many of the women stated that help came from their faith in God/ higher being. Many of the women reported that through prayer they were able to find answers, direction and strength to either overcome, or cope with, their challenges. For example, Charmain (AT; 50s; DV) stated that:

> *No well I was already a Christian when he met me so you know, so I had that belief that you know, through God all things are possible. That he will you know… because he promise us that he will help us through everything so seek him. So that's why I turn to him so my help was really more from him*

And Nana (IT; late teens; SD&DV) also stated that:

> *Umm well it just… By praying it just make me think different about like you know, if it is you're praying, God wouldn't want you to do things to hurt yourself. So that's why.*

Both Charmain and Nana revealed that through prayer they were able to cope with their situations. They prayed to God for help and this provided them a sense of hope and encouragement that the challenges they were experiencing would improve. Both Charmain and Nana chose to put their faith in a higher being, which minimizes the risk associated with disclosing to a relative, friend or religious leader. The threat of the abuser finding out is minimized, thereby, keeping peace within the household, and containing the risk of repercussions. Here the women's identities and sense of self as 'God fearing' helps them to cope, and to make sense of why they are experiencing abuse. Similar to Classic's explanation of spiritual help-seeking, they have chosen to seek assistance in a spiritual being that "*promises to help us through everything*", so, the risk of being disappointed is reduced. If the abuse stops, then it was God who assisted, consequently if the abuse continues, and she leaves, it was God who gave her the strength to do so.

These findings are similar to those of Sisley, Hutton, Goodbody and Brown, (2011). They found that African Caribbean women living in the United Kingdom also felt that their faith was vital in their coping. Some of the women in their study expressed that God was "the only man who's ever been there for me 100 percent" (2011, p.397). This suggests that the women felt 'safe' to disclose their challenges to a higher being because the potential repercussions of other forms of abuse were eliminated. In this study, by the women choosing either of these avenues the women felt that they have a reliable source of help that would never fail them. Therefore, helping them to cope and maintain emotional and mental stability, while also delaying them from disclosing them their situations to others. This avenue enabled some of the women to disclose their situations to another (God), and not fear that there would be repercussions from either an abusive partner or society.

Summary

Almost all of the women in this study turned to a "higher being" when faced with challenges and stressful situations. From this source of help some were able to find strength and hope to cope with their situations. Of importance, eleven of the twelve women who participated in this study, stated that their faith in God helped them, again supporting national (Trinidad) literature that in Trinidad, religion heavily influences the person's desire to seek help, and may determine from where help is sought (Maharajh, 2010).

Spirituality and the religious leaders' role in help-seeking for women with domestic violence experiences and somatic symptoms seem to be important (Becker & All Faris, 2002; Banks-Wallace & Parks, 2004; Giesbrecht & Sevcik, 2000; Kassiram & Maharajh, 2010; Levitt & Ware, 2006). Some of the women felt the religious leader either offered advice that tried to persuade them to return to their partner, or did not address their somatic symptoms, or instead provided them with 'local remedies' for their somatic symptoms that were not satisfactory. However, some of the women did feel that the religious leader provided the necessary support to give them hope to deal with their challenges. Additionally, this study highlighted the women's belief that a higher being (God) could help them overcome their challenges by providing them with guidance and a sense of comfort, thus reducing their realistic anxiety. This theme supports findings from study one (occurrences of somatization disorder and domestic violence experiences) provides an in-depth examination about why the women felt that the religious leaders were helpful or not. In Trinidad, religion and medicine tend to overlap (Maharajh, 2010); therefore, it is important that both medical doctors and religious leaders know how to intervene in domestic situations, and are aware of the treatment for persons who have somatic symptoms and domestic violence experience. Thus, study three (religious leaders and medical doctors intervention) of this thesis focuses on the knowledge, resources, willingness to explore and intervention strategies employed by religious leaders and medical doctors, when meeting with women who may have domestic violence experiences and somatization disorder; the findings are discussed in chapter six of this thesis.

As noted earlier, this study also specifically addressed the women's perception of how medical doctors' helped or not with regard to their somatic symptoms and domestic violence experiences; this will now be discussed in the following super-ordinate theme.

3. Rationalizing disclosure to the medical doctor: 'I was afraid to tell because I might get hurt'

As with study one, some of the women indicated that they had sought assistance from a medical doctor for either their somatic symptoms or domestic violence experiences. The findings of study one revealed that some of the women felt that the medical doctor was helpful as the treatment worked, or they were just generally satisfied with the help received. On the other hand, others complained that their problem was inadequately diagnosed or that the medical doctor only dealt with medical problems and they needed more. This study, then, sought to delve deeper into the reasons why the medical doctor was helpful or not; how the women made sense of this form of assistance and the meaning, understanding and interpretation the women attached to the assistance they received.

a. The medical doctor provided support:

Some of the women stated that their interaction with the medical doctor was beneficial to them as stated by Nana (IT; late teens; SD&DV):

> *I: How did you feel about the advice given to you by the medical doctor?*
> *P: I feel, felt like it was good advice to me and I should try to take it and face my problems.*

Here it seems that the advice given to Nana by the medical doctor challenged her to deal with her problems. She also appeared willing to accept this challenge and felt the doctor gave her the appropriate advice. The result of the doctor showing an interest (by offering advice) helped Nana feel a sense of comfort and thus she was able to accept the advice. The positive attention and advice seems to have given Nana the emotional strength and motivation to cope with her problem, as she stated that she now felt she could 'face her problems'. Nana's self-confidence was also improved, and she now seems to have gotten new faith in herself that she would be able

to overcome her situation and strive for excellence. Anna (IT; 30s; SD&DV) also spoke about a similar experience to Nana:

> *I: How did you feel about the umm treatment you got in the hospital from like the doctors, nurses…?*
> *P: Well the treatment was good. I feel good about that because they supported me.*
> *I: In what ways did they support you?*
> *P: Well they take care of me good when I told them what went on. They see about me good* [55]*, they give me all my medication, they wasn't… you know sometimes you go to the hospital, you meet a nurse or a doctor, they never want to listen to a problem, they just leave you on your own? Well they was not like that.*

Here Anna felt that the doctors or nurses actually listened to her problems. They seem to have spent some time with her, talking and providing her with comfort and assistance, which aided in the help-seeking experience being viewed as a fulfilling one. Anna also appears to have rationalized that since the medical staff were willing to listen that they must care, hence, she saw them as trustworthy and this encouraged her to disclose her abusive situation. Anna was in a relationship with someone whom she viewed as caring and who would not hurt her, therefore, being abused she may have lost this sense of trust if the person closest to her can hurt and abuse her, then others may do the same. Thus, her interaction with the medical staff seems to have paved the way for Anna to re-gain trust in others, and being able to disclose her abusive situation. Additionally, this may have provided her with the courage to leave the relationship, as she eventually did. This finding further supports study one, as women in study one stated that they wanted a more holistic approach to their treatment. That is, they wanted the medical doctor to not only address their physical symptoms, but also their psychological needs.

Hadeed et al., (2006) reported in their study that some of the Afro-Trinidadian women also stated that the medical doctor was helpful. The medical doctor sometimes acted as 'barrier' to further abuse, as they would prevent the partner from 'harassing' the woman while hospitalized, or in

[55] Gave good advice; satisfactory care

one instance, got the security guards the physically remove the abusive partner from the hospital compound. Therefore, it seems that by the medical doctor/nurse providing the desired holistic approach to treatment, the women (in this case, both Nana and Anna) rationalized that they could disclose their abusive situations because they trusted the medical staff. Therefore, an important element in disclosure for many of the women was trust, as the women seemed to have felt secure that disclosing would not cause the abuse to escalate, but provide a probable solution(s). (Please note that although these extracts may suggest this, Anna stated that she did not reveal the abuse until after she had left the relationship).

b. Afraid of disclosing:

Anna's experience of help-seeking occurred after she had left the abusive relationship and had an encounter with her "ex". When asked if during the relationship she had told the medical doctor about her relationship, she said 'no':

> *P: Actually I go many times to the hospital but I never really tell them problems, what causing the problems.*
> *I: Okay so when you go what would you tell them?*
> *P: I would always make up some excuse.*
> *I: Like?*
> *P: Like sometimes I go, I have a pain you know. I would tell them I fall down or I lift up something and something like… I never tell them the truth.*
> *I: How come you didn't tell them?*
> *P: Well probably was afraid what might've happen*

From this extract it seems that Anna did not disclose to the medical doctor her experience of abuse, because she was scared about what might happen. Disclosing after leaving the abusive relationship reduces the threat of further abuse by her partner. While still in the relationship, Anna seems to have experienced angst since she felt that disclosure may have led to more abuse by her ex-partner. Thus, Anna rationalized that if she did not disclose to the medical doctor then he/she would not be obligated to report the incident to the police. Thus, if the medical doctor was made aware of the abuse then he/she would report this to the police, and, to Anna, the

repercussions would be worse. Similar to Anna, Betty (IT; 30s; SD&DV) also seems to have internalized this fear which also contributed to her also not disclosing to the medical doctor the abuse:

> *I: Okay so when you went to the hospital did you tell the doctor what was happening?*
> *P: [Laughs] no.*
> *I: No? Why didn't you tell them?*
> *P: I don't know, I don't know, I-I don't know. I just I-I just don't know why this didn't come out because I even had the x-ray, the neighbour them know what happen, everything. They say if you… 'why you ain't tell the doctor? Because'… 'Let police lock him up nah* [56] *because he go kill you just now.' I don't know why I didn't do it.*

It seems that Betty appeared to have some remorse for not disclosing her situation and pursuing legal action against her ex-partner. Additionally, this regret could have been as a result of the neighbour encouraging or scaring her into thinking that her now ex-partner could kill her, a thought that may have already been present. Thus, Betty may not have told the medical doctor about the abuse because similarly to Anna, she feared the repercussions, and in order to maintain a peaceful household employed vertical thinking and decided not to inform the medical doctor. Now, she is confronted with her neighbour adding to this fear; thus Betty, when in the abusive relationship, felt that if she stayed silent the abuse would have subsided. Thus, by not disclosing to the medical doctor, she felt she was protecting herself from further abuse by her now ex-partner. This fear can be seen as a barrier to reporting, contributing to cases of domestic violence being underreported.

[56]:No; Also used when pleading or begging" (Mendes, 2012, p. 132). In this case it means to put the person in prison

c. No close bond:

While Anna and Betty did not disclose their abusive relationships to the medical doctor because of fear or uncertainty of further abuse, Cecilia (AT; 40s; DV) revealed that she did not disclose because she did not have a close relationship with the doctor:

> *No because I looking at them… I… you know, I never look at it that way to tell them because to me you don't have that relationship with them. They want you to get in, say what's happening umm physically and so and you get out. I never look at... I never thought of telling a medical doctor unless there's a-a added relationship that I have come to know the person for-for a length of time you know? But I would've felt that way but umm no I never thought of telling the doctor.*

And Rahni reported a similar lack of closeness and engagement (IT;30s;DV):

> *They never spent the time by me, they would just come and say 'Miss how you going?' and that was it.*
> *They just did their duty……*

For Cecelia the lack of a 'close' relationship with the doctor hindered her from disclosing the abuse. She felt that the doctor only desired that she tell him/her about her physical symptoms and had no interest in the psychological aspect or what else may have been contributing to the physical symptoms. Thus, by the medical doctor not asking and Cecelia not feeling a sense of comfort, she made sense of the encounter by rationalizing that disclosing to the medical doctor was not necessary or appropriate. Additionally, because the medical doctor did not provide the atmosphere for disclosure, it hindered Cecelia from even thinking that he/she was a possible option for her to disclose the abuse, as noted by her saying she 'never thought of telling the doctor'. Thus, Cecelia never entertained the thought of disclosing. Also, Rahni stated that the doctors/nurses did not come and ask exactly what was happening in her life, they would politely ask if all was well with her. Therefore, if the medical staff spent more time with the women, then they might be more encouraged to disclose the abuse and the appropriate assistance may have

been offered to them. Additionally, Ranhi, seem to have viewed the question '*Miss how you going*' as an automatic question. That is, they 'just did their duty'; the staff were not genuinely interested in her well-being, but were only doing what they were told too. This lack of closeness seems to have inhibited the women from disclosure to the medical doctor and by extension the medical staff. Sisley et al., (2011) also reported that the women in their study felt that the medical doctor could have been "quicker" in identifying their needs (2011, p.398). This impression may serve to further lengthen the emotional distance between the women and the medical doctors: creating an unsuitable environment for the women to feel secure to disclose.

d. Trivialization of symptoms:

Some of the women who had somatic symptoms chose not to inform the medical doctor about their symptoms, because they felt it was insignificant. Also, they chose to manage the symptoms on their own by employing 'local remedies', as noted by Lola (AT; 20s; SD):

> *Because I passed it off as being period pain or gas*[57] *or… Because Mum−when I tell Mummy about it she'll be like 'you're probably getting gas pain* [58]*because you're not drinking tea, any hot tea' and this and that. So I would try to drink some mint tea and it would help it to subside but it would always be there come and go.*

Here, Lola experienced temporary relief from her symptoms. Whereas, if professional medical assistance has been sought, maybe her health issues could have been lessened or resolved, resulting in an improvement in her overall well-being (physically and psychologically). Also, as noted throughout this discussion, Lola's may have viewed her mother as neglecting her duties as a parent. From this excerpt, it seems that instead of her mother recognizing that Lola may have a medical problem; she instead prescribes 'local remedies'. Therefore, because Lola views her mother as an important person in her life, she absorbs the advice given by her and is made to feel that her symptoms are trivial, and not worth going to, or informing the doctor about.

[57] Indigestion
[58] Pain as a result of indigestion or skipping meals

Additionally, Classic (AT; 30s; SD) and Lee (IT; 30s; SD) either minimized or trivialized their symptoms, as they stated that they interpreted their symptoms as either being 'normal' or 'not a big deal'. This is noted in the following extracts:

> *No I don't think I went to any doctors for any sort of… especially for that stomach problem because I never really took it on as something like a big deal* (Classic).

> *Because I think that it's probably, it's probably normal to me. I'm thinking it's probably normal and I could deal with it* (Lee).

Here, both women made sense of their symptoms by acting with indifference. It also seems that Classic and Lee were apathetic about their symptoms and did not attach any importance to their symptoms, and, as a result, chose not to seek medical attention. The women rationalized that their symptoms were not significant enough to seek assistance or by ignoring or minimizing them. Thus, they would not be required to deal with these problems, and the stress they were experiencing would be avoided or displaced. Additionally, both Classic's and Lee's symptoms can be said to be linked to their self-worth. It seems that they do not value their well-being (health), and thus they do not need to take care of themselves; they are not worth being taken care of. Additionally, both women may have also rationalized that if they vocalized their symptoms they may be seen as 'weak', and they thus ignored and trivialized their symptoms. These accounts support existing literature that women (in most instances Asians) with somatization disorder often disregard their somatic symptoms because of the fear associated with being stigmatized with a psychological ailment (Kassiram & Maharajh, 2010; So, 2008). Thus, despite having well-structured mental health care programs in Trinidad, negative attitudes towards their ailment may hinder people from seeking this type of assistance (Maharajh, 2010).

Summary

This super-ordinate theme revealed that many of the women did not feel content with the assistance received by medical doctors for either their somatic symptoms or domestic violence experiences. Although, some of the women did indicate that the help received did contribute to their overall sense of well-being improving, others did not. Women with domestic violence

experiences either felt they did not know the physician well enough to disclose their abusive situations or they were just not asked about it. Thus, ineffective communication between the patient and medical doctor may result in the patient's negative experiences (Dowrick et al., 2004; Robbins et al., 1994; Salmon et al., 2004). Additionally, according to Sugg and Inui (1992), some physicians are apprehensive about asking the patients about domestic violence, because they see it as "opening Pandora's box" (Sugg & Inui, 1992) and they themselves experience approach-avoidance conflict as they are uncomfortable with exploring such an issue, thus contributing to a communication barrier and the real reason(s) for physical symptoms not being explored. Also, as noted previously, fear of being stigmatized, or being seen as faking symptoms, may have contributed to some of the women choosing not to seek medical assistance for their somatic symptoms, and instead choosing to employ home remedies (Cheung, 1995; So, 2008).

The issue of women not seeking medical assistance for their physical ailments, and many of them not divulging to the medical doctor that they were/are in abusive situations is very important. Most of the women felt and expressed the view that their physical symptoms and abusive or stressful experiences were linked. This will now be discussed.

4. The manifestation of abuse as physical symptoms as a means of coping: 'My symptoms are linked to my abuse'

Another super-ordinate theme that emerged was, physical symptoms were linked to the women's abusive experiences. Central to this thesis is the notion that somatization disorder and domestic violence are linked (Brown, Schrag & Trimble, 2005; Hegarty et al., 2004; Holloway et al., 2000; McCauley, Kern and Kolodner et al., 1995; Samelius et al., 2007; Righter,1999). Study one showed that women in the sample were six times more likely to have somatization disorder if they also had domestic violence experiences. Research has suggested that people who experienced violence often present with PTSD (Bennice, Resick, Mechanic & Astin, 2003; Briere & Eliott, 1994; Golding, 1999; Woods, 2000). Additionally, as cited in chapter 2 (Literature Review), Holloway et al., (2000) states that experiencing or witnessing an act of violence are said to be predictive of subsequent somatic preoccupation in adulthood. As noted throughout this section, many of the women who presented with somatization disorder alone also

had either a childhood experience of abuse or abuse from a non-partner. Therefore, the question of whether or not somatic and physical symptoms were/are linked will now be discussed.

a. Past abusive experiences caused symptoms:

Lola (AT; 20s; SD), in study one (occurrences of somatization disorder and domestic violence experiences), initially did not meet the criteria for domestic violence experiences when screened using the Coercive Control Measure for Intimate Partner Violence, but when interviewed for study 2 she revealed that even though she was not abused she did witness physical and verbal violence between her maternal uncle and mother. Lola's embodiment of the abuse she experienced made her feel a sense of uneasiness living in an abusive household and witnessing violence from a young age. It may be argued that Lola experienced afterburn, in which past events influenced her daily schedule as she stated that she never knew what would happen when her uncle returned home, and, as a result, may have felt traumatized. Lola also noted that she did not initially establish a link between her somatic symptoms and the abuse she witnessed as a child, but upon thinking about it during the interview, realized that they were indeed related:

> *I: Okay. Did umm did those shortness and breath and all these things also kind of subside when the behaviours in the home improved?*
> *P: Thinking about it now, yes.*
> *I: Yes?*
> *P: Yes. I think it may have been psychological [laughs] thinking about it. Yes.*
> *I: Because how is the household now? Is it…?*
> *P: Now it's just my step-step-father and my mom and well my aunt comes and goes because she's here for medical treatment. But my step-father isn't here right now but since my uncle left it's been a lot better.*

As a means of coping with the violence she witnessed from a young age, Lola internalized it, and, perhaps because of her age, did not know how to express her feelings and thus, they were manifested as physical symptoms. Additionally, even at a young age, Lola may have made sense of her situation by rationalizing that if she reacted then her uncle may have caused harm to her, therefore, she adopted an anticipatory coping style and by remaining silent and adopting a 'sick

role' she obtained the secondary gain of sympathy instead of abuse may have been received. Lola's way of coping and managing the distress she was experiencing was by converting it into physical, noticeable symptoms. Even in the interview Lola appears still to not be comfortable speaking about her childhood and the abuse witnessed, as noted by the nervous laughter she displayed when telling this part of her story. Therefore, Lola, through this study, was able to gain a better understanding of, and possible cause(s) for, her symptoms. This level of insight gained assisted her awareness of her improving well-being.

Whereas, Reshma (IT; 30s; SD) not only witnessed violence, but also was physically and verbally abused by her father from early childhood until she was twenty-eight; she also embodied the abuse she experienced and presented with symptoms associated with somatization disorder. She admitted that she never told anyone what was happening because she felt ashamed and therefore dealt with the abuse on her own:

> *Umm well I was too ashamed to talk to my friends about it but they knew he was strict. I would tell them you know, when they asked me to go out with them I would tell them well 'I have a curfew. I have to be home at a certain time and I can't stay out late' and all this sort of thing. So they knew I came from a strict home but I didn't really discuss well you know, 'I got licks* [59] *this weekend' or 'my father slapped me up.'* [60] *It wasn't something I wanted to really share with anyone. Umm I didn't tell family about it because they never really did anything to say well they would come and talk to him so it was a moot point you know, to even go to them. I just swallowed it, I kept it inside, I locked it away.*

Reshma did not want her friends to know about the abuse, so she instead chose to fabricate stories about why she could not socialize, in an effort to preserve her looking-glass self. As a result of Reshma's sense of shame about the abuse, she internalized her distress and expressed it as physical symptoms. She was not able to speak about her symptoms and thus 'swallowed it, locked it away'. Reshma had to keep her abusive experiences and the emotions that accompanied

[59] "A beating; physical punishment" (Mendes, 2012, p. 115)
[60] Hit excessively in the face

it to herself, thus, she is employing the defence mechanism known as suppression. That is, she is intentionally removing the unwanted situation from her attention. By not having or knowing that she could disclose the abuse, she was now only able to express them as physical symptoms and avoid conforming to the stereotype threat of confirming that she had a psychological ailment instead of a physical one. Additionally, none of her extended family members came to her family's 'rescue', thus Reshma made sense of her situation by thinking that no one cared, therefore, affecting her sense of self and also she now had to deal with the situation herself. By so doing, she may not have known how to deal with the abuse, thus chose to keep her emotions bottled up and thus, it was expressed as somatic symptoms. Similar to Lola, by expressing her distress as physical symptoms she felt that she may have been able to reduce the abuse.

Similar reactions to abuse were observed with the women who were abused by a partner. Samelius et al., (2008) suggests that when investigating somatization in abused women, the expectation is that somatization disorder would be associated with childhood abuse, but in their study they found that the majority of abuse occurred in adulthood. Classic (AT; 30s; SD) stated during the interview that in her adulthood she was raped (this was not disclosed in study 1). She then scored significantly on the Brief Symptom Inventory for somatization disorder, but not on the Coercive Control Measure for Intimate Partner Violence, because the assault was not perpetrated by a partner. Classic described the embodiment of her somatic symptoms as outlined below:

> *P: Basically my stomach. I might feel a little fluctuation and something like that. I would feel nausea, a little nauseated that kind of stuff like that.*

Similar to Lola and Reshma, Classic also felt that her somatic symptoms were linked to the abuse she experienced:

> *I: Did it coincide with the trauma that you, you told me about earlier?*
> *P: It, it could be. I think it could be because there's always something on my mind that always there that you know, makes you think that… that makes me think that you know, I don't know what it is but it's something like you know,*

can I pick myself up? Like if I would start something I would start exercising, I'd be good and motivating myself and I would do it and then three quarter of the way or halfway during the way to finish, to go to the finish line, I can't seem to finish.

In addition to this extract illustrating Classic's embodiment of her symptoms, her metaphor of a 'finish line' conveys the impression that she believes that no matter the efforts employed in completing her goals, she is unable to succeed. Her temporal analogy suggests she does not envision the completion of any project(s); she lacks the self-motivation and confidence to do so. Thus, a cycle has developed, that is, Classic now has the pre-conceived notion that no matter how much she tries she will be unable to reach the 'finish line', as a result, she may even abandon her efforts.

What these participants had in common is that they all scored significantly for somatization disorder, but not abuse by an intimate partner. This suggests that symptoms of somatization disorder can develop with the person not being abused by a partner but by witnessing abuse at a young age, or being assaulted in adulthood. This contributes to the literature that individuals who are abused may develop PTSD, and, as a result, can present with somatic symptoms (Bennice, Resick, Mechanic & Astin, 2003; Briere & Eliott, 1994; Golding, 1999; Holloway et al., 2000; Woods, 2000).

These reports are consistent with the reports of the women who scored above a mean of 11 on the Coercive Control Measure for Intimate Partner Violence, but did not present as significant on the Brief Symptom Inventory for somatization disorder. All four women who fit the criteria for domestic violence linked their physical health problems to their abusive situations. For example, Charlie (IT; 30s; DV), stated that she felt that she developed diabetes because of the stress of being in an abusive relationship.

I: What about your health itself?
P: I was good. I was good until then.
I: Until then. So it did impact on your health?

P: Yes.
I: Tell me how did it impact on your health?
P: I think I became diabetic.

Additionally, Cecelia (AT; 40s; DV) stated that she also believed that she became hypertensive because of all the stress she was experiencing.

Yes and I said to him umm he-he's the one… I say 'I believe you-you is the one that have me umm… that I have high blood pressure now' because all the stress and you know, not being able to express it how you want.

In theme one because of her inter-subjective relationship with her grandmother and her advice, Cecelia was inhibited from expressing her 'true' emotions. She learnt that in order to maintain calm and avoid the risk of more abuse from her partner, she should not voice her distress, anger or frustration. In the extract above, Cecelia is again stating she feels unable to speak about her emotions, and as a result she has developed 'high blood pressure'. She has anchored and attributed her physical ailment to her partner's behaviours and not being able to express exactly what she is thinking and feeling.

Charlie and Cecelia both reported verbal, emotional, financial and psychological abuse, not physical abuse. Rahni (IT; 40s; DV) and Charmain (AT; 50s; DV) experienced physical, as well as sexual, financial and psychological abuse, and both linked their physical ailments to their then abusive relationships. This is seen from the excerpt below:

Yes it used to impact on my health because umm I used to take it on so much [61] *that I used to be in the hospital most of the time. You know at one point in time I went to the hospital and I remember the nurse asking me if I wanted to kill myself because I was getting so sick and then I was getting so small* [62] *and you know? It*

[61] "To brood over a problem" (Mendes, 2012, p. 184)
[62] "To lose weight" (Mendes, 2012, p. 172)

> *was really frustrating and everything so it was really impacting my health.* (Charmain)

Charmain's abusive situation manifested itself as physical symptoms. From the above excerpt, it can be seen that Charmain stated she would worry about her abusive situation; she made numerous trips to the hospital, and lost a significant amount of weight. Thus, she internalized her distress and expressed it as physical symptoms as a means of coping. Charmain may have felt she had no one to speak with about her situation, and thus, no avenue to vent her frustrations and receive advice and help.

Additionally, the women who scored significantly on both the Brief Symptom Inventory and Coercive Control Measure for Intimate Partner Violence also stated that they felt their somatic symptoms were linked to their experiences of abuse. As noted by Nana's (IT; late teens; SD&DV) interview:

> *Well I used to get headaches umm like; I think I used to get fever too. But I used to like cry a lot and like be down. Headaches never used to go, I used to feel dizzy, you know?*

Here Nana manifested the abuse she was experiencing in a similar manner to the other women, as physical symptoms. She also internalized her symptoms, and perhaps not knowing or having any other means of coping, the distress manifested as physical symptoms and caused her distress. What all the women appear to have done was to find a socially acceptable or safe means of venting and coping with the abuse they were/are experiencing. Interpreting the abuse as physical symptoms served to alleviate having to disclose to others that it was their abusive situations that were the cause, thus, attention was being paid to the physical symptoms, and hence, the women did not have to deal with the issue of disclosure. Additionally, for some of the women, speaking about their symptoms may have provided a temporary distraction from the abuse, that is, the women may have felt that they have learnt the acquired response that if they are physically sick, then their partner would not abuse them or they could minimize the risk of further abusive situations.

b. Relief of symptoms:

The women who left the abusive relationship stated that their symptoms subsided or diminished after leaving, again, reaffirming that they felt that their symptoms were directly linked to those experiences. This was noted by Cassie (AT; 40s, SD&DV):

> *I know that it was… I felt that it was directly related to that issue with my… you know, with the, the stresses I was having at home, is when I left and divorced him, it almost stopped entirely. You know, I had some problems for a while because I was still communicating with him but once that, that went away, the problem has not been the same at all. Now I probably, I probably get umm an attack maybe, maybe once a year if so often. Umm and I used to be on tablets full time as well but as time has gone on, I have stopped using medication completely.*

For Cassie, the therapeutic benefits of leaving the abusive situation were valuable. After she left the abusive situation she noticed a change in her symptoms. By not being in the situation, the elimination of the activating events, the fear of potential abuse, disclosure and not being in a stressful situation contributed to her physical symptoms subsiding. As a result of eliminating the abuse she now did not have to internalize any distress thereby, reducing the manifestation of the abuse as physical symptoms. Here, Cassie was able to make sense of the symptoms by linking them to her former abusive situation. The experiences described by the women in this super-ordinate theme suggest that somatization disorder and experiencing or witnessing abusive behaviours are linked.

Summary

While international (Brown, Schrag & Trimble, 2005; Hegarty et al., 2004; Holloway et al., 2000; McCauley, Kern and Kolodner et al., 1995; Samelius et al., 2007; ; Righter, 1999) and Trinidadian (Kassiram & Maharajh, 2010; Maharajh et al., 2010) research has reported a link between somatization disorder and domestic violence, women with little or no knowledge of this link also expressed their belief that these were linked in describing experiences in the manifestation of their own symptoms. This information supports the use of IPA to investigate somatization disorder and domestic violence in this study, as questionnaires may not have been

able to do so effectively by also capturing how the women felt and their insight and lived experiences of the link.

5. The restoration of self after abuse and somatic symptoms: 'I can plan for the future'

Thus far, the themes identified indicate that many of the women chose not to disclose their somatic symptoms or domestic violence experiences to others. Additionally, some of the women received either beneficial assistance or were left with feelings of ambivalence. Nonetheless, most of the women found the inner strength to overcome their challenges and leave the abusive relationship or seek treatment for their somatic symptoms. The resilience gained enabled many of the women to hope and plan for a better future.

a. Inner strength:

Rahni (IT; 40s; DV) stated that she would fight back with her ex-partner and it was through this hurt (emotional) that she eventually found the strength to leave:

:

> *Well when we start arguing sometimes he would slap me and I would, I would… I'm not taking any lash* [63] *sorry. I would fight back. I would fight back.*

> *Actually I-I feel hurt but I found like strength. The constant hurt gave me strength to get out and move on and stop feeling that I really need him. The hurt is what made me get stronger.*

Peres, Moreira-Almeida, Nasello and Koenig (2007) suggest that "trauma researchers have pointed to the importance of individual differences in resilience; the ability to go through difficulties and regain satisfactory quality of life" (p.3). Additionally, Bonnano (2004) stated that some personality traits can act as ''protectors'' of individuals exposed to extreme stress (p. 5). From the above extract it can be seen that because of Rahni's personality of being a 'survivor' she found strength to fight back and eventually leave the abusive relationship. She felt that it was because of the hurt that she was eventually able to realize that she no longer needed or wanted

[63] "Hit" (Mendes, 2012, p. 113)

her ex-partner in her life, and this made her 'strong enough' to leave. Therefore, it seems that Rahni found not only the physical strength, but also the psychological strength and this gave her the self-motivation to leave. Additionally, Rahni's future-oriented outlook motivated and encouraged her that it was 'time to leave'. Also, the paradoxical 'strength' she gained from the 'hurt' spurred her to untangle herself from the emotional, psychological, sexual and physically destructive relationship and instead choose independence and safety.

b. Re-gaining control:

Many of the women felt that after they left the abusive relationship their lives were significantly improved. They regained their independence, as seen by Nana's (IT; late teens; SD&DV) and Anna's (IT; 30s; SD&DV) accounts:

> *My life has gotten way better and like I meet new people you know. New people with better knowledge not to be like that, you know. Good things just keep coming my way. So…*(Nana).

> *Well now that I… My lifestyle… I could afford to sit down and watch a television show, nobody wouldn't tell me about it. I cook what I want, I eat what I want, you know, nobody to tell me anything so that have me more comfortable So all the thoughts that I used to think about, overdosing myself with tablets, going in the sea and killing myself, all that I overcome it* (Anna).

Bonanno (2004) stated that "positive emotions can help reduce levels of distress following aversive events both by quieting or undoing negative emotion" (2004, p.7). Hence, from these extracts it seems that both women are contented with the direction in which their lives are now going. The complex and difficult relationships they had with their ex-partners are now dissolved. As a result, Anna seems to be pleased with the sense of control she now has in her life and daily activities again. Both women re-gained their independence, as they are now in control of their own lives. They are able to socialize and plan their daily activities on their own; they no longer live in the fear that if they say or do something there is the possibility that they may be abused. The level of control exerted on them by their ex-partners is no longer present in their lives.

Activities that seem trivial for others (e.g. watching television) were not an option for these women, but on leaving the abusive relationships, they now regained this control over their daily activities, and their own lives. According to Anna, this eliminated her feelings of anhedonia and thoughts of suicide and instead replaced them with thoughts of plans for the future. As a result, Anna's sense of self is now being restored, and she is excited about her future, as she is now in a new relationship and is planning her future:

> ……*Well now that I comfortable [laughs], the first plan is to have a child now.*

Also, some of the women with somatic symptoms try to cope by engaging in activities such as reading or educating themselves about their various symptoms. As noted in an extract taken from Classic's (AT;30s;SD) interview:

> *It's very good because sometimes if you go and Google certain situations you get a lot of answers, you get a lot of people umm who probably had the same symptoms and you know, what they have tried and stuff like that. And it helps a lot.*

Classic found help through the internet from strangers who may be have experienced some of the same symptoms. She said that she felt this helped her, as they offered remedies to her challenges and she was pleased with this. Here Classic is taking control of her symptoms instead of them controlling her. She is educating herself and seeking out social support, thus providing herself with options for treatment. Therefore, this approach seems to be providing Classic with a sense of hope that her symptoms will eventually subside, and thus a feeling of restoration of self is being gained.

c. Still coping:

Cecilia (AT; 40s; DV), who is still in an abusive relationship, stated that she copes by praying and crying:

Well as I say you pray, you cr−and-and then I-I very emotional so you pray and you cry, that's about it and try to keep yourself happy.

Cecelia, as noted in theme one, has taken her grandmother's advice to not express her true feelings. As a result, of this inter-subjectivity she has decided to vent her frustrations by 'crying' and turning to God through 'prayer'. She is suppressing her situation and pretending that she is 'happy' and that all is well with her. By so doing, she is displaying avolition, a lack of drive to pursue any meaningful goals, not dealing with her feelings, and managing her situation by imagining the relationship is a satisfying one. Thus, in order for Cecelia to remain in the relationship, and cope with the abuse, she tries to deal with the situation on her own.

Summary

As noted by one of the women, the emotional pain she felt paradoxically gave her strength to leave the abusive relationship. It seems that when most of the women realized they had regained control over their lives, this gave them hope that they had a successful future to anticipate, and view themselves as a 'survivor' The women seem to have regained a sense of self and their identity as a women or person was now being re-formed.

5:13: Discussion

An IPA approach was adopted in the design, execution and analysis of this study. This approach aided in obtaining an understanding of the women's insight into their experiences and the meanings they have attached to their help-seeking behaviours for their somatic symptoms and domestic violence experiences. The results of this study revealed that both Indo-and Afro-Trinidadian women internalized their distress as a means of coping, and, as a result, their self-identities (daughter, sibling) were being eroded. Some of the women felt that in order to maintain a sense of calm, and reduce the risk of future abuse, they had to suppress their feelings. For many of the women, it was their faith in God that helped them to cope with their challenging situations. This avenue enabled some of the women to disclose their situations to another ('higher being' for example, God), and not fear that there would be repercussions from either an abusive partner or society. Some of the women rationalized that if they disclosed to a medical doctor that he/she might be obligated to report the abuse to the police. As a result, their partner may become more

abusive in the future; therefore, this hindered some of them from disclosing. All of the women seem to have manifested their experiences of abuse as bodily (somatic) symptoms. Despite this, many of the women found the strength to leave their abusive situations or seek help for their somatic symptoms. In so doing, they experienced restoration of self.

'My self-identity was being lost': Many of the women were fearful of revealing their abusive situation because of the repercussions. Some of the Afro-Trinidadian women were more inclined not to seek assistance for their domestic violence experiences because of fear, stigma, and the repercussions from their abusive partner. Thus, it may be suggested that some of the women in this study wanted to obtain normative influence and this may have impacted on their willingness to seek assistance. That is, their affliliative drive to be accepted and approved by others outweighed the perceived benefits of seeking help. It was noted in the literature review (chapter two) that Maharajh (2010) reported that more Indo-Trinidadian women experienced domestic violence because they were culturally taught to be docile and submissive. Additionally, Indo-Trinidadians are also raised to believe that family business should be kept private (Maharajh, 2010) and thus a reason for their reluctance to disclose abusive situations. Maharajh (2010) also stated that Afro-Caribbean women have been traditionally taught to be strong, independent, assertive and outspoken, hence, if they were abused, would tend to speak about it. This study reported in this chapter refuted this claim, as many of the Afro-Trinidadian women who had domestic violence experiences also chose not to disclose for similar reasons as their Indo-Trinidadian counterparts. They, too, were fearful that their partner would retaliate and the abuse would worsen.

Therefore, with regard to Afro-Trinidadian women's need for help, they may be neglected in this area, as they may be regarded as independent and not needing assistance. This may have dire consequences to Afro-Trinidadian women, as these women may suffer in silence, and may internalize their experiences, and manifest them as physical somatic symptoms. As a result, they may not seek out the necessary assistance, and continue to live in fear; while at the same time, their sense of self is being further eroded. As discussed in the findings section of this chapter, together with fear of repercussion, traditional shared values, resulting from cultural expectations may also hinder the women from speaking out about their challenges. Therefore, Trinidadians (in general) may benefit from more public forums in which issues about domestic violence and

mental health are discussed. This will be in an attempt to break down social barriers that culture has placed on society; that is, women should not speak about these issues.

More community programmes should be directed at Afro-Trinidadian women as they are often viewed as not needing help for such issues because they are regarded as being 'stronger' (Maharajh, 2010). Additionally, individual self- esteem programs at the local community center could be established with the aim of providing all women with the knowledge of how they can improve their self-confidence. It is hoped that these programmes will (re)build the women's confidence enough to seek help or, at least, provide them with coping skills if they choose to stay in the relationship.

While there are sources of help in Trinidad designed for victims of domestic violence, for example, the Domestic Violence Hotline (Nagassar et al., 2010), to date there are none regarding somatization disorder. From previous research cited in the literature review (chapter two) (Kassiram & Maharajh 2010; Maharaj et al., 2010) and statistics from this thesis presented in chapter three (religious leader and medical doctors intervention), it is noted that somatization disorder is a concern for both the Indo- and Afro-Trinidadian population (specifically women). Also, qualitative data presented in chapter four (occurrences of somatization disorder and domestic violence experiences) showed that most women in the general public were not aware or have even heard of the term somatization disorder. Therefore, there needs to be the establishment of educational programs for the general public, and help-agencies about this disorder, and how they can help.

Thus, study three (religious leaders and medical doctors intervention) sought to identify the knowledge, resources and understanding medical doctors and religious leaders possess about somatization disorder, and this in turn will help with what specific areas(s) need to be addressed. As for the general public (both women and men), research into their knowledge about somatization disorder needs to be extended, as currently there are no statistics regarding this, and study one (chapter three) provided only women's views. Therefore, community programs should target the general public's awareness of how to help others they think might be experiencing domestic violence and/or somatic symptoms. If and when this is accomplished, this will serve to help women similar to those who participated in this study, by the public, friends, or family members being more aware and being able to intervene in a more confidential and appropriate

manner. This should also address the fear of repercussion that the women held. It is hoped that with more education about domestic violence, the general public may become more sensitive and knowledgeable about the consequences, and should encourage confidentiality. In turn, this should help in alleviating women's fear of disclosure, and encourage more women to seek assistance for their domestic violence experiences.

Additionally, it is hoped with the public's new knowledge about somatization disorder, they, too, will become more aware and not trivialize the symptoms associated with the illness. Therefore, when women with somatic symptoms present to, for example, family members they will not only prescribe 'local remedies,' but instead refer them for the appropriate help; this will also encourage women to seek assistance, and, thus, reduce the women's suffering. Additionally, women who present with both somatic symptoms and domestic violence experiences will also benefit. It is hoped that persons in the general public will now have more knowledge and know where to turn for assistance.

The role that both culture and religion play in help-seeking these served to highlight the similarities that exist between the two prevalent ethnicities (Indo- and Afro-) in Trinidad (Ali, 2006; Brereton, 1996; Government of Trinidad & Tobago, 2008; Hadeed & El-Bassel, 2006). The findings also suggest that both Indo-and Afro-Trinidadian women could have been influenced by each other in the manner in which they seek and view assistance, and also the method in which the help is given. Also supported by the literature presented in chapter 2, for example that persons from different geographical regions within countries will differ in their interpretation of events (Cheng, 2001; Cohen, 2009; Kirmayer & Sartorus, 2007). To date, there have been no studies documenting the similarities between Indo-and Afro-Trinidadian women and how abusive experiences have affected their sense of self. This study explored this, and reported that both ethnicities had similar experiences, which is, their sense of self and the further development of their possible selves had been eroded to some extent by their help-seeking experiences. These two findings provoke an interesting query, that is, will there more variation 'with-in' culture than 'between-culture' (Cohen, 2009; Cheng, 2001; Kirmayer & Sartorus, 2007). Thus, would Indo- Trinidadians have influenced their Afro-Trinidadian counterparts or vice versa with regard to their help-seeking choices. For example, as noted above, even though Maharajh (2010) suggested that Afro-Trinidadian women were less submissive and more

outspoken, this study found otherwise. Afro-Trinidadian women were no more likely to speak about their abuse compared to Indo-Trinidadian women.

'My faith helped': As noted in this study, many of the women sought assistance from either the medical doctor or religious leader for their abusive experiences or somatic symptoms. In order for the above to be accomplished, as noted by Maharajh (2010), there needs to be more collaboration between these two groups. This study bore many similarities to both international (Mai, 2004; So, 2008; Sisley, 2011) and regional (Caribbean) (Hadeed et al., 2006; Maharajh & Kassiram, 2010; Maharajh, 2010; Nagessar et al., 2010) research on help-seeking for somatization disorder and domestic violence experiences, as many of the women in this study sought assistance from medical doctors, family or spiritual sources and had both positive as well as negative experiences. This study bridged the gap in knowledge by shedding light into how both ethnicities seek help for domestic violence experiences and somatic symptoms. However, what this study also revealed was that Afro-Trinidadian women hold similar beliefs and may be shared values or problem-solving culture to Indo-Trinidadian women when it came to help-seeking for somatization disorder and domestic violence experiences, such as, both ethnicities were fearful of disclosing their abusive situations because they might be subject to further abuse; they felt that the pastor was helpful in some instances, whereas, some of the women admitted that they were disappointed with the pastor's assistance. Others stated that because of their position in the church structure (pastors' wife), and having to present themselves in a manner that would be satisfactory to the parishioners (impression management); they could not speak openly about their issues. Notwithstanding this argument, the majority of the women agreed that the most helpful assistance they received was from God. Thus, this study further supported the notion that most of the Indo-and Afro-Trinidadian women also sought assistance from spiritual sources in the form of a religious leader or God instead of from a medical source.

Maharajh (2010) did note that, in Trinidad, well-structured psychiatric programmes were being underutilized and most individuals often seek spiritual before medical assistance. Maharajh (2010) recommended that a paradigm shift of the population and church leaders is needed with a greater collaboration between medical doctors and religious leaders. He also stated that attempts to work together with the various churches have failed, because local religious leaders attribute mental illness to possession of demon states. This view results in conflict between the priest and

the psychiatrist with opposing views on ‘demons and dopamine’. As noted in this chapter many of the women stated that the pastor told them that someone had ‘done witchcraft’, and that this was the reason for their abuse or symptoms, once again encouraging the women not to express their frustrations, but instead to internalize them. Nonetheless, some sort of spiritual or religious influence, for example, the priest, pundit or imam, remains today as the first contact for the majority of patients in Trinidad (Maharajh, 2010).

As a result, some of the women felt a sense of discomfort when expressing their symptoms or abusive situations to the religious leader. When this type of inner conflict occurs the women may be left with feelings of ambivalence, as they are unsure if they should seek assistance or stay silent. Thus, most of the women did not receive the proper care required to either treat their somatic symptoms or find avenues to lessen or leave the abusive partner. This would have hindered the women from fully disclosing their situation to their source of help; thus, the pastor may not be able to give the necessary advice as they are unaware of the entire situation. For this reason many of the women confided in some heavenly being, and most were satisfied with this route, as they were no longer fearful of retaliation by the abuser, or that the pastor would try to encourage her to stay in the relationship.

In Trinidad, many of the non-denominational churches (e.g. Pentecostals) do not require persons to attend counselling courses before becoming a pastor. Additionally, many belonging to Hinduism also do not require Pundits (Hindu Priest) to attend formal training. Therefore, some of these religious leaders do not possess the knowledge about how to advice women who are/still experiencing domestic violence. Since most persons tend to seek out spiritual help first rather than medical (Maharajh, 2010), this is an area that needs much attention. In order to help lessen these issues, again more educational programmes specifically directed at religious leaders can be implemented. These programmes could educate the religious leaders about how to screen, intervene, and access referral sources for women with domestic violence experiences and somatization disorder. Study three will attempt to uncover these issues in order to disclose how much intervention is needed in these areas for the religious leaders. These interventions should also include issues of confidentiality and self-esteem building, as, these were the issues most expressed by the women in this study.

'I was afraid to tell because I might get hurt': Maharajh (2010) notes that negative attitudes towards mental health and unwillingness to access mental health care remains a problem for the mental health professional in Trinidad, despite the existence of well-structured programs ("The country is divided into nine catchment areas, each with a multi-disciplinary team of psychiatrists, social workers, mental health officers and auxiliary workers" p.58). Similar to studies (Becker, Al Zaid & Al Faris, 2002; Hardin, 2002; Kassiram & Maharajh, 2010; Mai, 2004; So, 2008) cited in the literature review (chapter two) of this thesis which stated that Asian women tend to seek help for their somatic symptoms from family members because of shame and stigma, this study also found that Indo-Trinidadian women who have somatic symptoms also tend to seek help from family members. The findings of this study also indicated that many of the Indo-Trinidadian women reluctantly told no one about their symptoms because they were made to feel that their symptoms were trivial. However, many Afro-Trinidadian women in this study also voiced that they did not seek assistance for their somatic symptoms because they too felt that their symptoms were not important. Afro-Trinidadian women also sought assistance from their family members and they were either told by them that the symptoms were not worthy of seeking medical treatment, or the medical doctor themselves did not seek to fully understand the reasons for the somatic symptoms. As a result, many of the Afro-Trinidadian women did not seek suitable assistance for their symptoms associated with somatization disorder.

Thus, it may be assumed that some of the women in this study problem solved in this manner because 'traditionally' this approach has been met with success in the past. Therefore, some may have adopted this manner of coping as a means of dealing with their distressing situations (Cheng, 2001; Na & Kitayama; 2011; Kirmayer & Sartorius, 2007; Sewell, 2005; Straub et al. 2002). Thus, study one revealed that even though more Indo-Trinidadian women somatized (consistent with previous research by Kassiram & Maharajh, 2010), their Afro-Trinidadian counterparts also somatized their distress. This study further highlighted that many Afro-Trinidadian women who have somatic symptoms held the same or a similar belief to Indo-Trinidadian women with regards to the importance of their symptoms and the help received. This creates many obstacles for the women with regard to help-seeking, as they are not encouraged to speak about their challenges, and if they do, it is not met with much concern or care. Therefore, the medical doctor may have overlooked many cases of domestic violence because the women

were not encouraged to speak. Additionally, many of the women revealed that the medical doctor did not probe their symptoms, that is, they were not asked if they were experiencing any trauma. As a result, the women chose not to inform the medical doctor about their abusive situations. This is unfortunate, because the medical doctor may be the first contact the women have for disclosing information about their problems.

According to some researchers (Dowrick et al., 2004; Epstein et al., 2006; Mai, 2004; Quill, 1985; Robbins et al., 1994; Salmon et al., 2004), medical doctors may be hesitant to investigate somatic symptoms because of their own insecurities; their drive to rule out any organic ailments; their ignorance of the condition; the fear of overlooking an organic disease and their discomfort in exploring psychological issues. As a result, women visiting the GP for their somatic symptoms do not receive the appropriate care. These findings from international studies were also echoed in this study, as noted above. Additionally, both ethnicities had similar experiences in general for help-seeking for their somatic symptoms, suggesting that the cultural composition of Trinidad could have impacted not only on the sources of help but also the help given. That is, the persons providing assistance could also have been raised in Trinidad and thus, were influenced by the factors such as culture. They too may view psychological illness as a sign of 'weakness' and therefore treat the individual in this manner, because of their own insecurities (Dowrick et al., 2004; Epstein et al., 2006; Mai, 2004; Quill, 1985; Robbins et al., 1994; Salmon et al., 2004).

Also, Gerbert et al., (2002) note that some physicians still view domestic violence as a 'private' matter, and, as a result, are hesitant to intervene. This can also be related to the expression of somatic symptoms since some international research has reported that some physicians because of their own discomfort in exploring psychological issues may not investigate somatic symptoms (Mai, 2004 & Quill, 1985). Again, this can be linked to culture, as some of these physicians may have been socialized in a culture that promotes psychological ailments as 'weak' and, as such, hold these beliefs despite being formally educated about such ailments. Consequently, some may struggle with learning-performance distinction, as they are not overtly expressing what they learnt in medical school but rather their own beliefs. These assumptions are further discussed in

chapter seven (discussion). Additionally, study three (chapter six; religious leaders and medical doctors intervention) seeks to address some of these concerns.

In order to help alleviate these issues, screening programmes at local hospitals and health centres may be needed. For example, as medical doctors have many patients in a short space of time, a brief screening tool could be implemented where the doctor asks 'yes' or 'no' questions that address possible abuse situations. Also, similar to the religious leaders, educational workshops in dealing with domestic violence should be implemented for medical doctors. This will serve to address any personal fears the medical doctors may have about discussing domestic violence with their patients, as this is a concern noted by Gerbert et al., (2002). Other medical workers (nurses) would also benefit from such programmes, as in many instances they are the ones who first ask the patient about their symptoms or injury. As such, if the medical doctor identifies possible abuse, they can then refer the women at that moment to another health care worker for assistance. This will serve to provide the women with immediate help, and ensures she does not have to wait. Also, brochures about domestic violence and specifically somatization disorder should be readily available to be given to women about what somatization disorder is, and where help can be sought. This may also encourage women to seek assistance, as while collecting data for study one, many of the women were appreciative of the debriefing sheet that contained telephone numbers for help agencies.

Gerbert et al., (2002) and Elliot, Nerney, Jones and Friedman (2002) stated that some of the most frequent barriers physicians face when screening for domestic violence were a lack of training, and thinking they would not be able to "fix" the problem. As a result, it may be argued that some physicians experience double-approach conflict. Therefore, it is further recommended that all health care workers can also be advised to take courses specifically designed to address interpersonal relationships, as many of the women stated that they had no close bonds with the medical doctor and therefore they were not encouraged to disclose. These courses will not create a bond but might provide the medical doctor with the knowledge of how to help create a satisfactory bond that will encourage disclosure. Some researchers (Mai, 2004; Quill, 1985) have suggested that physicians need to be better educated about somatization disorder because they have first contact with persons with somatic symptoms. Ali (2003) and Taket et al., (2003)

suggested that screening may reduce subsequent psychological and physical abuse to the women, and by uncovering hidden cases of domestic violence this would make it easier for women to access support services.

'My physical symptoms are linked to my abuse': This study also served to further close the gap in the literature by bringing to light that both Indo-and Afro-Trinidadian women linked their somatic symptoms to some form of abusive experience(s). As noted earlier in this chapter, some researchers (Brown, Schrag & Trimble, 2005; Hegarty et al., 2004; Holloway et al., 2000; Kassiram & Maharajh, 2010; McCauley, Kern & Kolodner et al., 1995; Samelius et al., 2007; Righter, 1999) have suggested a link between domestic violence experiences and somatization disorder. What these studies did not report were differences between ethnicities, specifically Indo- and Afro-Trinidadians. This study did so, and it was revealed that both Indo-and Afro-Trinidadian women felt that their physical ailments (somatic symptoms) were linked to either their past or present experiences of abuse.

As noted in the findings section of this chapter, many of the women were distressed by their physical ailments, and it caused them much discomfort, it may be further argued that this sometimes causes some to experience afterburn in their daily functioning. If the above suggested educational and other programs are implemented for religious leaders, medical doctors, and the general public, when the women present they will be properly screened, reassured and encouraged to disclose. If this is accomplished, the women's stress-related ailments would be properly treated and may cause them less distress. The women will not also have a better understanding about their challenges; they may also be more encouraged to seek out assistance and, therefore, symptom/situation improvement, leading to an enhancement in their daily functioning.

'I can plan for the future': International and local (Trinidad) studies (Hadeed et al., 2006) have reported that when the women leave their abusive partner or situation they may experience catharsis and as a result, achieve some form of self-actualization thus, their quality of life may improve. Studies such as, Hadeed et al., (2006) and Sisley et al., (2011) both examined either Afro-Trinidadian women or Afro-Caribbean women's experiences in help-seeking for domestic violence and managing emotional distress. The experiences of both Indo-and Afro-Trinidadian

women were explored in this study. It was revealed that both ethnicities had similar experiences; that they were able to re-gain a sense of control over their own lives and feel empowered to make decisions regarding their futures.

Although some of the women found inner strength to leave the relationship or overcome their somatic symptoms, many may not. Thus, educational programmes involving women with past experiences may help others (Bennett, Riger, Schewe, Howard & Wasco, 2004; Tutty, Bidgood & Rothery, 1993). For example, these women could give seminars at one of the local community centers encouraging other women. When other women realize that they are not alone, they may be motivated to seek out more assistance.

For the women who have successfully overcome their challenges, it is important that they are able to maintain their independence. Some of the women might still be surrounded by persons who speak negatively about their symptoms, encouraging them to return to the abusive situation or accepting the ex-partner in socialization with the family of origin. The women will still have to cope with these issues; the introduction of short self-help courses addressing self-esteem could help, as it will educate the women about how to preserve the courage it took to overcome their negative situations, and provide additional social support.

The findings of this study have brought to the forefront the help-seeking behaviours that exist within the two majority ethnicities in Trinidad (Ali, 2006; Brereton, 1996; Government of Trinidad & Tobago, 2008; Hadeed & El-Bassel, 2006) in terms of help-seeking for somatization disorder and domestic violence experiences which no other study has accomplished. While some Indo- and Afro-Trinidadian women felt they received beneficial support for either their somatic symptoms or domestic violent experience from the religious leader or medical doctor, others felt the help received was not useful, because their problems were not adequately dealt with. These findings also informed study three of this thesis. The implications of these findings suggest that help agencies should tailor their services to meet the needs of women with the knowledge that Indo-and Afro-Trinidadian women tend to experience these intersecting issues in a similar manner. Maharajh (2010) noted that racism in Trinidad is most frequently defined by two dominant ethnic groups (Indo- and Afro-), where there is often hostility between them. These findings will also serve to educate the general public (Trinidad) about similarities and differences between the ethnicities with regard to help-seeking for domestic violence and somatization

disorder, and hopefully reduce some of these conflicts. For example, both Indo- and Afro-Trinidadian women shared fears and experiences in common with regard to domestic violence experiences, contrary to cultural stereotypes of 'Indo-Trinidadian women are 'submissive' and Afro-Trinidadian women being 'strong' (Maharajh, 2010). Thus, study three will seek to investigate the knowledge, resources, willingness to explore and intervention strategies employed by medical doctors and religious leaders when meeting with women who may have domestic violence experiences and somatization disorder.

5:14: Limitations

Similar to Sisley et al., (2011) this study also employed semi-structured interviews, with the intention of allowing flexibility in following the participants' accounts of their experiences. In so doing, this approach could have hindered the participants from disclosing their true experiences. That is, participants may have modified their responses in order to either gain the researcher's support, or to conceal information. Additionally, Trinidad is still seen as a somewhat traditional society (Maharajh, 2010) and the participants may have modified or concealed information because they were fearful of being judged or as the over-arching theme of this study suggests, they were afraid of the consequences of disclosing. In order to try to overcome these challenges, Sisley et al.,'s (2011) approach was adopted. That is, employing an open and non-judgmental method and encouraging participants to speak openly. Participants were reassured that all issues of confidentiality were observed, and that they were free to withdraw without consequences. Additionally, many of the women did not initially link their somatic symptoms to their abusive experiences until they were asked by the interviewer. This could have encouraged some of the women to believe that there may have been a link between their symptoms and abuse. This prompting may be viewed as either positive or negative. Prompting may have encouraged some of the women into thinking that the probable cause of their somatic symptoms was/is their abuse. Moreover, some of the women may have stated that these issues were linked, not because they are, but because they were prompted to believe that they are.

Chapter 6

Help agencies' knowledge, understanding and intervention for women with somatization disorder and domestic violence

6:1 Introduction

This thesis has sought to report and compare experiences of domestic violence and somatization disorder amongst Indo- and Afro-Trinidadian women living in Trinidad and their help-seeking experiences. The first two studies mapped the routes to help the women took, and explored the impacts these had on their outcomes. Data gathered in studies one (chapter 4; occurrences of somatization disorder and domestic violence) and two (chapter 5; IPA analysis of help-seeking) demonstrated that while many of the women sought assistance from various sources for either their somatic symptoms or domestic violence experience (such as a friend, a relative or the police) the majority stated that they sought help from either religious leaders or medical doctors. Hence, this study focused on the knowledge, resources, willingness to explore and intervention strategies employed by religious leaders and medical doctors, when meeting with women who may have experienced domestic violence and somatization disorder.

This chapter also discusses the methodology and rationale for the third study. It highlights the rationale for adopting a quantitative approach (questionnaires), and describes the demographics of participants, materials, procedure, analysis and coding. This chapter concludes with a results section that presents the findings

6:2 Rationale for adopting a quantitative approach for study 3:

As noted in the rationale for adopting a mixed methods approach (chapter 4; occurrences of somatization disorder and domestic violence), quantitative data is beneficial because it focuses on a positivistic view of the world and utilizes science to clarify the phenomenon being investigated and support findings (Potter, 1996). Additionally, Matveev (2002) maintains that "quantitative research consists of the measuring of events, counting, and performing statistical analyses on numerical data. This is because it is assumed that there is an "objective truth existing in the world that can be measured and explained scientifically" (Matveev, 2002, p. 59). Thus,

Mateveev (2002) argues that one of the major advantage of quantitative research is that the measurement is valid, reliable and illustrations any statistically significant associations in the data.

Additionally, it has been reasoned that quantitative research has many strengths (Geinsinger, 2010; Johnson & Onwuegbuzie, 2004; Matveev, 2002). For instance, it enables the testing of hypotheses that have been constructed before data collection began (which is essential to this study). Second, it provides the researcher with numerical, precise data that can be collected quickly (this study had a total of 100 participants), and finally, the results obtained are comparatively independent of the researcher (Johnson & Onwuegbuzie, 2004). However, despite all these advantages there are still some weaknesses. Matveev (2002) contends that the information obtained may be considered too abstract or general for it to be applied to specific situations, or, due to closed-ended questions and structured format there may be "limited outcomes to those outlined in the original research proposal" (Matveev, 2002, p.19).

Nonetheless, compared to the rationale for qualitative data for study two (chapter 5; IPA analysis of help-seeking for Indo- and Afro-Trinidadian women), quantitative data for this study was more appropriate, as this study did not seek to explore participants' emotions, experiences or how they make sense of their world. Instead, it sought to look for trends, and draws comparisons between the religious leaders and medical doctors' knowledge, resources and intervention strategies for women with somatization disorder and domestic violence experiences.

Rationale for utilizing questionnaires

Some researchers have argued that questionnaires (Geinsinger, 2010; van Gelder, Bretveld & Roeleveld, 2010; Wright, 2005) are one of the best tools for data collection. It has been further proposed that questionnaires are "inventories" that are used to collect an assortment of data from different individuals (Geinsinger, 2010). As a result, questionnaires may access a large number of participants at a relatively low cost to the researcher. Moreover, a questionnaire may remove researcher bias and provides the respondent with a sense of anonymity. Finally, the data gathered may assist in providing information that will help in planning program evaluations. For example, this thesis is funded by the Government of Trinidad and Tobago; thus, based on the data gathered

from this study, it may help in the formulation and implementation of programmes that help-agencies can adopt when meeting with women who have somatic symptoms and domestic violence experiences. However, according to Mann (2001) there are some disadvantages to using this method of data collection, such as, the completed questionnaires may only reflect the opinions of those who were willing or had the time to respond due to various factors, and, as such, the responses may not be a true representation of the sample. However, properly designing the questionnaire reduces these disadvantages. Additionally, a low response rate may also hinder the collection process; in order to reduce this, on-line questionnaires were also used in this study, as noted below.

On-line Questionnaires

This study offered participants the option to complete either an on-line or paper version of the questionnaires. In the past decade, there has been a huge increase in computer use, and, internet usage, as a result many researchers find the internet very valuable for conducting research (Wright, 2005). There are many advantages to using this method to collect data; for example, it allows the researcher to access participants for those completing an internet version would be more convenient (for example, medical doctors, because of their busy schedules). Also, it is less time-consuming for the researcher; since data collection for this study incorporated 100 participants and had to be accomplished over a three month period, this method helped the researcher to access participants in a shorter period of time. Additionally, it saves the researcher money, as the printing of paper questionnaires is reduced (van Gelder, Bretveld & Roeleveld, 2010; Wright, 2005).

The overarching research question was: *'Do medical doctors have better resources, greater willingness to explore and better intervention strategies than religious leaders when meeting with women who may have somatization disorder and domestic violence experiences?'* The following hypotheses were proposed:

H1: Medical doctors will have more resources available to them about domestic violence than religious leaders.

H2: Religious leaders will be more willing to discuss with women their experiences of domestic violence than medical doctors.

H3: Medical doctors will be more willing to discuss somatic symptoms with their patients than religious leaders.

H4: Religious leaders will have little knowledge about somatization disorder compared to medical doctors.

6:3 Method
6:4 Participants

Participants for study three consisted of 100 individuals: 50 medical doctors and 50 religious leaders (from various spiritual orientations, including Christianity[64] (30), Hinduism (10) and Islam (10), all from Trinidad and including both males and females. The participants were recruited from the eight administrative boundaries (counties) in Trinidad utilizing the non-probability sampling technique of snowballing[65] through gatekeepers. Gatekeepers, similar to studies one and two, were selected based on either their familiarity of that county, that is, if they worked or lived in the county and knew potential participants. At the beginning of the study there were a total of nine gatekeepers (7 females and 2 males). As data collection progressed three more gatekeepers were added (2 males and 1 female) bringing the total to twelve. Their occupations included primary and secondary school teachers (currently employed and/or retired), psychologist, medical doctor, senior lecturer, religious leader, police corporal and housewife. The ages of the gatekeepers ranged from 25 years to 71 years, and were from diverse ethnicities.

[64] Pentecostal, Presbyterian, Roman Catholic, Evangelical, Spiritual Baptist, Jehovah Witness's, Church of Jesus Christ of Latter Day Saints, Anglican, Seventh-Day Adventist, Salvation Army of Trinidad and Tobago, Church of the Nazarene.

[65] Identify one person who meets the inclusion criteria and then ask them to recommend other persons who fit the inclusion criteria (Trochim, 2006)

Table 12 below illustrates demographic data for both the religious leaders and medical doctors.

Table 12: Demographic Data by Samples

Demographic Data	**Categories**	**Religious Leaders (%)**	**Medical Doctors (%)**	**Entire Sample (%)**
Religious Orientation	Christian	60	44	52
	Hindu	20	38	29
	Muslim	20	12	16
	*Other	00	06	03
Ethnicity	Indo-Trinidadian	58	64	61
	Afro-Trinidadian	24	12	18
	Mixed Ethnicity	16	14	15
	**Other	02	10	06
Gender	Male	76	50	63
	Female	24	50	37
Age	18 – 25	00	12	06
	26 – 30	02	48	25
	31 – 40	20	24	22
	41 – 50	22	00	11
	51 – 60	30	04	17
	61 – 70	16	10	13
	71 and over	02	02	02
	No Answer	08	00	04

* Atheist
**Asian

Table 12 con't: Demographic Data by Samples

Demographic Data	***Categories***	***Religious Leaders (%)***	***Medical Doctors (%)***	***Entire Sample (%)***
Where qualification was obtained	In Trinidad	58	76	67
	Outside Trinidad	20	24	22
	N/A	22	00	11
Hours spent in either religious/medical setting	None	00	10	05
	< 1 hour	06	00	03
	1 – 20 hours	70	10	40
	21 – 40 hours	14	52	33
	41 – 60 hours	00	14	07
	61 – 80 hours	02	14	08
	> 80 Hours	02	00	01
	No answer	06	00	03
Year Medical/Religious qualification was obtained	1950s	00	02	01
	1960s	04	00	02
	1970s	04	12	08
	1980s	08	02	05
	1990s	12	02	07
	2000s	38	60	49
	Since 2011	02	22	12
	N/a	32	00	16

* Atheist
**Asian

Table 12 shows that the majority of the sample were Christians, aged between 26 – 30 years old, with a minority older than 70 years. Overall, more religious leaders were males, whereas the gender distribution for the medical doctors was more equal. Table 13 also shows that the majority of the sample obtained either their religious or medical qualification from an institution within Trinidad. Additionally, the majority of religious leaders and medical doctor attained their

qualifications during the 2000s. Finally, the majority of the sample spends between 21 to 40 hours per week attending to either parishioners or patients within their respective settings.

Table 13 shows the setting in which the religious leaders practice, and their highest level of education. Table 14 illustrates the medical doctors primary practice site, specialty, and whether they are a generalist or specialist.

Table 13: Education and Practice Setting Data for Religious Leaders

Demographic Data	**Categories**	**Religious Leaders %**
Highest Level of Education	Certificate	30
	Diploma	12
	Associate Degree	06
	Bachelor's Degree	24
	Master's Degree	14
	Other (PhD)	14
Practice Setting	*Private Group Practice	26
	**Private Solo Practice	10
	***Formal Institution	64

*Operate religious establishment in collaboration with other leaders
**Own and operate religious establishment independently
***Religious institution is operated by a governing body

Table 14 shows that the majority of religious leaders indicated they are affiliated with a Formal Institution, while the minority owned and operated their religious establishment independently. Additionally, the majority of religious leaders obtained a certificate level of education, while the minority has an Associate Degree.

Table 14: Primary Specialty and Practice Site Data for Medical Doctors

Demographic Data	Categories	Medical Doctors %
Primary Specialty	Family Practice	14
	Internal Medicine	16
	General Internal Medicine	04
	*Other	66
Generalist/Specialist	Generalist	74
	Specialist	26
Setting of Primary Practice	Private Group	02
	Private Solo	10
	University/Teaching Hospital	60
	Government-Owned Hospital	02
	Public Community/Government-Owned Hospital	02
	Private Solo/University Teaching Hospital	02
	University Teaching/Government Owned	06

* Psychiatry (n=4), Emergency Medicine (n=21), Surgery (n=2), Public Health (n=1), Anaesthesia (n=1), Dermatology (n=2), Orthopaedics (n=1), Paediatrics (n=2), Family Medicine (n=1)

Table 14 shows that the majority of medical doctors' primary specialty was 'other' and the minority were general internal medicine. Additionally, the majority of the medical doctors were generalist; with the more medical doctors indicating that their setting of primary practice was a university/teaching hospital.

6:5 Materials

This study used two questionnaires that had only minor differences between them. For example, the words 'religious leader' or 'medical doctor' in the questions were used for the appropriate questionnaire. The questionnaires for this study were constructed using an outline from Gerbert et al., (2002).

There were three sections of the questionnaire for religious leaders (see appendix Sa) and medical doctors (see appendix Sb). Section A, which included demographic data, such as, the participants age, gender, ethnicity, level of education, year of obtaining their qualification, where it was obtained, religious orientation, setting where they practiced (either as a religious leader or medical doctor), and how many hours they spent per week in these settings.

Section B of the questionnaire was designed to gather information on the religious leaders' and medical doctors' knowledge, resources and willingness to intervene with women who had somatic symptoms. This section required that participants either tick or circle their answers, with only one question asking for a written answer to *'If yes, briefly state what you understand the term somatization disorder to mean'*. The other questions included items such as, 'I know how to assess women for somatization disorder'.

Section C was designed similar to section B, as this section also sought to gather data about religious leaders' and medical doctors' knowledge, resources and willingness to intervene with women who have/had domestic violence experiences. This section also required participants to tick or circle their answers, with one question asking them to provide a definition of domestic violence. The other questionnaire included items such as; '*I know how to intervene with patients (women) to address the risk of domestic violence*'. Each questionnaire concluded with a question asking participants to give an estimation (in percentages) of how many women they had encountered who had experiences of domestic violence also had somatization disorder.

This study also had an on-line version of each questionnaire. As mentioned earlier this method enabled the researcher to access participants easily and it was less time consuming, as the researcher would not have to actually meet with participants. Additionally, it allowed

participants to complete the questionnaire at a time and place convenient to him/her. Therefore, a link was emailed to participants who were willing to complete this version which contained the information sheet, informed consent, questionnaire and debriefing sheet. It is to be noted that only one of the participants chose this option.

6:6 Procedure

Gatekeepers and the researcher identified and contacted potential participants either by telephone or in person, and asked if they would be willing to participate in a study about somatization disorder and domestic violence. Participants for this study were recruited via snowballing, in which both the gatekeepers and the researcher recruited participants they knew and then asked for referrals. Both the gatekeepers and the researcher contacted participants living within each of the eight administrative boundaries (see appendix T for details) over a period of three months (February to May 2013). The researcher then either contacted the participant via telephone or in person.

If the participant was contacted via telephone, a day, time and place was decided upon for him/her to complete the questionnaire. Also, if the participant was contacted in person and if he/she agreed to complete the questionnaire on the spot, this was done; if not, then the same procedure above was followed for an appropriate time to meet. That is, for medical doctors a visit to their office and for religious leaders during their vestry hours. All participants were informed that there was on on-line version. For participants who chose to complete an on-line questionnaire, the invitation to participate (see appendix U) was emailed to them which included all the instructions, including a link to the questionnaire.

If the religious leader or medical doctor agreed to participate in the study, the researcher gave and explained details about the study with the aid of the information sheet (see appendix V). If he/she was willing to participate, he/she was presented with an informed consent to sign (see appendix W). After this, the person was handed a questionnaire, which took approximately 15 to 20 minutes to complete. On completion of the questionnaire, each of the participants was given a debriefing sheet (see appendix X), and thanked for his/her time and participation in the study.

6:7 Coding
Quantitative Data

For data analysis to be conducted some of the questions needed to be coded in order to be entered into SPSS. See appendix Y for the questions from the religious leaders' and medical doctors' questionnaires, and the categories they were coded into. All of these were coded, as this facilitates the organization, retrieval, and interpretation of data, and leads to conclusions on the basis of that interpretation (Lockyer, 2004).

Analysis
Quantitative Data

All of the data were entered into the Statistical Package for the Social Sciences (SPSS) software; where a range of statistical analyses were conducted including, chi-square, independent samples *t*-tests and frequency distributions, in order to compare responses of religious leaders and medical doctors and to look for any relationships among the data. This was done first for the entire sample then for the religious leaders and the medical doctors separately. Each of these tests was specifically chosen in order to aid the understanding of the religious leaders' and medical doctors' knowledge, understanding and resources for somatization disorder and domestic violence. Each of these tests will now be briefly discussed.

Similar to study one, chi-square analysis was used to examine the similarities between the two populations; for example, with regard to resources available for somatization disorder, chi-square analysis helped to determine if any similarities existed between religious leaders and medical doctors (Field, 2009). This served to identify how likely it was for medical doctors to have more resources for somatization disorder than religious leaders (hypotheses one, two, three and four). Also similar to study one, independent samples *t*-tests were used, as this test seeks to establish if two means collected from independent samples differ significantly (Field, 2009). For example, this test helped to determine if more religious leaders than medical doctors were willing to discuss with women their experiences of domestic violence (hypothesis four). Finally, frequency distributions were calculated in order to quantify demographic information and make comparisons between the samples.

Qualitative Data

Open-ended Questions

Two questions required participants to write an answer. The two questions were: '*briefly state what you understand the term somatization disorder means'* and '*briefly state what you understand the term domestic violence means'*. Transcription of the data was completed similarly to study one. That is, the responses were transcribed word for word from the questionnaires, under the headings 'domestic violence' and 'somatization disorder'. When this was completed, the same steps highlighted in chapter four for formulating themes were adopted. That is, I familiarized myself with the data by reading the responses multiple times, after which initial codes were formulated and reviewed. After this was completed, final themes were decided upon (Braun & Clarke, 2006). Thus, this approach produced what each sample believed somatization disorder and domestic violence to be, while, at the same time, drawing comparisons between the samples, thus, providing rich data. When the relevant codes were grouped and themes were finalized, the end report was then produced.

Analysis

Thematic Analysis

A qualitative approach was adopted for these two questions because of the advantages cited in chapter 5 of this thesis (Kitto, Chesters & Grbich, 2008; Merriam, 2002; Whitley & Crawford, 2005), and qualitative research is concerned with the participants "own categories of meaning" (Johnson & Onwuegbuzie, 2004, p.20). Therefore, for this study participants were able to state what they believed somatization disorder and domestic violence to be, thus, providing the researcher with insight into how the participants conceptualized these terms. Furthermore, qualitative research "allows the researcher to conduct cross-case comparisons and analysis" (Johnson & Onwuegbuzie, 2004, p.20). Therefore, this approach enabled the researcher to draw comparisons between and across each sample (religious leaders and medical doctors).

Thematic analysis was utilized for this phase of data analysis. Thematic analysis, as noted in chapter 4 (occurrences of somatization disorder and domestic violence), is "a method for identifying, analyzing and reporting patterns (themes) within the data. It minimally organizes and

describes your data set in (rich) detail" (Braun & Clarke, 2006, p. 97). For that reason, and advantages such as, flexibility this approach was best suited because responses were brief yet rich in content. It has been further argued that thematic analysis may generate unanticipated insights into the data gathered, and summarizes the key findings of a large body of data and offers a 'thick description' of the data (Braun & Clarke, 2006). As a result, it is very useful for producing qualitative analyses that are suited for informing policy development, and highlights the similarities and differences that exist within the data (Braun & Clarke, 2006). Therefore, similar to study one, the answers served to support the quantitative portion of this study.

6:8 Ethical Considerations

Similar to studies one and two, all proposals for research using human participants are reviewed by an Ethics Committee at Middlesex University before they can proceed. The Middlesex Psychology Department's Ethics Committee reviewed this proposal and granted approval prior to the commencement of data collection (please see appendix Z for approval forms). This study, unlike studies one and two, did not require participants to divulge information that was considered to be sensitive in nature. Nonetheless, there was no way to anticipate if any of the participants did or were still experiencing any situations for which this study might evoke negative emotions. Therefore, the researcher had to ensure that if any of the participants did have an emotional reaction he/she would not be left unsupported. Thus, even though the debriefing sheet contains contact information for various organizations located in Trinidad that offer free counselling services, if any participant did have an emotional reaction they were offered support at that moment by the researcher, and then referred to one of the help-agencies listed on the debriefing sheet. As noted in the ethics sections for both studies one and two, I hold a Master of Sciences degree in Clinical Psychology (2004) and have been trained in various counselling skills. Throughout my years of clinical work, I have also counselled individuals from various ethnic, cultural and religious backgrounds.

The data gathered is highly confidential; therefore, all data, in addition to the informed consent sheets, were coded to protect the identity of participants, and securely stored in a password protected file on a password protected computer. The primary researcher was the only one with access to the password; if supervisors need access to the data they are only given access to the

coded data, hence no names will be revealed. This study, as with studies one and two, also took place outside of the United Kingdom, and to ensure that proper guidance was available throughout the data collection period, contact was maintained with all supervisors via email (once every two weeks or more frequently as required).

Therefore, all ethical considerations were upheld to ensure that this study was properly implemented.

6:9 Results

This section provides an analysis of the knowledge, resources, willingness to explore and intervention strategies employed by religious leaders and medical doctors, when meeting with women who may have domestic violence experiences and somatization disorder. Firstly, comparisons between religious leaders and medical doctors will be examined for somatization disorder. This is followed by the religious leaders and medical doctors' experiences of domestic violence among their patients/parishioners.

6:10 Somatization Disorder

When exploring the religious leaders' and medical doctors' knowledge about 'what is somatization disorder', more medical doctors indicated they had heard the term somatization disorder (χ^2 (1) =53.20, p<.05) than religious leaders (providing support for hypothesis 4). Additionally, an Independent samples *t*- test showed that on average, religious leaders (M=1.78, SE= .418) had less knowledge about what is somatization disorder than medical doctors (M=1.06, SE=.240). There was a statistical difference *t* (78.07) =10.555, p<.05; which represented a large effect (*r* = 1.121).

The majority of the religious leaders did not know what the term somatization disorder meant. However, the minority who did attempt to provide an answer stated that the symptoms were psychologically based but manifested as physical symptoms. Similarly, the medical doctors also stated it was a mental disorder with no organic cause for the symptoms, but it had emotional or mental origins. Figure 7 below illustrates some of the explanations given by both the religious leaders, and medical doctors.

Figure 7: Thematic map illustrating the participants' knowledge of what somatization Disorder is

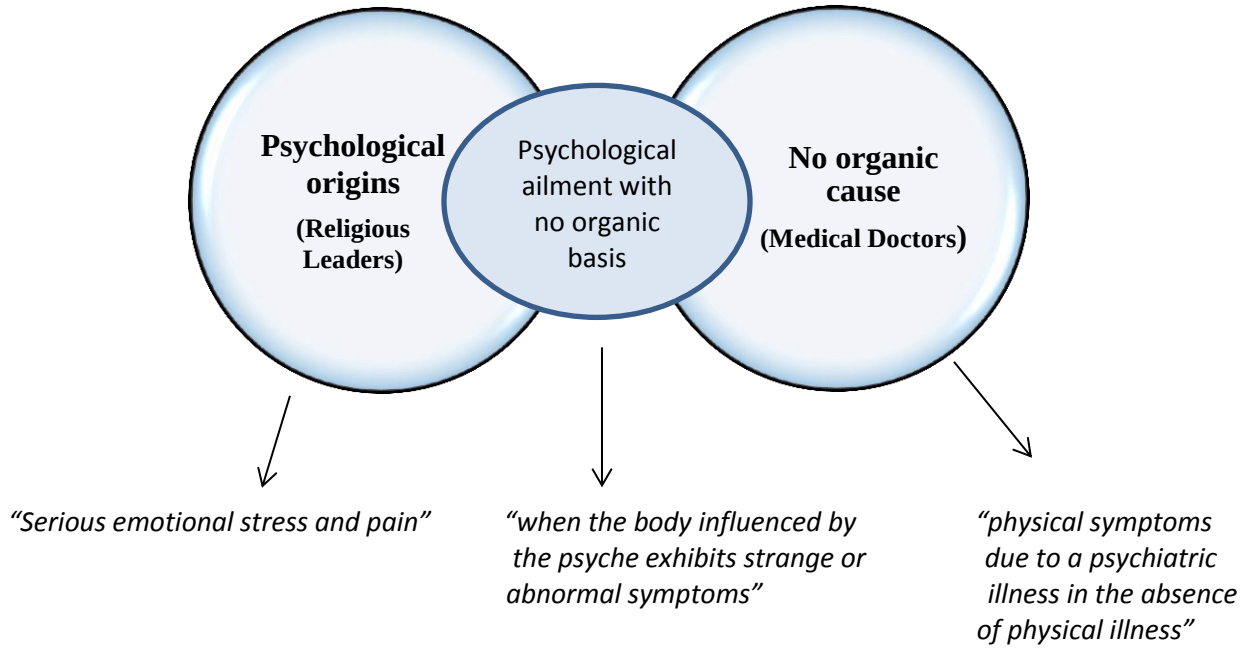


Table 15 below shows the significant association between both the religious leaders and medical doctors for knowledge**,** understanding and intervention for women with domestic violence experiences.

Table 15: Knowledge, Resources and Intervention Strategies by Religious Leaders and Medical Doctors for Somatization Disorder

Inquiry	**Significant Sample**	**Medical Doctors (%)**	**Religious Leaders (%)**	**Statistic (Chi-Square)**
Importance of intervening if symptoms associated with somatization disorder is identified	Medical Doctors	38.8	61.2	χ^2 (4) =14.91*
Assessing for somatization disorder	Medical Doctors	75.6	24.4	χ^2 (4) =30.91**

*p< .05
** p< .001

Table 15 con't: Knowledge, Resources and Intervention Strategies by Religious Leaders and Medical Doctors for Somatization Disorder

Inquire	**Significant Sample**	**Medical Doctors (%)**	**Religious Leaders (%)**	**Statistic (Chi-Square)**
Knowledge of how to intervene when symptoms of somatization disorder are identified	Medical Doctors	74.4	25.6	χ^2 (4) =24.22*
Able to facilitate change when somatic symptoms are identified	Religious Leaders	46.9	53.1	χ^2 (4) =10.78*
Time discussing somatic symptoms	Religious Leaders	26.7	73.3	χ^2 (4) =16.26*
Amount of women somatic symptoms were discussed with	Medical Doctor	70	30	χ^2 (6) =52.62**
Adequate resources to refer women identified with somatic symptoms	Medical Doctors	'strongly agree'55.5; 'agree 71.8	'strongly agree'44.4; 'agree 28.2	χ^2 (3) =16.08*
Documenting symptoms associated with somatization disorder	Medical Doctors	91.7	8.3	χ^2 (4) =18.46*
Time spent with other patients	Medical Doctors	'strongly agree' 45.8;'agree' 54.2	'strongly agree' 15.4;'agree'84 .6	χ^2 (5) =14.94*
Look to God for a solution	Religious Leaders	8.3	91.7	χ^2 (3) =19.45**
Suggest the women turn to God for answers	Religious Leaders	8.3	91.7	χ^2 (4) =16.81**

*p< .05
** p< .001

When both samples were asked to rate the importance of intervening if symptoms associated with somatization disorder were identified, there was a significant association between the religious leaders and importance, with the majority of religious leaders stating it was a very

important role for them, compared to the medical doctors (supporting hypothesis three). However, despite the fact that more religious leaders viewed their role as very important in the intervention of symptoms associated with somatization disorder, the majority did not know how to assess women for somatic symptoms. More medical doctors agreed that they possess the knowledge to assess women for symptoms associated with somatization disorder compared to religious leaders.

There was also a significant association between the medical doctors and their knowledge of how to intervene when symptoms of somatization disorder are identified, with the majority of medical doctors indicating they 'agree' that they knew how to intervene when symptoms of somatization disorder is identified compared to religious leaders.

Even though more medical doctors stated that they knew how to assess and intervene with women in whom symptoms of somatization disorder were identified, they were not confident they could facilitate change in this area, as there was a significant association between religious leaders and the belief that their efforts to facilitate change would be more successful. With more religious leaders agreeing that they would be able to facilitate change compared to medical doctors.

More religious leaders spent between 31-60 minutes discussing symptoms associated with somatization disorder with women than medical doctors (providing support for hypothesis three). However, medical doctors had discussed symptoms of somatization disorder with more women in the past six months than the religious leaders. More medical doctors (28%) discussed somatic symptoms with approximately 1-5 women in the last six months compared to religious leaders (12%).

There was also a significant relationship between having adequate resources to refer women for further assistance for symptoms associated with somatization disorder and medical doctors. The majority of medical doctors indicated that they 'strongly agree' and 'agree' that they did have resources that were adequate to refer the women compared to the religious leaders.

A significant association was also found for medical doctors documenting symptoms associated with somatization disorder. More medical doctors stated that they 'always' documented symptoms associated with somatization disorder compared to religious leaders. Most of medical doctors indicated they recorded the abuse as an '*additional information note in her record*' (8%), while other stated that they record the abuse in a '*specific section of her record*' (4%).

Additionally, there was a significant association between the medical doctors and how the amount of time spent with other patients affected their time with women who had somatic symptoms. With medical doctors stating they 'strongly agree' and 'agree' that work with other patients affected the time spent with women who have somatic symptoms than the religious leaders.

Significant associations were found between the religious leaders, and their faith in God when interacting with women with somatic symptoms. More religious leaders stated that they 'always' look to God for a solution compared to medical doctors. Additionally, more religious leaders indicated that they 'always' suggest the woman turn to God and pray for a solution regarding her somatic symptoms compared to medical doctors.

Summary

This section addressed the knowledge, resources, willingness to explore and intervention strategies employed by religious leaders and medical doctors, when meeting with women who may have somatization disorder. The results suggest that more medical doctors reported they knew what the term somatization disorder was. Also, more medical doctors knew how to assess women for symptoms associated with somatization disorder, as well as, how to intervene when these symptoms were identified compared to religious leaders. Additionally, the medical doctors stated that they did have adequate resources to refer women for additional assistance when somatic symptoms were identified, and tended to document the symptoms more than the religious leaders. The medical doctors also indicated that the time spent with other patients negatively impacted on the time spent discussing symptoms of somatization disorder with women. However, more religious leaders stated their role in intervening when symptoms of somatization disorder were identified was very important compared to medical doctors. The

religious leaders also held the belief that their efforts to facilitate change would be successful. Finally, the religious leaders indicated that they would often turn to God through prayer and advised the women to do the same when dealing with and trying to find remedies for somatic symptoms.

6:11 Domestic Violence

The entire sample (100%) stated that they had heard of the term domestic violence. The majority of medical doctors defined domestic violence as violence within the home. That is, violence between member of the household, regardless of if they are partners or not. Whereas, others stated domestic violence was violence between spouses and, the minority defined it as violence in different forms, for example, physical, financial, emotional, psychological or sexual abuse. Some of the religious leaders also cited these forms of abuse in their definitions, with the exception of one participant, who stated domestic violence was *"spiritual terrorism"*. From the responses given by the religious leaders it appears that the sample was split regarding identifying abuse as either from a spouse/partner of member of the household, as some defined domestic violence as violence between member of the family and others as between spouses. Also, both the religious leaders and medical doctors' stated domestic violence can be perpetrated by either males or females. Figure 8 below illustrates some of the explanations both the religious leaders and medical doctors gave for what they understood the term domestic violence to mean.

Figure 8: Thematic map showing participants' knowledge of domestic violence

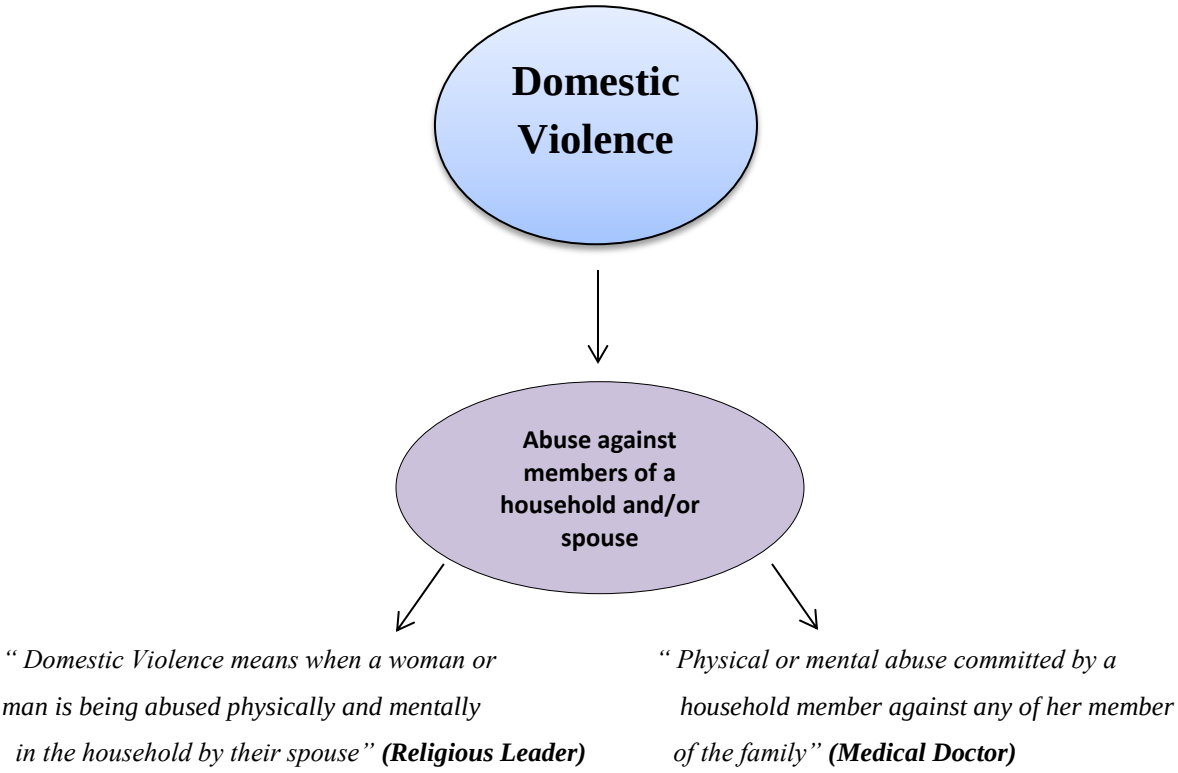


Table 16 illustrates the significant associations between both the religious leaders and medical doctors for knowledge**,** understanding and intervention for women with domestic violence experiences.

Table 16: Knowledge, Resources and Intervention Strategies by Religious Leaders and Medical Doctors for Domestic Violence

Query	**Significant Sample**	**Medical Doctors (%)**	**Religious Leaders (%)**	**Statistic (Chi-Square)**
Importance of intervening if domestic violence is identified	Religious Leaders	37.3	62.7	χ^2 (5) =13.67*
Able to facilitate change if domestic violence is identified	Religious Leaders	'strongly agree'33.3; 'agree'36	'strongly agree'66.7; 'agree'64	χ^2 (4) =15.00*

*p< .05
** p< .001

Table 16 con't: Knowledge, Resources and Intervention Strategies by Religious Leaders and Medical Doctors for Domestic Violence

Query	Significant Sample	Medical Doctors (%)	Religious Leaders (%)	Statistic (Chi-Square)
Time discussing domestic violence	Medical Doctors	48.9	51.1	χ^2 (7) =15.16*
Work with other parishioners/patients	Religious Leaders	34.2	65.8	χ^2 (5) =14.09*
Documenting domestic violence	Medical Doctors	80.8	19.2	χ^2 (4) =26.00**
System to record domestic violence	Medical Doctor	52.4	47.6	χ^2 (2) =8.88*
Adequate resources to refer women identified with domestic violence experiences	Medical Doctors	61.9	38.1	χ^2 (4) =12.76*
Arrange follow-up visits	Medical Doctors	Rarely 85.7 Always 36	Rarely 14.3 Always 64	χ^2 (4) =14.73*
Look to God for a solution	Religious Leaders	11.1	88.9	χ^2 (4) =12.76*
Suggest the women turn to God for answers	Religious Leaders	16	84	χ^2 (4) =29.27**

*p< .05
** p< .001

The importance placed on intervening if domestic violence experiences were identified was examined. There was a significant association between the both, with more religious leaders indicating that their role in intervening if domestic violence is identified as 'very important' as opposed to medical doctors (supporting hypothesis two)

There was also a significant association between the religious leaders and their belief that they are able to facilitate change with regards to dealing with women who have/had domestic violence

experiences. The majority of religious leaders are of the opinion that their efforts to facilitate change in this area were likely to be successful compared to the medical doctors.

The amount of time (in minutes) both religious leaders and medical doctors spend discussing domestic violence with women they come into contact with was also examined. The religious leaders and medical doctors both reported that they spent less than 30 minutes discussing domestic violence once it was identified (providing support for hypothesis two). Additionally, more religious leaders 'disagree' that their work with other parishioners affected the amount of time they spend with women who have domestic violence experiences than medical doctors. However, more medical doctors 'agree' that their work with other patients affected the amount of time spent discussing domestic violence when identified, compared to the religious leaders.

There was also a significant association between medical doctors and the documenting of domestic violence. More medical doctors stated that they 'always' document domestic violence compared to religious leaders. This can be as a result of the majority of medical doctors indicating that their office or institution has a system to record domestic violence cases (supporting hypothesis one). Most of medical doctors indicated they recorded the abuse as an '*additional information note in her record*' (20%), while other stated that they record the abuse in a '*specific section of her record*' (8%).

There was a significant association regarding medical doctors and referring women with domestic violence experiences to another source of help. The majority of medical doctors indicated that they would 'always' refer to women identified as experiencing domestic violence to another source compared to the religious leaders. The referral sources identified by the medical doctors were: police (54%), psychologist (30%), institution that deals specifically with domestic violence (22%), shelter (16%), another medical doctor (14%), religious leaders (8%) and other (12%). This could be a possible reason why the majority of medical doctors stated that they 'rarely' arrange follow-ups compared to religious leaders. The religious leaders indicated that they 'always' arranged for a follow-up visit with women who have been identified as having domestic violence experiences compared to medical doctors.

Similar to the finding that religious leaders tend to suggest that the women turn to God and prayer for their symptoms associated with somatization disorder, religious leaders were more inclined to suggest to women identified as having domestic violence experiences to turn to God and pray for a solution to their abusive situations and were also more disposed themselves to turn to God for a solution regarding how to help the women.

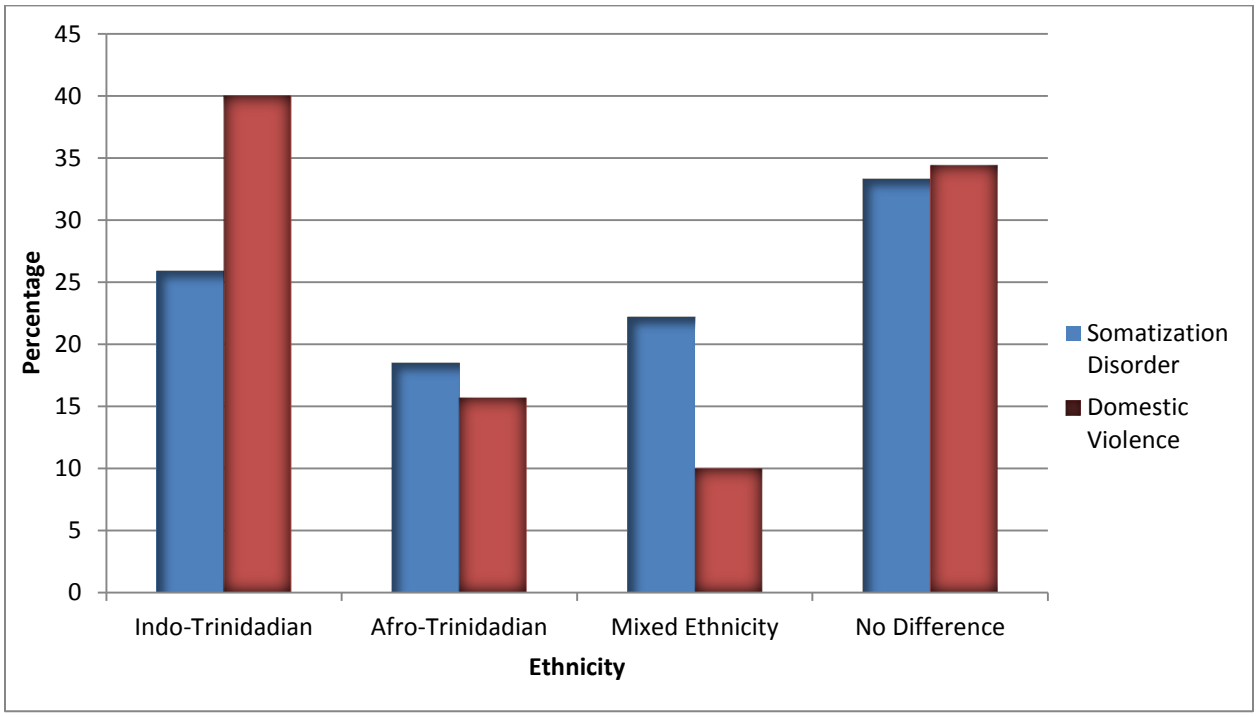
Summary

This section focused on the knowledge, resources, willingness to explore and intervention strategies employed by religious leaders and medical doctors, when meeting with women who may have domestic violence experiences. Religious leaders believed that their role of intervening when domestic violence is identified was very important, and that their efforts to facilitate change would be successful compared to the medical doctors. Additionally, religious leaders reported that they turned to God to pray for solutions and direction when dealing with domestic violence, and suggested this avenue to the women. Religious leaders also indicated that the time spent with other parishioners did not affect the time spent discussing domestic violence with women who have/are experiencing abuse. Whereas, medical doctors reported that they would document domestic violence cases more than religious leaders, would often refer women for other sources for assistance with domestic violence experiences, and the time spent with other patients affected the amount of time spent with women who were/are in abusive situations.

6:12 Somatization Disorder, Domestic Violence and Ethnicity

This section highlights which ethnicity the religious leaders and medical doctors believed were more likely to have somatic symptoms and domestic violence experiences. This section also shows the religious leaders and medical doctors' opinion of what proportions of women who have symptoms associated with somatization disorder also have domestic violence experiences. Figure 9 below illustrates the entire sample's (religious leaders and medical doctors) opinion of which ethnicity is more likely to have symptoms associated with somatization disorder and domestic violence experiences.

Figure 9: Somatization Disorder and Domestic Violence Experiences according to Ethnicity (entire sample)



Although there were no significant associations, the general pattern revealed that the majority of the sample (both religious leaders and medical doctors) are of the opinion that there was 'no difference', with regard to which ethnicity was more likely to have somatic symptoms. While, others stated, Indo-Trinidadian women were also likely to have somatic symptoms, then women with mixed ethnicity (Afro- and Indo-), and finally, Afro-Trinidadian women. Additionally, the majority of the sample stated that Indo-Trinidadian women were more likely to have domestic violence experiences. The minority of the sample indicated that there was no difference in ethnicity with regard to women experiencing domestic violence, and Afro-Trinidadian women and women of mixed ethnicity (Indo- and Afro-) were also likely to have some domestic violence experiences.

Again, despite no significant associations, some of the participants (48%) indicated that they were 'unable to judge' the proportion of women who have experienced domestic violence and also have somatization disorder. While, 15 percent of the entire sample stated, that less than 10 percent of the women who had domestic violence experiences also have symptoms associated

with somatization disorder, and 7 percent stated that 31-40 percent of the women who had domestic violence experiences also have somatic symptoms.

Summary

The findings presented above reveal that both the religious leaders and medical doctors are of the opinion that more Indo-Trinidadian women have experienced domestic violence, while others were of the opinion that there were no differences between ethnicities with regard to women who have symptoms associated with somatization disorder. Also, the majority of the religious leaders and medical doctors stated that they were unable to judge the proportion of women who have experienced domestic violence and also have symptoms associated with somatization disorder.

6:13 Discussion

The results presented in this chapter indicate that medical doctors possess better knowledge of how to assess and intervene for somatization disorder. They also had more resources available to them to refer the women for additional assistance for somatization disorder compared to the religious leaders. Additionally, medical doctors were more inclined to document both somatization disorder and domestic violence compared to the religious leaders. However, as opposed to the religious leaders, medical doctors did not view their role as encompassing intervention if symptoms of somatization disorder and domestic violence were identified as important. Additionally, medical doctors were of the opinion that their intervention strategies would not likely produce any positive changes with regard to women who have somatic symptoms and experiences of domestic violence. These findings could be a result of many physicians having a pessimistic view regarding the treatment of somatization disorder Mai, 2004; Quill, 1985). As noted in the literature review (Chapter Two), to date there are no pharmacological or psychotherapeutic interventions that have produced meaningful improvements for patients with somatization disorder (Allen et al., 2006; Salmon et al., 2006).

This could be a possible reason why despite medical doctors having more resources and intervention strategies for meeting and treating women who have symptoms associated with somatization disorder, they still were still ambivalent and cautious about intervening. Whereas, some religious leaders may not possess any knowledge regarding recovery rates for women with

somatic symptoms, thus, the reason they are more optimistic that their intervention would produce meaningful change. Also, because some medical doctors would also have more scientific knowledge about how they 'should' treat women with somatization disorder, this may impede them from intervening. Some medical doctors instead of utilizing latent learning (as discussed in chapter two, Literature Review) may tend to follow exactly how they would have been taught to treat women with somatization disorder. As a result they rule out any organic ailments; their ignorance of the condition; the fear of overlooking an organic disease and their discomfort in exploring psychological issues could have also contributed to their belief that intervening was not important (Mai, 2004; Quill, 1985). This view is further discussed in chapter 7 (Discussion, Limitations, Implications, Future Research and Conclusion Chapter).

Despite medical doctors having more resources and intervention strategies for meeting and treating women who have symptoms associated with somatization disorder and domestic violence experiences compared to religious leaders. The majority of medical doctors often referred the women to other sources of help, did not arrange follow-up visits, were not optimistic that they could produce positive changes if they did intervene, and that the time spent with other patients affected the amount of time they spent with women who have somatic symptoms and experience of abuse. Ineffective communication may have contributed to these findings. As Epstein et al., (2006) stated, some patients would visit the physician to obtain a meaningful explanation for their symptoms. However, some physicians may experience difficulties with some cases, and this could result in patients feeling discounted and misunderstood. Consequently, because of this ineffective communication between the patient and the physician some of the patients have negative experiences. Additionally, the physician's own anxieties regarding treating patients with somatic symptoms may contribute to some not wanting to treat women with somatic symptoms (Dowrick et al., 2004; Robbins et al., 1994; Salmon et al., 2004).

Again, some religious leaders may not be subject to these anxieties, as they may not work with a formal organization and therefore do not have a higher authority to report to. Hence, it may be argued that they do not employ the same vertical thinking as some medical doctors. This may therefore alleviate any fears to rule out any organic ailments, as with medical doctors. Furthermore, as stated above some medical doctors' discomfort in exploring psychological issues

may hinder them from exploring somatic symptoms with the women. Whereas, women who seek assistance from the religious leader may expect some sort of psychological counselling. Thus, some religious leaders may be more comfortable with offering this type of assistance, as they usually do not provide medical advice but psychological and/spiritual guidance. All of the religious leaders stated that they would turn to God for solutions and advised the women to do the same, whereas some of the medical doctors did not. According to Maharajh (2010) in Trinidad there is no line drawn between religion and psychiatry. Maharajh (2010) further stated that two-thirds of all patients presenting to a psychiatric clinic will interpret their symptoms as being caused by "spiritual wickedness from high places", "obeah", "spiritual lash" or "evil influences" (Maharajh, 2010, p. 52). Therefore, cultural, traditional and religious belief systems may have influenced the women regarding where they sought assistance. Some of the women, because of shared cultural beliefs may already be of the opinion that their symptoms are being caused by spiritual forces. Thus, visiting with the religious leaders offers them the opportunity to express this view in an acceptable environment. Therefore, religious leaders are more comfortable and optimistic about referring the women to God to pray for solutions to their symptoms compared to medical doctors.

With regard to domestic violence experiences, religious leaders also reported that they would often turn to God and prayer for solutions and advice the women to do the same. For the reasons cited above (culture, tradition and religious beliefs), this type of advice from religious leaders may be seen as more acceptable. Medical doctors may tend to deviate from offering spiritual advice as this may not be viewed as scientific; additionally, religious advice may not be permitted within the specific medical setting where they are working.

Religious leaders were also more likely to hold the opinion that their intervention and efforts to facilitate change with women with experience of domestic violence would be successful compared to medical doctors. Furthermore, medical doctors also tended to refer women with domestic violence experiences to other sources of help more often that religious leaders. International research (Sugg & Inui, 1992) has reported that some physicians find exploring domestic violence in the clinical setting equivalent to "opening Pandora's Box". Additionally, it may be further argued that because of some of the physicians availability heuristic they may still

view domestic violence as a taboo topic (Gerbert et al., 2002) and this may have contributed to some of them being hesitant to explore domestic violence experiences with the women, as a result they more often refer the women to other help sources. Gerbert et al., (2002) and Elliot, Nerney, Jones and Friedman (2002) also state that one reason why some physicians do not treat domestic violence cases is a lack of training. This may be quite different from religious leaders' experiences of dealing with domestic violence experiences. Maharajh (2010) noted that some sort of spiritual or religious influence, for example, the priest, pundit or imam, remains today as the first contact for the majority of patients in Trinidad (Maharajh, 2010). Therefore, religious leaders may have grown accustomed to dealing with what the physician may classify as a 'taboo' topic. This may be a possible reason why some religious leaders may not refer women to other sources of help and hold the opinion that their efforts to facilitate change will be successful.

Finally, as noted previously, despite not being statistically significant, it is still worth noting that the majority of religious leaders and medical doctors were of the opinion that more Indo-Trinidadian women had experienced domestic violence. According to studies by Hadeed and El Bassel (2006) and Rawlins (2000) there is the 'perception' that East Indian women in Trinidad experience more domestic violence than their counterparts belonging to other ethnic groups. Study one (chapter 4; occurrences of somatization disorder and domestic violence) has provided the empirical data missing to support this 'perception'. It was shown that Indo-Trinidadian women do have a higher occurrence of domestic violence experiences than other ethnic groups in Trinidad. Therefore, religious leaders and medical doctors' observations regarding this finding proved to be valid. All of these findings are further considered in the discussion chapter (7).

Chapter 7
Discussion, Limitations, Implications, Future Research and Conclusion

7:1 Introduction

This thesis sought to report and compare experiences of domestic violence, somatization disorder and help-seeking behaviours amongst Indo- and Afro-Trinidadian women living in Trinidad. Study one (chapter 4; occurrence of somatization disorder, domestic violence and help-seeking) investigated the occurrences of somatization disorder and domestic violence, while study two (chapter 5; IPA analysis of help-seeking) maps the routes to help the women took and explores the impact these had on their outcomes. Study three (chapter 6; religious leaders and medical doctors intervention) built on studies one and two, and focused on help agencies' knowledge and resources about women with somatization disorder and domestic violence experiences.

This chapter provides a discussion which evaluates if this thesis addressed the proposed research questions. It also includes sub-sections discussing the limitations encountered and implications of these. Recommendations for future research are also presented.

7:2 Discussion

This thesis sought to address four research questions, which will now be discussed in relation to the findings of the studies conducted.

7:3 Research question one: 'Do Indo-Trinidadian women have a higher occurrence of somatization disorder and domestic violence than Afro-Trinidadian women?' (Study one):

The findings of this thesis indicated that the occurrences of somatization disorder were more prevalent among Indo-Trinidadian women than their Afro-Trinidadian counterparts. There was a significant association between Indo-Trinidadian women and somatization disorder, with Indo-Trinidadian women being three times more likely to have symptoms associated with somatization disorder than Afro-Trinidadian women, according to their scores on the Brief Symptom Inventory-18 (BSI-18). These findings are consistent with international research that somatization disorder is more prevalent among Asian cultures (Bhui, 2002; Chaturvedi &

Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Sarason, 1999; Saxena, Nepal & Mohan, 1988).

However, even though Study one reported rates of somatization disorder for Afro-Trinidadian women that were three times lower than Indo-Trinidadian women, analysis of interviews with Afro-Trinidadian women during Study two showed that they did report symptoms that appeared to be somatic in nature, and many also reported domestic violence experiences. That is, although Afro-Trinidadian women may not have fit the diagnostic criteria for somatization disorder, they still experienced symptoms associated with it. How Afro-Trinidadian women view and categorize their symptoms may have impacted on the answers given on the assessment tool (BSI-18). If Afro-Trinidadian women interpret their somatic symptoms as not causing functional disturbances (DSM-IV-TR, 2002) when asked to what extent their symptoms caused them distress, because of their personal attributions they may have indicated on the assessment tool (BSI-18) 'not at all' or 'a little bit', compared to Indo-Trinidadian women who perceive their own somatic symptoms as a coping mechanism and interprets their symptom as 'quite a bit' or 'extreme'. Therefore, Afro-Trinidadian and Indo-Trinidadian women, because of the norms of their respective cultures, may have attached different meanings to their symptoms and experiences and the extent to which they represent a 'functional disturbance' to their everyday lives (Kress et al., 2005). These findings will be discussed further, with reference to the assessment tool, below.

Somatization disorder may be culturally specific (So, 2008) and despite western cultures having well-established mental health programmes, persons with somatic symptoms are still viewed as having maladaptive coping skills (So, 2008). Over 100 years ago Indians came to Trinidad from India through the Indentureship Programme and it has been argued that they have retained many aspects of their culture (Maharajh, 2010) compared to Africans who arrived to Trinidad through the slavery system (Ali, 2006; Brereton, 1996) and thus, they still express psychological distress in a similar manner to their ancestors from their country of origin (Bhui, 2002; Chaturvedi & Venugopal, 1994; Saxena, Nepal & Mohan, 1988; Fernando, 2002). However, Maharajh's (2010) statement may be refuted, as, between 1776 and 1834 approximately 135,100 Africans came to Trinidad (Curtin, 1975) almost the same amount as Indo-Trinidadians (130,000; Ali,

2006; Brereton, 1996). Thus, it is evident that Afro-Trinidadian women may also have maintained many aspects of their culture of origin, such as their food, dress and music, which can still be seen in numerous aspects of Trinidadian culture (Coutsoukis, 2001). Thus, it may be further argued that the retention of their culture may also have contributed to their expression of illness being different or similar to Indo-Trinidadian women.

Many Indo-Trinidadian women may indeed have retained some aspects of their culture of country of origin; which includes their expression of illness as discussed in the literature (Bhui, 2002; Chaturvedi & Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Sarason, 199; Saxena, Nepal & Mohan, 1988). As noted by Maharajh (2010), the Indo-Trinidadian family is not supposed to speak publicly about what may be occurring within their household; speaking about such events is viewed as unacceptable by other members of the Indo-Trinidadian community. For that reason, it may be further argued that some of the Indo-Trinidadian woman may experience some form of social inhibition and consequently may choose the acquired response that is seen as acceptable. Additionally, if such ailments are spoken about, the family will then have to deal with the shame and stigma of a family member having a psychological disorder or being 'mad', 'insane' or 'having crazy papers'[66]. There would be a ripple effect, that is, not only the person with the psychological ailment will be stigmatized but the entire family. Thus, it may be that through cultural practices, Indo-Trinidadian women in particular, may have learnt to manifest their psychological distress into one or more physical complaint. Additionally, it can also be argued that this behaviour has been so ingrained into the Indo-Trinidadian community that the women themselves may be unconsciously manifesting their somatic symptoms physically, as an adaptive coping strategy (Kress, Eriksen, Rayle & Ford, 2005; Sewell, 2005). Conversely, this may also be viewed from a social learning perspective (De Gucht & Maes, 2006) providing another plausible explanation for the higher occurrence of somatization disorder within the Indo-Trinidadian community (women).

Mai (2004) states that these maladaptive behaviours are socially reinforced and therefore, encouraged. Additionally, research has shown that many women who have somatization disorder also have a female relative with the symptoms (DSM-IV-TR, 2000). This may be applied to the

[66] To possess discharge papers from the 'mad house' (Mendes, 2012)

Indo-Trinidadian community. When the woman is distressed and expresses her symptoms physically, she gains sympathy from others (secondary gain), whereas, if she reports a psychological ailment she may be shunned and isolated. Therefore, it may be further considered that Indo-Trinidadian women may express their emotional distress as physical ailment out of fear of being a social outcast, because this is the socially approved method or a problem-solving strategy that has been traditionally learnt and passed down through culture (Cheng, 2001; Na & Kitayama; 2011; Kirmayer & Sartorius, 2007; Sewell, 2005; Straub et al. 2005). It may also be that this type of expression of illness has implications for the generations to come as Goleman et al., (1993) argued that through the child observing the sick parent or relative, the child now anchors their behaviour by utilizes this one piece of information to make future decisions, consequently, expression of illness is learnt. Depending to the severity the symptoms, the child may later in life also develop somatic symptoms. Moreover, when the ill parent fails to cater to the needs of the child, the child is unable to differentiate between internal states, causing the child later in life to express emotional distress as physical symptoms as a means of gaining attention. Therefore, it may be that the parent is unconsciously rewarding the symptoms by allowing the child to stay home from school when 'sick'. Nonetheless, in either case, physical symptoms are now being used to express deep emotional needs (Goleman et al., 1993). The child observing her mother expressing her emotional distress as physical symptoms may also learn to do the same. Based on these findings and discussions, a cycle of expression of illness can be framed and applied to Indo-Trinidadian women, as a possible reason why there are more occurrences of somatization disorder within this ethnicity. Figure 10 below illustrates this cycle utilizing concepts of social learning theory.

Figure 10: ***The cycle of somatic symptoms being learnt within the Indo-Trinidadian Community***

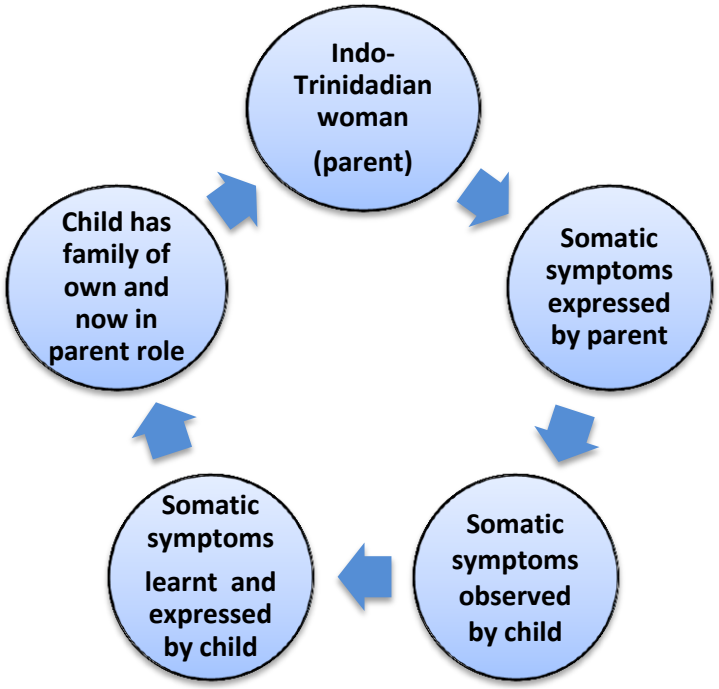


Figure 10 represents the cycle through the parent (specifically the mother); the child observed how the mother expressed her distress, in order that her distress be culturally approved. Then through observations, the behaviour is learnt and expressed. Finally, when the child reaches adulthood, she too teaches her child(ren) the same behaviours. Even though this cycle may be applied as a plausible explanation for the higher occurrence of somatization disorder within the Indo-Trinidadian community, it still does not provide a substantial explanation, It does not take into account the underlying cause(s) of the distress; that is, if the parent (mother) does not have any distressing events occurring but still has somatic symptoms, would the mother still present with somatic symptoms because they are learnt through society, that is, observing members not within the immediate family? Then the manifestation of somatic symptoms may be attributed to a learning style within this ethnic group and not necessarily as a coping mechanism.

Afro-Trinidadian women may also be influenced by learning styles. Maharajh (2010) asserts that Afro-Trinidadian women are often viewed as being ‘strong’ (Maharajh, 2010), which might provide a possible explanation why women from this ethnic group have a lower occurrence of

somatization disorder than do Indo-Trinidadian women, however this would be problematic as it would be based on the uncritical imposition of a cultural stereotype. Many Afro-Trinidadian women when interviewed described symptoms associated with somatization disorder but did not meet what could be considered the stringent criteria for diagnosis during their formal assessment (as discussed in the 'defining somatization disorder' section in the literature review) (Hartung & Widiger, 1998, So, 2008; Creed, 2006). Even though culture may have impacted on the higher occurrence of somatization disorder among Indo-Trinidadian women, it may have also affected the lower occurrences among Afro-Trinidadian women. That is, according to the DSM-IV-TR (2002) and the ICD-10, symptoms such as pains, neurological disturbances and body weakness etc. need to be present for a diagnosis of somatization disorder to be made. Additionally, these symptoms must cause the women social, occupational and other functional disturbances (DSM-IV-TR, 2002). Velasquez at al. (1993) asserted that the diagnosis of minority groups is vulnerable to human error. Thus, it may be that Afro-Trinidadian women have been susceptible to what Kress, Eriksen, Rayle and Ford (2005) and Lehman, Chiu and Schaller (2004) described as classifying persons based on racial or mental characteristics for the diagnosis of mental illness and consequently create a belief-bias effect.

Cross-cultural studies have shown that culture does influence the manifestation, duration, and prognosis of mental illness (Bhui, 2002; Chaturvedi & Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Sarason, 199; Saxena, Nepal & Mohan, 1988). Additionally, how individuals perceive their reality may be further influenced by culture, as a result the meaning they attach to and how they perceive their symptoms might impact on how they report their symptoms (Kress, Eriksen, Rayle & Ford, 2005; Lehman, Chiu & Schaller, 2004). Since Afro-Trinidadian women may have a 'strong' image to portray, they may also be socialized in this manner. That is, it may not be the cultural norm within their community to express their distress as physical symptoms. Miranda, Belin and Kohn-Wood (2005) have also stated that African-American women tend to experience milder somatic symptoms than White Americans. This finding may also be critically applied to Afro-Trinidadian women, as; they too may have also categorized their somatic symptoms as milder than Indo-Trinidadian women. Conversely, how Afro-Trinidadian women view and categorize their symptoms may have impacted on the answers given on the BSI-18 (diagnostic tool used for this thesis for somatization disorder). That is, if

Afro-Trinidadian women interpret their somatic symptoms as not causing functional disturbances (DSM-IV-TR, 2002) then when asked to what extent their symptoms caused them distress, they may have indicated on the assessment tool (BSI-18) 'not at all' or 'a little bit', compared to Indo-Trinidadian women who perceives their symptoms as a coping mechanism and interpret their symptoms as 'quite a bit' or 'extreme'. Therefore, Afro-Trinidadian women, because of culture, may have attached different meaning to their symptoms and experiences (Kress et al., 2005). Thus, this may have contributed to Afro-Trinidadian women not meeting the diagnostic criteria for somatization disorder, and being perceived as having a lower occurrence of somatization disorder than their Indo-Trinidadian counterparts, when in fact, many Afro-Trinidadian women when interviewed did report symptoms very closely related to somatization disorder. Thus, as previously suggested, when formulating diagnostic criteria for mental health ailments the issues of culture need to be at the forefront, as diagnosing mental health issues purely from a pre-determined set of symptoms can be problematic. As a result, the addition of a thorough interview may help to reduce this possible inaccuracy (Kress et al., 2005; Lonner & Ibrahim, 2002).

Therefore, even though, Afro-Trinidadian women may not have fit the diagnostic criteria for somatization disorder, they still presented with symptoms associated with it. Thus, when interviews instead of quantitative methods were employed, there was a similarity between Indo- and Afro-Trinidadian women's expression of distress, as all of the women interviewed reported some form of abuse, for example, from either a parent or relative. However, it can still be argued that empirical findings from this thesis support the international literature that Asians tend to somatize more than other ethnic groups (Bhui, 2002; Chaturvedi & Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Sarason, 1999; Saxena, Nepal & Mohan, 1988). Additionally, the findings also provide new insight into the possible reasons why Indo-Trinidadian women in particular somatize their distress more than Afro-Trinidadian women.

These explanations can also be extended into the possible reasons why Indo-Trinidadian women in this thesis also reported more domestic violence experiences than their Afro-Trinidadian counterparts. There was a signification association between Indo-Trinidadian women and domestic violence experiences, with Indo-Trinidadian women being two times more likely to report domestic violence experiences than Afro-Trinidadian women. It should be noted that even

though more Indo-Trinidadian women reported abusive experiences, findings from the qualitative aspect of this thesis (chapter 5; IPA analysis of help-seeking for Indo- and Afro-Trinidadian women) revealed that many Afro-Trinidadian women had domestic violence experiences and stated that they experienced anticipatory anxiety and thus, were afraid of disclosing their abuse because of the repercussions. One can argue that culture may have also impacted on this occurrence. Maharajh (2010) stated that Indo-Trinidadian women have been traditionally raised to be passive, obedient and conscientious, compared to Afro-Trinidadian women, were taught to be strong, independent, assertive and outspoken; thus, a possible reason why Indo-Trinidadian women are more susceptible to abuse than Afro-Trinidadian women (Maharajh, 2010). However, numerous researchers have suggested that other factors, such as how women define their situations or social status may influence domestic violence (Campbell, 1995; Ellison, Trinitapoli, Anderson & Johnson, 2007; Grossman & Lundy, 2007; Hadeed & El Bassel, 2006; Liang et al., 2005; Nagassar et al., 2010).

Additionally, domestic violence is still viewed as a private matter by many, Indo-Trinidadian women are taught to not speak about family matters publicly (Maharajh, 2010), the woman may be of the opinion that she must not speak about her abusive experiences. If she speaks out about her abuse then the community will judge her, that is, she is the one who has caused the abuse to occur. Thus, it may be argued that through inductive reasoning she instead chooses to deal with the abuse herself, therefore her only avenue may be to somatize her distress. However, this assertions can also be refuted, as findings from this thesis reported that Afro-Trinidadian were just as much hesitant of disclosing their abusive situations because of the fear of repercussions, from their partners, family and society. Therefore, this assumption does not offer a clear explanation why there is a higher occurrence of domestic violence within the Indo-Trinidadian community.

Indo-Trinidadian women may be viewed as more passive or submissive by society, compared to Afro-Trinidadian women. Also, Indo-Trinidadian men are traditionally viewed as the bread-winner in the home. As a result, some Indo-Trinidadian men, because of culture, may still hold these opinions: that they are in control of the household and therefore the woman (Maharajh, 2010) and have the authority to exercise power and physical authority over women (Bell &

Naugle, 2008; Flood & Pease, 2009 Jewkes, 2002; Millett, 1970; Singh, 2007; Walby, 1990; Oakley, 1972) but this may not be the case. As was argued in chapter two (literature review) of this thesis, how women define their situation may impact on them speaking out, seeking assistance and which source to seek assistance from (Kasturirangan, Krishnan & Riger, 2004; Liang et al., 2005; Rickwood et al., 2005).

Thus, similar to somatization disorder cultural influences may have impacted on how both Indo- and Afro-Trinidadian women define their abusive situations. For example, if the Afro-Trinidadian women are experiencing financial abuse and does not recognize it as abuse, when questioned about this aspect of their lives may be inclined to indicate 'no', when in actuality they are susceptible to this form of abuse. This example was chosen as findings from this thesis indicated that only a few women (out of 150) were able to identify financial mistreatment as a form of abuse.

However, while findings from this thesis confirm the commonly held belief that Indo-Trinidadian women are more susceptible to experiences of domestic violence, there seems to be no clear understanding at this point why this may be the case, as, only assumptions can be made regarding this. Therefore, it can only be suggested that how women define their abuse, may be influenced by culture, and may have impacted on reporting. Thus, by Indo- and Afro-Trinidadian women defining their abusive experiences differently this may have impacted on reported domestic violence occurrences within these ethnicities. Additionally, fear of disclosure may have influenced occurrences, since if one ethnic group is more fearful of the repercussions then even when data was collected for this thesis they may have chosen not to disclose, thereby contributing to the differences in occurrence.

Despite the above arguments, it was also found that Indo-Trinidadian women were three times more likely to have symptoms associated with somatization disorder if they had experienced domestic violence compared to Afro-Trinidadian women. Therefore, once again it can only be assumed that as a result of Indo-Trinidadian women being socialized through culture, stigma and social learning when in abusive situations, they may only know how to express their distress through physical symptoms. As noted in the qualitative findings of study two (Chapter 5; IPA

analysis of help-seeking), many Indo-Trinidadian women internalized their distress as a means of coping, because they were afraid of disclosing because their partner may find out and more abuse may follow. Also, as noted earlier in this chapter, some Trinidadians (women) may not want the stigma attached to being viewed as 'crazy' or 'mad'. As a result, if the woman speaks about her depression and/or anxiety as a result of the abuse, there is the risk that they will be misunderstood and labelled. Therefore, instead of expressing her abusive distress as a psychological issue, she may report physical symptoms, such as unexplained bodily aches and pains, as this may be viewed as more socially acceptable.

From the discussion above, it can be noted that some Indo- and Afro-Trinidadian women, because of cultural beliefs, have manifested their distress as physical symptoms. Additionally, some of the women may not have been taught to seek assistance for their problems because of cultural restrictions, for example, being viewed as 'mad' or because speaking publicly about their challenges is frowned upon. Therefore, research question two sought to address if and to whom Indo- and Afro-Trinidadian women go for assistance for these intersecting issues and general problems.

7:4 Research question two: **'What sources of help do Indo- and Afro-Trinidadian women seek for their general problems, somatic symptoms and domestic violence experiences?' (study one).**

As noted in chapter four (occurrences of somatization disorder and domestic violence), data from this phase of this thesis did not yield lengthy answers, but it did produce informative responses. As a result, this section provides a brief overview of the various sources of help Indo- and Afro-Trinidadian women sought for their somatic symptoms, domestic violence experiences and general problems. Findings indicated that many of the women sought assistance from a variety of sources. To review, these included religious leader, medical doctor, counsellor, family/relative, friend, police and government organization. Some of the women stated that they were contented with the help they received from these sources. This sense of satisfaction seems to be as a result of the women feeling that they were being heard, and the person providing the assistance cared. Additionally, when the women did not receive an avenue to vent and express their challenges, they felt insignificant, and this contributed to some not being pleased with the assistance

received. Therefore, it is important that help avenues seek to promote an atmosphere where individuals seeking help feel comfortable. By providing a safe and supportive environment, persons will be more encouraged to seek the appropriate help and find solutions for their problems.

These findings, in addition to the overall conclusions of this thesis (culture is an important component in help-seeking, as well as the intersecting issues explored), suggest that despite being faced with cultural restrictions in the expression of illness and domestic violence experiences, some of the women still persevered and sought assistance. Accordingly, it may be argued that some of the women possessed an independent construal of self (Gerrig & Philip, 2002), as they did not conceptualize their selves from the perspective of others but rather based on their own feelings, thoughts and actions. However despite this, again cultural practices seem to have hindered not only the help-seeking process, but the ability to receive assistance. Some of the older women (70+), particularly Indo-Trinidadian women, indicated that the counsellor was not helpful. Noted throughout this discussion thus far, Indo-Trinidadian women were taught that it is not appropriate to discuss their challenges with other persons. Therefore, seeking assistance from someone outside the family could be seen as taboo or inappropriate. However, as noted earlier, in study two (IPA analysis of help-seeking) many Afro-Trinidadian women in this thesis also reported that they did not disclose their problems because they were not comfortable, or fear of repercussion. Therefore, while it may be assumed that for some Indo-Trinidadian women socialization may have deterred them from seeking assistance or impacted on their experiences of help-seeking, this may also be applicable to Afro-Trinidadian women since both ethnicities reported very similar reasons for their experiences of help-seeking being either a pleasant and beneficial experience or not.

Furthermore, some of the women reported that they did not feel a sense of comfort disclosing to the counsellor because of cultural constraints, and as a result, some turned to family members/relatives. Becker, Al Zaid and Al Faris (2002), asserted that in Saudi Arabia, women tend to be cautious when addressing persons outside their family group with regard to their challenges. This may be applied to Trinidadians, as many of the women, reported that when they sought assistance from a family/relative or friend it was beneficial, as they felt they could trust

the person. It may be debated that this may also be linked to some of the women being socialized and taught through shared cultural values practices (Sewell, 2005; Straub et al. 2002) to not speak about their challenges, but instead seeking solutions and support within the family unit. Consequently, some of the women in an effort not to expose their challenges to others in the community (because of shame and stigma, discussed earlier), may prefer to seek assistance from the family. In so doing, this form of assistance may be viewed as culturally acceptable and causes less distress to the women. However, some of the women stated that the family/relative was not helpful, as they were either biased or were not interested in assisting them. Again, this can be related to how the family is socialized within the community. For example, if the women are seeking assistance for domestic violence (then this form of abuse still being viewed as a private or family matter), in order to avoid dealing with the perpetrator, the family member may have chosen to not get involved. Thus, leaving some of the women disenchanted with the assistance received.

When discussing domestic violence, many of the women reported that when they sought assistance from the police, the help received was unsatisfactory. The major reason was that they were not provided with any solutions to their problems. Similar to the women who participated in this research, police officers would have been socialized with the same cultural norms as them. Some of the police officers may still hold on to the notion that domestic violence is a family matter. Consequently, even though the police should intervene, some may not or chose not to thoroughly explore the matter, because they, too, have been taught not to 'intervene'. This may create several challenges not only for the women but for society as a whole, as police officers are viewed as the persons who must provide protection for persons who are in abusive situations, and when they do not, then a lack of confidence may be instilled. This may have encouraged some of the women to express their distress as somatic symptoms (as discussed previously) as a means of coping.

Thus, with regard to this research question, it may be concluded that when the main sources of help were identified by the women, some were experienced feelings of ambivalence as some were either satisfied or not. For women who expressed their dissatisfaction with the sources of help identified, their reasons included: absence of a close relationship with the person providing

the assistance, lack of trust and no solution(s) to their problems were found. Whereas, for the women who were satisfied, they stated that they found inner peace, experienced encouraging results, the treatment worked and they felt they could trust the helper. Many of the women also identified both religious leaders and medical doctors as sources of assistance for either their somatic symptoms or domestic violence experiences. Several of the women stated that the medical doctor only treated their symptoms and did not provide a holistic approach to their challenges, which was greatly desired, whereas, other stated that the treatment recommended worked for them. Similar findings were reported by some of the women when assistance was sought from religious leaders. Some of the women reported that religious leaders provided the necessary support, while others contended that there was 'no change' to their situation, as a result they were dissatisfied. As noted in chapter four (occurrences of somatization disorder and domestic violence), data in this phase of this thesis did not yield lengthy answers, but it did produce informative responses. As a result these sources of help were further explored with some of the women in study two (chapter five; IPA analysis of help-seeking), which are discussed in the following section.

The major sources of help for both somatization disorder and domestic violence experiences that were investigated in this thesis were: religious leaders and medical doctors. As these sources were identified by most of the women in this phase of data collection and additionally, some researchers (Kress, Eriksen, Rayle & Ford, 2005; Maharajh, 2010; Rickwood et al., 2005) have stated that in most circumstances women tend to seek assistance from both formal and informal sources; specifically, medical doctors or some sort of spiritual sources. Thus, to explore more in-depth the findings gathered from study one of this thesis an Interpretative Phenomenological Approach was adopted to address the third research question. The assistance received from both religious leaders and medical doctors are discussed in the following section.

7:5 Research question 3: 'Do Indo- and Afro-Trinidadian women find medical doctors and religious leaders supportive when dealing with their somatic symptoms and domestic violence experiences?' (study two).

In the literature review (chapter two) of this thesis, three processes or stages of help-seeking with regard to women who experienced domestic violence were discussed. These are: defining the

problem; deciding to seek help and selecting the source of help (Liang et al., 2005). In this thesis the majority of the women sought assistance from a religious leader, medical doctor or both, with most of the women reporting mixed experiences of help-seeking from these sources.

Religious Leaders: Trinidad not only has a diversity of ethnicities, but also a broad religious blend (Ali, 2006; Brereton, 1996). Therefore, the influence that religion may have on intervening for domestic violence experiences cannot be ignored. Copel (2008) asserted that religious leaders may have an important impact on the intervening and preventing of domestic violence, as the victim may view the religious leader as a source of support. There were mixed opinions regarding the assistance the women received from this source for their abusive experiences. Some of the women (both Indo- and Afro-) reported that the religious leaders tried to resolve the situation by speaking with both themselves and the perpetrator. In so doing, some of the women expressed that the end goal of the religious leader was to get them to continue in the relationship. It has been argued by several researchers (Coyle, 2001; Fallot & Heckman, 2005; Giesbrecht & Sevcik, 2000; Gillum, Sullivan & Bybee, 2006; Levitt & Ware, 2006; Potter, 2007) that some religious leaders appeared to have experienced approach-avoidance conflict discussed in Chapter two (Literature Review), as they struggle with the idea of freeing the woman from the abusive relationship and maintaining the marital relationship. As a result of religious boundaries, the religious leader may feel a sense of obligation to God to keep the relationship together, with the hope that God may be able to 'heal' or stop the abuse from occurring. This argument may be related to religious leaders in Trinidad, as from the reports by the women some of the religious leaders seem to have tried to reunify the abusive relationship. Therefore, it may be argued that they, too, struggle with upholding religious beliefs regarding the family and marriage. As a result, recommending that some of the women stay in the abusive relationship.

On the other hand, many religious leaders are viewed as supportive when dealing with domestic violence experiences (Levitt & Ware, 2006). Some religious leaders who argued for equal relationships tended to interpret the scripture on marriage as communicating values that would have been appropriate for that period, but in these cases the traditions were upheld, but in a more modern context. Many of the women (both Indo- and Afro-) reported that the religious leaders did provide support by helping then regain their sense of self-confidence when dealing with both

their domestic violence experiences and somatic symptoms. Through counselling from the religious leaders, many of the women were able to come to the realization that their somatic symptoms did not define who they are, thus it may be debated that some of the women experienced a sense of abreation, by integrating these new schemas into their thoughts. However, for many of the women, some of the religious leaders suggested that the abuse was occurring because of 'spiritual forces'. Thus, as noted in chapter five (IPA analysis of help-seeking for Indo- and Afro-Trinidadian women) here the religious leaders are shifting the responsibility from the perpetrator to an 'outside' source. Maharajh (2010) has contended that this is not a new occurrence in Trinidad, as on most occasions when interviewing patients at psychiatric clinics, many would attribute their symptoms or experiences to "spiritual wickedness from high places", "obeah[67], "spiritual lash[68]" or evil influences.

This assertion may be critically approached from the religious leader's standpoint also. The religious leaders in this thesis were all from Trinidad, so, being Trinidadians, they too would have been brought up with the same cultural values as the women interviewed; as a result they may also adhere to same or similar cultural practices and beliefs, for example, the commonly held belief that domestic violence is a family or private matter and should be dealt with accordingly. Thus, the religious leader may be hesitant to even suggest the woman report the abuse to the police or persons in authority. Instead, they may choose to deal with the matter themselves. However, it may also be argued that religious leaders may be of the opinion that they have a responsibility to refer women with domestic violence experiences to God for assistance. As findings from this thesis stated that over 80 percent of religious leaders recommended that the women seek God for assistance for their abusive situations. However, it may be further argued from these statistics that some of the religious leaders did not recommend such an approach (almost 20 percent). Therefore, it may be that some of the religious leaders were of the opinion that they could rectify the situation themselves.

Moreover, not only may religious practices influence the religious leaders' response and approach to domestic violence, but also cultural boundaries. It has been argued that some

[67] A kind of witchcraft or sorcery in the Caribbean; a survival of African magic rites (Mendes, J. 2012, p.136).
[68] To harm one physically with necromancy (Mendes, J. 2012, p. 177).

religious leaders who held strong to the sanctity of marriage, emphasized practices instead of values (Levitt & Ware, 2006). It has been further suggested that these religious leaders felt that God wanted the woman to be in this marriage for a reason beyond their intelligibility. In Trinidad, because some sort of religious contact is usually the first for mental health issues (Maharajh, 2010), religious leaders may be viewed by the community as a 'peace maker' or one who is not supposed to suggest the relationship/marriage should end, but have faith in God that the abuse will cease. Therefore, if the religious leader advises the woman to leave the abusive partner he/she will be going against these religious and cultural expectations. Thus, faith in that religious leader within that community will be lost, and he/she may be seen as incompetent. Consequently, similar to some of the women, it may be further argued that some of the religious leader may also be trying to uphold a certain impression (impression management) of themselves to the public. That, is they possess the knowledge and expertise nesceeary to deal with these issues. As a result of the religious leader making all efforts to maintain the relationship, the woman may experience further abuse. It may be argued that this is a possible reason why some of the women in the study stated that the religious leader tried to get her to stay. This action may not have anything to do with the woman, but more so because of religious and cultural expectations of society towards the religious leader.

Further, it may also be that religious leaders are viewed as a more culturally acceptable source of assistance regarding both domestic violence experiences and somatic symptoms. As some of the women viewed religious leaders as a source of assistance that they could openly speak to about their physical symptoms and the religious leader at times provided them with solutions. For example, one of the women in this thesis stated that the religious leader advised her to drink Guinness (discussed in chapter 5; IPA analysis of help-seeking) for her stomach ailments. When women are treated for their physical ailments, they are now distracted from the fact that these may not have physical origin, but rather a psychological one. Therefore, they may not be labelled as 'mad' or 'unstable', but instead be able to freely seek assistance for less stigmatized complaints. As discussed earlier (chapter two; literature review) for many cultures (especially Asian) psychological ailments are stigmatized (Bhui, 2002; Hardin, 2002; Smith, 2004; So, 2008), so if the women seek assistance for such from a medical doctor, she in turn, may be considered 'weak'. However, obtaining help from religious leaders may give the impression that

their symptoms are spiritual in nature. Since, again, in Trinidad some sort of spiritual contact seems to be the first (Maharajh, 2010), as a result it may be argued that this form of assistance is more socially acceptable.

For some of the women (both Indo- and Afro-) who were dissatisfied with the assistance from religious leaders for either their somatic symptoms or abusive experiences, stated that they turned to God for help. Researchers have argued that for some victims of domestic violence the unconditional love and acceptance from a higher being (God) provided them with feelings of healing and hope after distressing situations (Coyle, 2001; Giesbrecht & Sevcik, 2000; Sisley et al., 2011). This statement may be applicable to both Indo- and Afro-Trinidadian women in this study, as many reported that when they turned to God or Jesus for assistance they felt that He could be trusted, thus, the fear of repercussion was eliminated. Additionally, confiding in God assisted them with coping, and to make sense of why they were experiencing, for example, either somatic symptoms or an abusive situation. Furthermore, trusting in a higher being also seems to have reduced the risk of being disappointed, as God or Jesus may be viewed as the all-encompassing altruistic being and hence, would always be there to support them. Coyle (2001) argued that spirituality may help some women to cope with adversity and may help to promote a positive, calm and harmonious state of mind; provides a sense of purpose to one's life, as seem from the reports by some of the women in this thesis. Though, for those who with negative religious coping they may be of the opinion that God was punishing them in some manner, or God had abandoned them. However, in this thesis none of the women reported such experiences when seeking assistance from a higher being.

For these reasons, it can be noted that many of the women (both Indo- and Afro-) did not report much confidence in the assistance received from the religious leader for either their somatic symptoms or domestic violence experiences. Instead, most of the women stated that it was their faith in God that helped them to either overcome or deal with these intersecting issues.

Medical Doctors: Mixed opinions regarding assistance received by medical doctors for their somatic symptoms and domestic violence experiences were also reported by the women (both Indo- and Afro-). Some of the women stated that the assistance provided to them by the medical

doctor helped them to overcome their challenges because they felt that the doctor cared. The medical doctor was not only concerned about their physical well-being but also their emotional health. Hence, the holistic approach to treatment provided by the medical doctor gave the women confidence that either their situation or symptoms would improve. It may be argued that some women visit the physician for validation of their symptoms and to obtain meaningful explanations of these (Epstein et al., 2006). Therefore, it may be further argued that some of the women in this study may not have been seeking solutions to their challenging situation but conversely they only needed someone to recognize that their symptoms are 'real'. As, in some instances some of the women are said to be 'faking' in order to receive attention from a significant other (Cheung, 1995; So, 2008), or alternatively as a means of gaining sympathy from their spouses in order to reduce or stop the abuse from occurring.

However, some physicians often experience challenges providing the necessary assistance to women for either their somatic symptoms or domestic violence experiences (Elliot, Nerney, Jones & Friedman, 2002; Gerbert et al., 2002; Sugg & Inui, 1992) and this may lead to the woman feeling discounted and misunderstood. It has been further argued that for some medical doctors the need to reassure women that their symptoms are 'normal' without providing them with explanations for the cause(s) leads to ineffective communication between the both and may underline some of the patients' negative experiences (Epstein et al., 2006). This could be a possible explanation for why some of the women (both Indo- and Afro-) in this thesis reported that medical doctors tended to trivialize their symptoms. Many of the women in this thesis also reported that they did not disclose their abusive situation to the medical doctor because they did not have a close relationship with him/her. If women present at one of the public hospitals on more than one occasion, they more than likely will not be seen by the same doctor. Therefore, it may be argued that no bonds would have been developed between patient and doctor, creating distance between them. As a result, the women may not be inclined to trust the medical doctor to disclose her abusive experiences. This, combined with cultural constraints of not seeking formal assistance, and not being taught how to express emotional distress (discussed earlier), would not create an environment conducive for disclose of either somatic symptoms or domestic violence experiences.

It may be further argued that this lack of close bonding between the women and the medical doctors may have contributed to some of the women reporting that they were afraid to disclose their abusive situations to the medical doctor he/she would be obligated to report the matter to the police. As discussed earlier, for some women when negative assistance was received this impacted on how they coped with their distressing situation (Coyle, 2001). Thus, it may be further debated that if the women are of the opinion that the support from the medical doctors would result in them being placed more at risk, then through the use of avoidance learning, to eliminate any anticipatory and realistic anxiety, then they may choose not to report the abuse to them. Some of the women also stated that if the abusive partner found out that they had disclosed to others the abuse; more abuse would follow, thus, many of the women refrained from disclosing. As noted earlier in this chapter, some of the women stated that the police did not provide them with helpful assistance. Therefore, if the women are of the opinion that the police would not be able to provide protection from the abusive partner, then they would be subjected to further and even more severe abuse if reported; thus, encouraging the women to keep silence to even the medical doctor.

Furthermore, as noted in the help-seeking section of the literature review for domestic violence, Liang et al., (2005) noted that how women define their situations may determine which source(s) of help they may choose. Moreover, Laing et al., (2005) and Rickwood et al., (2005) both asserted that women with a more problem-focused coping style are more likely to seek legal intervention, whereas, a woman with emotion-focused coping style are more likely to seek social support from friends or religious leaders. This may be a possible explanation why some of the women in this thesis may have chosen not to report their abusive experiences to the medical doctor. As they may be of the opinion that if their situation is seen as a personal psychological one where she requires emotional support, thus they may choose to seek assistance from a friend, as opposed to another who may support from a religious leader if she defines her situation as a spiritual battle. Therefore, it may be argued that some of the women interviewed for this thesis coping and relational styles may have impacted upon their choice of assistance. Thus, if they did not define their abusive situation as a medical problem, this may account for why some of the women reported that they felt no close bond or were afraid to disclose their situation to them, and as such resulted in some of the women stating that this source of help was not beneficial.

Another point of discussion, as previously noted, despite Trinidadian medical doctors receiving formal training, culture may have influenced how they respond to these intersecting issues. In some cases, it may be argued that some of the medical doctors experienced learning-performance distinction. That despite being taught how to treat with domestic violence cases, this was not expressed in their overt behaviours as cultural traditions may have hindered some of the medical doctors from intervening. Additionally, it has also been contended by Kress et al., (2005) that medical doctors need to be aware of their own personal biases, values and stereotypes, as these may hinder their own abilities to respond to their patients accordingly. Consequently, if they are not, this may result in the medical doctors projecting his/her own cultural schemas upon the women (Hardin, 2002), and thus, the women may feel dissatisfied and accordingly report this discontentment with the service received.

Therefore, this may be another explanation why some for the women in this thesis reported such disapproval with the assistance received from the medical doctor. It may be further argued that if the medical doctors encountered in this phase of the thesis were from outside Trinidad, their approach to the woman may have been different. That is, it may be argued that some Trinidadian doctors experienced some apprehension and this may have been further restricted by cultural practices, however, non-Trinidadian doctors may approach these intersecting issues differently from them. Thus, resulting in some of the women reporting satisfaction with the assistance received, however this was not the case, as noted many women were not contented with the assistance received from some of the medical doctors. For reasons, such as, they felt there was no close bond between the medical doctor and themselves, and their symptoms were being trivialized by some of the medical doctors.

Therefore, when addressing the research question, it may be determined that the minority of women (both Indo- and Afro-) in this study were of the opinion that religious leaders and medical doctors were supportive for these interrelated issues. With the majority of the women (Indo- and Afro-) stating that both religious leaders and medical doctors did not provide them with the support required for their somatic symptoms, domestic violence experiences or both. As a result, despite previous findings from this thesis that more Indo-Trinidadian women have domestic violence experiences and somatization disorder, there was Afro-Trinidadian women

who had experiences of these intersecting issues. Additionally, when they sought assistance from medical doctors and religious leaders, both Indo- and Afro-Trinidadian women reported the same or similar experiences of help-seeking for these interconnecting issues.

7:6 Research question 4: ‘Do medical doctors have better resources, greater willingness to explore and better intervention strategies than religious leaders when meeting with women who may have somatization disorder and domestic violence experiences?’ (study three):

Domestic Violence: Findings from this thesis suggest that medical doctors in Trinidad do have adequate resources (for example, assessment skills, referral facilities) in terms of screening for both somatization disorder and domestic violence experiences compared to religious leaders. However, even though medical doctors are more knowledgeable, adequately trained to assess and intervene, and know how to treat these intersecting issues, some are not willing to do so. Specific findings regarding domestic violence from this thesis will be discussed, followed by those for somatization disorder.

The findings from this thesis are consistent with international research which also reported that only one-third of managed care organizations (in the United States of America) had some sort of policies or guidelines for the screening of domestic violence (Gerbert et al., 2002). Nonetheless, despite increasing support and recommendations for physicians to screen for domestic violence, most do not, with only one in ten medical practitioners reporting that they would ask their patients about domestic violence experiences (Gerbert et al., 2002). It may be argued that many of the medical doctors in this thesis may not have screened for domestic violence because as Gerbert et al., (2002) contended many physicians still view domestic violence as a taboo topic. As noted in chapters two (literature review) and five (IPA analysis of help-seeking), Trinidad is still seen as a traditional society (Maharajh, 2010), and, as a result, medical practitioners may not exempt from these views. The medical doctors in this study were all from Trinidadian heritage and included: Indo (64%), Afro (12%), mixed (14%) and other (10%) ethnicities. Thus, it may be debated that if being brought up within the same culture as the general public may have impacted on their views of domestic violence, for example, domestic violence being a ‘private’ matter and therefore, they should not intervene. Still, as also noted previously, each ethnicity may possess

different cultural meanings to domestic violence experiences. As a result, it may be further argued that if Afro-Trinidadian medical doctors respond differently from Indo-Trinidadian doctors. However, statistical analyses revealed that there were no such differences. Thus, it appears that the arguments put forward for why Indo-Trinidadian women had higher occurrences of domestic violence (cultural interpretations) may not be applicable here. As, the majority of the sample (both Indo- and Afro-) seem apprehensive about exploring domestic violence with their patients.

Possible explanations for this may lie within the medical doctors own apprehension and fear of exploring what is considered a taboo topic with patients (Gerbert et al., 2002; Snugg & Inui, 1992). Despite being educated about intervening and assessing for domestic violence it may be argued that some of the medical doctors in this thesis, because they may not have been comfortable exploring this issue, had time constraints, or did not have want to offend the person chose not to intervene (Snugg & Inui, 1992). Consequently, the argument presented above and several times in this thesis that some of the medical doctors may be subject to the learning-performance distinction may also be applicable. As despite being professionally trained to deal with domestic violence cases, this may not be expressed in their overt behaviours because of cultural restrictions. Additionally, time restrictions seem to have influenced some of the medical doctors' responses to women with domestic violence experiences, as more medical doctors compared to religious leaders reported that that their work with other patients affected the amount of time spent discussing domestic violence with women. As a result, this could have affected the women, as, if they felt hurried may not have felt comfortable disclosing to the medical doctors, resulting in an overlooked case.

Conversely, it may also be argued that some of the medical doctors in this thesis may have found exploring domestic violence in the clinical setting equivalent to "opening Pandora's Box" (Sugg & Inui, 1992). Since, some of the medical doctors because of a lack of comfort regarding discussing domestic violence with women may have unconsciously chosen not to. Therefore, it may be deliberated if some of the medical doctors' memory was anoetic since they may have reacted without being aware of where their behaviour may have originated from. Nonetheless, as argued earlier Kress et al., (2005) contended that if medical doctors are not aware of their own

personal biases, stereotypes and values when treating with patients these may hinder their own abilities when responding to patients. As a consequence the medical doctors may be projecting his/her own cultural schemas upon the women (Hardin, 2002). Thus, when this occurs this may negatively impact on the assistance provided to the women, because of the medical doctor's own inhibitions he/she may choose to spend less time women discussing their abusive experiences or choose to refer to other sources of help because they do not want to manage the case themselves. Referring may not be a negative response if the medical doctors choose an agency that deals specifically with domestic violence, and then the women will be able to access specialized help, if they attend the suggested referral site. As noted by Rickwood et al., (2005) even though the women decide to seek assistance, the desire to actually follow through may not happen. Therefore, while referral may be viewed as beneficial, it may also deter the women from going. For example, if the women came to the hospital for muscular aches and may have been hesitant about disclosing her abusive situation, but when questioned chose to divulge such information, if the matter is not adequately dealt with at that moment (because of time constraints) they not have another opportunity or motivation to seek other forms of assistance.

Additionally, many of the medical doctors compared to religious leaders in this thesis were of the opinion that their efforts to facilitate change when it came to domestic violence would not be successful. It may be further argued that this may be as a result of some of the medical doctors feeling powerless or that they did not have control of the situation (Elliot, Nerney, Jones & Friedman, 2002; Gerbert et al., 2002; Sugg & Inui, 1992). It may also be debated that some medical doctors faced as a result of a lack of training, resources, inability to be able to "fix" the problem and feeling overwhelmed may have also contributed to them not believing that they would not be able to improve the women's situations (Elliot, Nerney, Jones & Friedman, 2002; Gerbert et al., 2002; Sugg & Inui, 1992)

It may be further considered if the medical doctors in this study as a result of this abstract thinking did not want to intervene as a result of them not viewing their role of intervening for domestic violence as important. Additionally, many of the medical doctors were of the opinion that their efforts to facilitate change would be successful. Additionally, it has been argued that for some medical doctors the feeling of the inability to "fix" the problem, a belief that the

patient's situation would not change and a sense of feeling overwhelmed (Gerbert et al., 2002; Elliot, Nerney, Jones & Friedman, 2002) may be considered as possible explanations regarding medical doctors' lack of desire to intervene and the belief that their intervention may not produce meaningful results. However, the utilization of questionnaires at this stage of data collection did not facilitate these issues to be explored; this is discussed further along in this chapter.

Nevertheless, this pessimistic view was not echoed by the religious leaders in this thesis. With the majority of religious leaders being optimistic that their intervention for domestic violence was important and positive change would be observed. A possible explanation for the differences of opinion between these professionals could be involvement within the community. Kirmayer (2001) contended that women are less likely to open up to health care providers about their problems, including emotional and social states; instead, emotional issues are viewed from a socio-moral perspective which should be dealt with by a family member, spiritual or community leader. Thus, as a result of religious leaders perhaps being more involved in community activities that require them to interact more with women in the local area, they may be more inclined to disclose the abuse to a religious leader. Subsequently, the religious leaders may feel a further sense of responsibility for not only the women's welfare, but the family. This contributes to the religious leader having a greater sense of obligation to intervene in domestic violence cases because of emotional closeness to the family compared to the medical doctors, supporting assertions such as those by Copel (2008) who argued that a religious leader can have an important impact on the intervening and preventing of domestic violence, as the victim may view the religious leader as a source of help to which she can turn to obtain support.

Specific to Trinidad, Maharajh (2010) indicated that in Trinidad medical doctors may be the second choice of help, and some sort of spiritual contact is usually the first. Many of the religious leaders in this thesis reported that they would recommend that women seek God through prayer for answers for their abusive situations. Additionally, many of the religious leaders also stated that similarly they too would seek God for direction regarding how to manage such situations. Some researchers (Giesbrecht & Sevcik, 2000; Hickson & Phelps, 1998; Maloy, 2000; Mattis, 2000; Samuel-Hodge et al., 2000) have argued that spirituality may have an important role in life satisfaction, healing and hope, and that spirituality may influence most

domains of life. Thus, it may be argued that recommendations to seek God for assistance may provide religious women with a sense of hope.

Moreover, this assertion may be further applied to religious leaders, because if religious leaders consult with God for answers and direction, it may be argued that they too may feel a sense of hope and encouragement that they will be able to effectively assist these women. Thus, alluding to the findings that religious leaders were of the opinion that they would be able to facilitate positive change in women's lives that had domestic violence experiences. It may be further contended that spirituality may help some cope with adversity and may help to promote a positive, calm and harmonious state of mind (Coyle, 2001). These assertions may also be critically applied to religious leaders, as it has been argued that they possess a sense of calm because of their spirituality and may be less susceptible to anxiety, fear of feeling powerless or thinking they do not have control of the situation, inability to "fix" the problem, a belief that the patient's situation would not change and a sense of feeling overwhelmed as medical doctors (Elliot, Nerney, Jones & Friedman, 2002; Gerbert et al., 2002; Sugg & Inui, 1992), thus, contributing to their optimistic views of their interventions strategies and producing positive changes for women with domestic violence experiences.

Since medical doctors and religious leaders are some of the major sources of assistance for domestic violence it can be suggested that medical doctors may need to abandon some of their vertical thinking and instead employ more lateral thinking (as discussed in chapter two; literature review) and be more willing to screen, intervene, and improve their understanding of abuse. Taket et al., (2003) specified that screening for domestic violence may uncover hidden cases; may change perceived acceptability of violence in the relationship; would make it easier for women to access support services; help maintain the safety of the woman and change health professionals' knowledge and attitude towards domestic violence, and hence reduce the social stigma attached to it. Therefore, if these recommendations are employed for both religious leaders and medical doctors, they may prove beneficial for both Indo- and Afro-Trinidadian women with experiences of domestic violence.

Somatization Disorder: Most medical doctors in this study were not only unwilling to explore domestic violence, but also somatic symptoms with the women. The findings regarding resources, willingness to explore and intervention strategies can be likened to the discussion above, regarding domestic violence. These will be discussed in relation to somatic symptoms. In the literature review it was discussed that somatization disorder presents as a major challenge to many health care providers (in the USA specifically) (Allen et al., 2006; Salmon et al., 2006). Moreover, many researchers are of the opinion that some medical doctors because of the chronic nature of the disorder and through their use if abductive reasoning are pessimistic and held negative evaluations of the effectiveness of the treatment of somatization disorder (Mai, 2004). These assertions may be critically applied to this thesis, as; findings indicated that the majority of medical doctors because of their own attributional biases did not view their role of intervening for somatic symptoms as important, compared to the religious leaders. If medical doctors possess this information and knowledge regarding the prognosis of women with somatic symptoms this may contribute to some being deterred from actually intervening. Since some medical doctors know that positive change will not occur, some may consciously or unconsciously desire not to intervene.

This once again brings to the forefront the argument presented several times in this discussion regarding culture (Birukou et al. 2013; Cohen, 2009; Cheng, 2001; Na & Kitayama; 2011; Sewell, 2005; Straub et al. 2002). According to Kress et al., (2005), personal biases, stereotypes and values that some medical doctors may attune to when treating with patients may hinder their own abilities when responding to them. Importantly, this may result in some medical doctors projecting their own cultural schemas upon the women (Hardin, 2002). Consequently, this may hinder some medical doctors' desire to intervene when somatic symptoms are identified. While this assertion may be applicable, it may be argued that this component on its own may not hinder medical doctors from intervening but other issues may contribute. Therefore, it may be further argued that medical doctors' own anxiety with regard to treating women with somatic symptoms may have contributed to their resistance in and viewing their role of intervening as important. As some researchers have argued, some medical doctors drive to rule out any organic ailments; their ignorance of the condition; the fear of overlooking an organic disease and their discomfort in exploring psychological issues may all contribute the some struggling in managing and

intervening with women who have somatic symptoms (Mai, 2004; Quill, 1985). However, these assertions cannot be firmly grounded, as noted previously, this phase of data collection utilized questionnaires that did not facilitate delving deeper to explore medical doctors reasoning for their lack of desire to intervene. This limitation, as well as recommendations for addressing it, is discussed later in this chapter.

However, these findings were not echoed by some of the religious leaders in this thesis, many of whom reported that they were willing to intervene, and that their intervention would produce meaningful change. Similar arguments presented for domestic violence experiences may also be put forward for somatization disorder regarding this finding. It may be argued that since some religious leaders may have more community involvement they may have developed more trusting relationships with women in the community. Moreover, since the manifestation of distress as psychological ailments can be considered more stigmatized (Hardin, 2002; So, 2008; Tseng, 2005) some women because of this social influence may have created within them social inhibitions. Thus, as a result some of the women may be less likely to disclose to medical doctors their emotional problems, but instead may seek assistance from a spiritual or community healer (Kirmayer, 2001; Kress et al., 2005). Therefore, it may be argued that it is more culturally acceptable to seek assistance from a religious leader for somatic symptoms, as a more socially acceptable explanation for the symptoms may be offered (Hardin, 2002). For example, according to Maharajh (2010) most women presenting at psychiatric clinics in Trinidad reported that supernatural phenomena and 'demon possession' are responsible for psychological ailments.

As a result, arguably, many women may interpret their symptoms as being caused by "spiritual wickedness from high places", obeah, "spiritual lash" or evil influences (Maharajh, 2010, p. 52). Therefore, instead of the women being left with the stigma of having a psychological ailment, they now have another source for their 'sicknesses'. Subsequently, some of the women may be more inclined to disclose their somatic symptoms to them rather than to medical doctors, thus disclosing more to religious leaders through in-depth discussions they may have uncovered the possible cause(s) of their symptoms. When this occurs because religious leaders possess more knowledge about the women's situation and ailments, they may be able to offer more appropriate advice. Consequently, this may result in religious leaders having a more positive impact on

improvements in the women's outlook. This may be a possible explanation for why some religious leaders hold the opinion that they are likely to produce positive changes.
Similar to domestic violence, most religious leaders in this thesis recommended that women turn to God for guidance and assistance for their somatic symptoms. Furthermore, most of the religious leaders also reported that they would also seek God for guidance regarding how to treat women with somatic symptoms. Again, as Coyle (2001) contended, spirituality may help to promote a positive, calm and harmonious state of mind; as such some religious leaders possessing a sense of calm because of their spirituality may be less susceptible than some medical doctors to try to rule out any organic disease and their discomfort in exploring psychological issues. As such, some religious leaders' faith in a higher being (God) may have impacted on their belief that whatever God wanted for a reason beyond their intelligibility (Levitt & Ware, 2006), they would be able to impart this information to the women and thus, gain greater confidence that a higher being would be able to heal the women of their somatic symptoms. Whereas, some medical doctors may not adhere to this divergent way of thinking and thus, this belief, as the vast majority (over 90 percent) stated that they would not seek God for assistance with dealing with women with somatic symptoms.

However, these explanations are not without flaws, as, factors such as time constraints may also have impacted on some medical doctors' and religious leaders' opinion that they would be able to facilitate positive changes. However, before discussing this aspect of help offered to women with somatic symptoms, the finding that despite religious leaders being more willing to intervene and their beliefs that their efforts to facilitate change would be successful, the majority did not know how to assess somatic symptoms compared to the medical doctors. This finding may suggest that some religious leaders overlook some health issue, and choose to offer treatment options not suitable to the cause. This may stem from the finding that the vast majority of religious leaders in this thesis reported that they had never heard the term somatization disorder; therefore, they are not knowledgeable that some of the physical symptoms could be organic rather than spiritual or psychological. Recommendations for dealing with this problem are discussed further in this chapter. This finding may be considered important as it can be linked to time constraints mentioned earlier.

Many of the medical doctors in this thesis stated that they spent less time with women with somatic symptoms compared to religious leaders. Additionally, for some medical doctors time spent with other patients negatively impacted on the time spent with women with somatic symptoms than some religious leaders. This does not necessarily have to be a result of the medical doctors' own reservations of handling somatic cases, but a reflection of their current workload. Some religious leaders, compared to most general medical doctors (private and public hospitals) in Trinidad tend to meet with the women on an appointment basis. Therefore, they are in a more relaxed environment and can spend more time discussing symptoms and suggesting possible solutions, compared to medical doctors (especially in a public hospital setting) who may have many patients to assess within a shorter timeframe. As a result, recommendations to reduce these are discussed later in this chapter.

The findings from this thesis state that medical doctors do have better resources than religious leaders for both domestic violence and somatic symptoms. However, the medical doctors were less inclined to explore these intersecting issues with their patients, On the other hand, religious leaders were more willing to explore with the women both their somatic symptoms and domestic violence experiences, and to suggest intervention strategies, they supposed would be beneficial, for example, prayer.

7:7 Limitations

This thesis yielded unique findings; however, there were still some limitations. As noted in chapter 5 (IPA analysis of help-seeking), some participants may have altered their responses in an effort to maintain a certain impression of themselves in order to gain the researcher's approval. Trinidad is still viewed as a traditional society (Maharajh, 2010); also some Indo-Trinidadians seem to still place a lot of emphasis on "looking good" to their fellow neighbours (Kassiram & Maharajh, 2010). As a result some of the women, because of stigma (discussed earlier in this chapter) may not have disclosed true details about either their somatic symptoms or domestic violence experiences. They may have been apprehensive that despite the reassurance that strictest confidentiality was being upheld that others may still have access to their information. Consequently, the fear of stigma and the shame that accompanies this may have motivated some of the women to withhold or modify their experiences. As a result, this may

have hindered some of the women from revealing more information about the issues being investigated.

Also, as discussed in chapters 4 (occurrences of somatization disorder and domestic violence) and 8 (reflexivity) the questionnaire utilized for study one was lengthy. There may have been the possibility that some of the women became fatigued and may not have thought about their answers before responding. This may have been especially so for the women who had no experience of domestic violence, as they may have believed that the questions were not applicable to them. As a result, some of the women could have missed the questions that may have been relevant to their experiences. As a consequence, limiting the scope of the data collected. Therefore, it is recommended that future researchers try to minimize the length of the questionnaire, while at the same time employing a wide-ranging questionnaire that incorporates all forms of abuse.

As noted throughout this thesis, these intersecting issues have never been researched, specifically in Trinidad. Therefore, more research is needed for wide-ranging comparisons to be made. For, example, only two studies[69] to date has been conducted with regard to Indo-Trinidadians and somatization disorder, and apart for this thesis none with Afro-Trinidadian women. For that reason, this may have limited the scope of analysis, as, despite arguments put forward for the retention of culture as a major contributor to the manifestation of distress as psychological complaints, further comparative research may reveal other possible explanations. This is explored further in the recommendations section.

Moreover, this thesis focused on the major ethnic groups in Trinidad, for the reasons cited previously. While the benefits of so doing were substantial, as findings have provided insight into a population regarding these intersecting issues, something which has never been accomplished before. It may have been beneficial to have also included the minority ethnic groups within Trinidad, specifically Chinese. For example, some of the research cited in this thesis was based on Asian (Chinese) populations (Hardin, 2002; So, 2008) and Trinidad's Chinese population came to the island between 1853 to 1866 with approximately 2,500 arriving

[69] Kassiram and Maharajh,(2010); Maharaj et al.,(2010)

during this period (Brereton, 1989). By not including this ethnic group, this may have limited the scope of analysis, as discussed earlier. Thus, in order to fully investigate the impact that culture may have on the somatization of distress, domestic violence experiences, and help-seeking it may be beneficial to survey the other ethnic groups. In so doing, research of this nature may reveal if the dominant cultures have impacted or influenced these interesting issues for expression of illness for the minority ethnic groups. Thus, the argument put forward that Indo- and Afro-Trinidadians may have retained their culture from the country of origin may or may not be applicable also to this ethnic group.

Furthermore, if interviews were conducted with the religious leaders and medical doctors then more of their personal apperceptions may have been gleaned and insight into their personal opinions and feelings may have been conveyed. For example, how male religious leaders or medical doctors may have felt about counselling with women who have domestic violence experiences, and if they were of the opinion that their gender may have impacted on the women's disclosure (because of culture) for these interesting issues. On the other hand, as noted in the discussion, Sugg and Inui (1992) discussed that some physicians found exploring domestic violence analogous to "opening Pandora's Box", and did not explore the issues of domestic violence because of: lack of comfort, fear of offending the individual, loss of control, time constraints and powerlessness. Definitive arguments could not have been made regarding possible explanations as to why some medical doctors in Trinidad did not wish to intervene. The questionnaire utilized did not specifically address these issues, thus, limiting the scope of analysis. Accordingly, either more in-depth questionnaires or interviews may have proved beneficial in exploring these issues with both medical doctors and religious leader.

7:8 Implications

In the discussion section of chapter 5 (IPA analysis of help-seeking) several recommendations were outlined that could be implemented to assist women, religious leaders, medical doctors and the general public. These are discussed further below, as well as other recommendations.

There should be the implementation of educational and self-help programs specifically targeted at Afro-Trinidadian women. It was noted by Maharajh (2010) that Afro-Trinidadian women are

often viewed as ‘strong’ and hence, will be able to cope with their challenges on their own. However, this study did not substantiate this assertion. What was revealed was that although not statistically significant, many Afro-Trinidadian women did have symptoms associated with somatization disorder and domestic violence experiences. As a result they do require assistance for both of these intersecting issues. It may be important to specifically design help programmes for this ethnic group and not overgeneralize, as although two persons may share the same worldview their cultural identities may differ vastly (Cohen, 2009; Cheng, 2001; Kirmayer & Sartorus, 2007; Lonner & Ibrahim, 2002), as such the meaning that one ethnic group attaches to their symptoms may differ vastly for the other (Kress et al., 2005). Additionally, since each culture may differ from each other in terms of what is defined as ‘normal’, it is important to not categorize mental illness based on a pre-determined set of criteria, since this may contribute to the medicalization of society, and, consequently, the over-diagnosis of mental illness within particular cultures (as argued with the use of the DSM 5; Khoury et al., 2014; Möllen et al., 2014). For that reason, assistance offered should not be based just on standardized programmes, but instead should seek to thoroughly explore the individual’s own meaning attached to their symptoms, thereby, creating help that is specifically tailored to an individual’s needs. By so doing, it is hoped that the Trinidadian physician’s view of mental illness may be changed and, as a result, may reduce the risk of the over- or mis-diagnosing of women with not only somatization disorder but other mental illness.

All the studies in this thesis brought to light that some people in the general public were not knowledgeable about somatization disorder, nor were they adequately able to identify the different forms of domestic violence. Specifically, many of the women did not recognize financial mistreatment as a form of abuse. Sharpe and Carson (2001) have argued that more emphasis needs to be placed on educating the public in a positive and non-judgmental manner regarding such sensitive issues. When emphasis is placed on the integrity of social, physical and psychological factors of somatization disorder this could lead to the reduction of stigma attached to such a disorder. Therefore, based on these, the introduction of educational programs in Trinidad aimed at the general public about what somatization disorder is and about forms of

domestic violence, may increase awareness of these intersecting issues. The Ministry of Health[70] and the Ministry of Gender, Youth and Child Development[71] in Trinidad could seek to introduce these educational programs as they may be the ones who have initial contact with data regarding these issues, therefore, being better equipped to deal with them. Thus, it may be debated that when persons accommodate this new information into their already existing schemas or thoughts that it is also anticipated that with this increased knowledge, the stigma of a mental illness (Hardin, 2002; So, 2008) may also be reduced or eliminated.

Additionally, this thesis revealed that many medical doctors did not wish to intervene for either somatic symptoms or domestic violence experiences. It has been argued that some of the medical doctors' loss aversion regarding their drive to rule out any organic ailments; their ignorance of the condition; the fear of overlooking an organic disease and their discomfort in exploring psychological issues (Mai, 2004 & Quill, 1985) because of their own insecurities have resulted in many medical doctors own aversion in dealing with such matters (Dorwick et al., 2004; Robbins et al., 1994; Salmon et al., 2004). Additionally, for some medical doctors, the long standing view that domestic violence is a private topic (Gerbert et al., 2002) may also contribute to some of them not exploring such issues with women. As a result, additional training in these areas may help alleviate these concerns and thus encourage and motivate some medical doctors to explore these issues with women. This may also influence medical doctors' own biases and stereotypes that may be inhibiting them from enquiring about causes (Hardin, 2002; Kress el at., 2005). The various Regional Health Authorities in Trinidad (there are four[72] Regional Health Authorities in Trinidad) may be of assistance, since all medical doctors employed in the public sector must be retained by one of these authorities. Educating medical doctors may help to reduce the medicalization of society, as some of the medical doctors now being educated about possible causes for the symptoms, may be less inclined to diagnose a mental or physical ailment without first assessing the women for any underlying stressful events that may be contributing to their illness.

[70] This Ministry deals with, but not limited to, mental health, social services and counseling and psychiatric services (Government of Trinidad and Tobago, 2015)

[71] This Ministry deal with, but not limted to, monitor and supportive services for women (Government of Trinidad and Tobago, 2015, Ministry of Gender, Youth and Child Development)

[72] Eastern, North Central, North West and South West Regional Health Authorities all of which come under the guidance of the Ministry of Health (Government of Trinidad and Tobago, 2015, Ministry of Health)

Also, medical institutions, (as this may be the first contact some women have for these issues; Maharajh, 2010) should consider implementing guidelines for screening for both somatization disorder and domestic violence experiences. Although Ali (2003) argues that there is no evidence that routine screening will alter morbidity and mortality levels, it has been proposed that screening may uncover hidden cases of domestic violence; may change perceived acceptability of violence in the relationship; would make it easier for women to access support services; and may change health professionals' knowledge and attitude towards domestic violence and hence reduce the social stigma attached to it (Taket et al., 2003). By implementing such programmes in Trinidad some of these benefits may also be attained.

Formal training programmes for religious leaders aimed at improving their knowledge and assessment skills for domestic violence and somatization disorder may also prove beneficial. As reported by some researchers (Maharajh, 2010; Hadeed & El Bassel, 2006; Kress et al., 2005) and as noted throughout this thesis, some women seek spiritual assistance for their challenges, in an effort to avoid shame and fear of stigmatization (So, 2008). The majority of religious leaders who participated in this thesis were not knowledgeable about what somatization disorder is, despite having steady contact with women with somatic symptoms. Despite this, most held the perceived control[73] (Gerrig & Philip, 2002) that their intervention would produce positive changes with the women. Additionally, this thesis revealed that somatization disorder is occurring at a high rate within Trinidad (specifically Indo-Trinidadian women) and many are seeking assistance from their religious leaders. It may therefore be beneficial to educate religious leaders about the disorder, in an effort to improve their intervention strategies, and increase resources. Equally, such educational programmes may also be beneficial for domestic violence, as these may also increase religious leaders' knowledge, intervention strategies and resources for dealing with such matters. The Ministry of Community Development[74] and the Ministry of Diversity and Social Integration[75] in Trinidad may be of some assistance, as these services may

[73] "The belief that one has the ability to make a difference in the course or the consequences of some event or experience; often helpful in dealing with stressors" (Gerrig & Philip, 2002).
[74] This Ministry deals with, but not limited to, skills training, adult education and self-help programs (Government of Trinidad and Tobago, 2015)
[75] This Ministry deals with but not limited to, developing an inclusive and cohesive society (Government of Trinidad and Tobago, 2015)

be able to help facilitate some Community Educational programmes to educate religious leaders about their role in helping women with somatization disorder and domestic violence experiences.

Finally, there should be more mental health campaigns, for example, television advertisements which specifically address somatic symptoms. Hopefully, when women (and men) learn about the symptoms and that they are not alone, they would be encouraged to seek out assistance and not 'suffer in silence'. Additionally, since stigma seems to have a major role in seeking assistance for somatic symptoms, they may now be directed to where they can seek assistance, and may aid in reducing or eliminating the stigma of psychological ailments.

7:9 Future Research

Based on the findings of this thesis, there are several recommendations for further research into somatization disorder and domestic violence, specifically within Trinidad. Study three (religious leaders and medical doctors intervention), gathered data from religious leaders and medical doctors regarding their knowledge, resources, willingness to explore and intervention strategies through a quantitative method. As discussed earlier, while this approach did yield valuable information regarding these professionals concerning these intersecting issues, mostly numerical data was derived. Consequently, this did not enable the researcher to fully understand how these professionals actually conceptualize their understanding, motivation and feelings regarding intervening with women with these intersecting issues. Therefore, additional research employing semi-structured interviews may give insight into the barriers that some religious leaders and medical doctors may encounter, for example, personal obstacles, lack of resources or cultural beliefs (Dowrick et al., 2004; Epstein et al., 2006; Gerbert, 2002; Mai, 2004; Quill, 1985; Robbins et al., 1994; Salmon et al., 2004). Some medical doctors also stated that they did not wish to intervene for these intersecting issues, nor were they of the opinion that their efforts to facilitate change would be beneficial, whereas, some religious leaders did. For that reason, interviews with these professionals also may provide information regarding why Trinidadian religious leaders and medical doctors hold these beliefs. The root cause(s) of these concerns may therefore be revealed; thereby resulting in more knowledge, to inform the development of educational programs to alleviate these concerns may be developed. Similar to the above, the Ministry of Community Development and the Ministry of Diversity and Social Integration in

Trinidad may also be of some assistance, as they may be able to help facilitate Community Educational programmes to educate religious leaders about their role in helping women with somatization disorder and domestic violence experiences.

Stemming from the current findings, another area that would benefit from additional research would be investigating the differences in the occurrence of somatization disorder with regard to the geographical location of women. Study one (occurrence of somatization disorder and domestic violence) sampled both Indo-and Afro-Trinidadian women from each of the eight administrative counties within Trinidad. However, no research was conducted to explore if the ethnic composition of those specific counties may have had an impact on the occurrence of somatization. Thus, some researchers (Cheng, 2001; Cohen, 2009; Kirmayer & Sartorus, 2007) have argued that persons from different geographical regions within countries will differ in their interpretation of events. As a result, different regions of countries will possess their own practices, values and norms. Since this thesis revealed a higher occurrence of somatization disorder among Indo-Trinidadian women, further research into the ethnic composition of those counties may be fruitful. Research may assist in determining if counties with more Indo-Trinidadian women have a higher occurrence of somatization. This may provide further support for theories (e.g. De Gucht & Maes, 2006; Mai, 2004) that somatization disorder may be a result of social learning.

Finally, as noted in the limitations section, the omission of Chinese-Trinidadians from this thesis may have limited the scope of the findings. As a result, it is recommended that somatization disorder be explored within this ethnic group, as much research has found that somatization disorder is very prevalent in this culture (Bhui, 2002; Chaturvedi & Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Sarason, 1991; Saxena, Nepal & Mohan, 1988; So, 2008; Tseng, 2005). Additionally, even though the Chinese population in Trinidad (6,500; CSO, 2000) may be considered small compared to Indo- or Afro-Trinidadian, it may still be worth investigating. Research of this nature may reveal if the dominant cultures have influenced these interesting issues for expression of illness for this minority ethnic group. Additionally, comparisons similar to Indo-Trinidadians may be made, that is, despite the Chinese population arriving in Trinidad between the periods 1853 to 1866 it may be that they too have retained

cultural aspects of their country of origin such as expression of illness. When this is accomplished, the Ministry of Diversity and Social Integration and Ministry of Health in Trinidad may benefit. They will now have more knowledge regarding the expression of illness among this population, thus, now be better equipped to develop health care programs to specifically cater to Chinese-Trinidadians' needs. In this way, the Chinese population in Trinidad may be more effectively integrated into the Trinidadian society without the fear of stigmatization, thus creating a more cohesive society.

7:10 Conclusions

Limited research regarding somatization disorder and its links to domestic violence in the Caribbean, and, specifically, Trinidad, West Indies has been conducted. One of the main objectives of this thesis was to address this lack of knowledge. Thus, this thesis explored Indo- and Afro-Trinidadian women's experiences of domestic violence and somatization disorder. One of the major findings of this thesis was that Indo-Trinidadian women, similar to their ancestors from their country of origin (India), also somatized their distress, possibly as a coping strategy for challenging situations (Kress et al., 2005). Or, as discussed in the literature review (Chapter Two), it may be argued that, for some women, this form of expression of illness is cultural, as culture may be seen as a form of 'traditional' problem-solving that has been met with success (Cheng, 2001; Na & Kitayama; 2011; Kirmayer & Sartorius, 2007; Sewell, 2005; Straub et al. 2002). That is, traditionally Trinidadian and even Indian society have come to accept certain behaviours (somatic symptoms) as a form of survival and socially approved coping strategy, and thus, after some time, these behaviours are seen as a part of their cultural identity (Straub et al., 2002).

This supports previous international research that somatization disorder seems to be culturally specific (Bhui, 2002; Chaturvedi & Venugopal, 1994; DSM-IV-TR, 2002; Fernando, 2002; Hardin, 2002; Sarason, 1999; Saxena, Nepal & Mohan, 1988). However, possible explanations for this occurrence in Trinidad may still not be clear, as theories such as social learning did not provide a concrete justification. As argued earlier, despite two persons possessing similar worldviews their cultural identities may differ vastly (Cheng, 2001; Cohen, 2009; Kirmayer & Sartorus, 2007; Lonner & Ibrahim, 2002). Women from different geographical regions within

Trinidad may differ in their interpretation of traumatic events, and, as a result, different regions of Trinidad may possess their own practices, values and norms. Thus, Afro-Trinidadian women, because of their cultural background, may interpret their somatic symptoms differently from Indo-Trinidadian women. Nonetheless, there are ample findings from this thesis to support the view that the expression of somatic symptoms seems to be culturally linked, especially among Indo-Trinidadian women.

These findings have made significant contributions to the literature regarding these intersecting issues, as, prior to this study, there existed extremely limited research in Trinidad about these topics (as discussed in chapter two; literature review). Researchers, policy makers, for example, the Ministries of People and Social Development, Community Development, Health, Gender, Youth and Child Development and Diversity and Social Integration in Trinidad as well as and the general public will now have access to empirical research to increase their own knowledge about these inter-related issues. Consequently, the potential impact of these findings will also be substantial. As discussed in the 'implications' sections of this chapter, educational and self-help programmes at a macro and micro level can now be employed. For example, the local community centres throughout Trinidad (such as, Servol) may now be able to implement educational programmes (designed to target women of all ethnicities), with the aim of 'exploring in-depth with the women if they had any previous knowledge regarding these interacting issues'. Additionally, another aim would be to 'increase the women's knowledge of somatization disorder, domestic violence and avenues of help they could utilize'. It is hoped that when (but not limited to) these aims are achieved with the women's increased awareness and knowledge regarding these intersecting issues, some stigmatization of psychological ailments (as discussed in chapters 2 and 7) may be reduced, and therefore, the women may be more inclined to seek appropriate assistance, thereby reducing or alleviating some of their distress.

Furthermore, as discussed earlier, research has indicated that Indo-Trinidadian women were more likely to have experienced domestic violence than any other ethnic group (Hadeed & El Bassel, 2006), despite Rawlins (2000) reporting that this belief was not supported. Findings from this thesis supported this notion, as Indo-Trinidadian women did report more domestic violence experiences than Afro-Trinidadian women. One of the arguments for this is that culture may also

have impacted on domestic violence experiences for this ethnic group. As culture may be seen as an agent in which core values of a specific society are passed down to future generations (Sewell, 2005; Straub et al., 2002). Thus, as discussed earlier, Indo-Trinidadian women, because they may have been traditionally raised to be passive, compared to Afro-Trinidadian women, who were taught to be assertive, may have contributed to Indo-Trinidadian women being more susceptible to domestic violence experiences. Therefore, because of Indo-Trinidadian women's cultural beliefs they may be of the opinion that they 'should' be compliant with their passive upbringing and accept that domestic violence is a part of life. Although some research has suggested otherwise, for example, how women define their situations or social status may contribute to higher rates of domestic violence cases in some ethnic groups (Campbell, 1995; Ellison, Trinitapoli, Anderson & Johnson, 2007; Grossman & Lundy, 2007; Hadeed & El Bassel, 2006; Liang et al., 2005; Nagassar et al., 2010). However, this does not negate the fact that empirical findings from this thesis have shown that Indo-Trinidadian women who took part in the first study had more domestic violence experiences than their Afro-Trinidadian counterparts. Moreover, these findings have contributed to the body of literature regarding domestic violence both internationally and locally (Trinidad). The data highlighted the fact that Indo-Trinidadian women experience domestic violence at similar rates as Asians in other parts of the world (for example, India; Singh, 2007). While, as discussed earlier, the exact reason(s) for this is still not known, these findings of this current research not only have increased knowledge and awareness of Indo-Trinidadian's women experiences of domestic violence, but have also have laid the platform for more research to be conducted in this area. For example, more studies are needed employing a qualitative approach with Indo-Trinidadian women to explore their perceptions about why they may be experiencing more domestic violence than Afro-Trinidadian women.

Furthermore, similar to the findings of somatization disorder, the impact of these results regarding domestic violence is also substantial. With this increased awareness and knowledge of the occurrences of domestic violence, not only within the Indo-Trinidadian community, but also with Afro-Trinidadian women, the education of the general public concerning these issues may now be structured to cater to the needs of society. Thus, one aim (but not limited to) could be to 'seek to inform and educate the public about domestic violence and sources of help available'. In order to achieve this aim, the social services in Trinidad need to become involved. For example,

the Ministry of Gender, Youth and Child Development, Community Development and Health could all colobrate to formulate strategies and policies that may be beneficial to women in Trinidad with these intersecting issues. These Ministries may seek to launch public talk forums involving professionals in this area, as well as past victims of domestic violence who may be willing to speak about how they have overcome their challenges. Furthermore, achieving this may serve to reduce the medicalization of society, as medical doctors will have more awareness regarding the various factors that may contribute to women's physical ailment (e.g. abuse) and be less inclined to 'label' the woman as having a medical disorder. Moreover, the Domestic Violence Act in Trinidad has not been revised since 1999 (Domestic Violence Act 27 of 1999). Therefore, with the new information provided by this research, policy makers may now be able to make amendments, for example, cater to the health needs of the women in abusive situations. Thus, the women who may have somatic symptoms as a result of their abusive experiences will now be able to access medical and psychological assistance specifically for intersecting issues.

By so doing it is also hoped that the Trinidadian general public (both men and women) will become more knowledgeable and aware of domestic violence, such as, the types of domestic violence (as reported in studies one (chapter 4) and three (chapter 6) many women, religious leaders and medical doctors surveyed were not able to identify the different forms of domestic violence). Thus, the impact would be to reduce the stigma attached to being a domestic violence victim, and, at the same time, increase knowledge about help agencies. As a result, fewer women may suffer in silence regarding this issue, and, as a result, the incidences of somatization disorder related to domestic violence may be reduced. Consequently, some of the women will now have a safe and confidential environment to speak about their challenges and will not have to keep their feelings 'bottled up', as stated by one of the women in study two (chapter 5). This then leads to the discussion below.

This thesis also sought to add to the limited literature regarding the link between somatization disorder and domestic violence with regard to ethnicity in Trinidad. It was revealed that Indo-Trinidadian women were also more likely to present with somatic symptoms when domestic violence experiences were reported. Possible explanations for this occurrence include that Indo-Trinidadian women may be socialized through culture to express their distress as a physical

ailment. This may be as a result of the stigma attached to having a psychological complaint compared to a physical one (Chaturvedi & Venugopal, 1994; Hardin, 2002; Kassiram & Maharajh, 2010; Sarason, 1991; So, 2008). Additionally, it may also be that some Indo-Trinidadian women presented with somatic symptoms as a coping strategy (Kress et al., 2005) in order to manage their abusive situations. That is, if they are physically ill, then their secondary gain would be that the abuse may lessen or stop or they receive more attention, albeit for a different expereince.

Similar to the above discussion, this current body of research has illustrated the link between domestic violence experiences and somatic symptoms. Thus, not only international scholars would benefit from such findings, but also Trinidadian policy makers. As highlighted throughout this entire thesis, to date there has been only two published studies regarding somatization disorder and domestic violence. Thus, not much is known about these interesting issues by the Trinidadian general public (as noted previously from results gleaned from studies one and three). Therefore, these findings similar, to the discussion already put forward for somatization disorder, may have the desired impact, as, again, public education and self-help programmes designed to specifically to target women with domestic violence experiences and somatic symptoms may help to reduce stigma. Thus, as mentioned, the Ministries of Gender, Youth and Child Development, Community Development, and Health may all benefit from this research, as these authorities may now be able to use the findings to make amendments to their existing policies. For example, prior to this study, not many persons knew what somatization disorder was thus, they will now be aware that women who have domestic violence experiences may manifest their distress as somatic symptoms, and, as a result, develop educational and help programs (discussed above) to assist with these intersecting issues.

These assertions highlight the findings regarding help-seeking for these intersecting issues. As noted throughout this thesis, no research to date has been conducted on the combination of these issues in Trinidad. In many circumstances, women may tend to seek help from both informal and formal sources, specifically, from either medical doctors or some sort of spiritual source (Kress, et al., 2005; Maharajh, 2010; Rickwood et al., 2005). Thus, this thesis sought to provide data to accommodate this absence in the literature. The major findings suggested that many Indo- and

Afro-Trinidadian women held mixed views regarding the assistance received from either religious leaders or medical doctors for these intersecting issues. Many of the women felt that the religious leaders were trying to find a resolution to the situation by trying to persuade them to continue in the relationship. However, some of the women did report that some of the religious leaders offered advice that helped them to regain their self-confidence regarding their somatic symptoms or domestic violence experiences. On the other hand, some women were of the opinion that not having a close relationship with the medical doctor deterred them from disclosing the possible underlying cause(s) for their somatic symptoms, such as domestic violence.

This links to the findings that many of the medical doctors in this thesis were not willing to intervene and were of the opinion that their intervention for both somatization disorder and domestic violence experiences would not produce meaningful results; this is in direct opposition to the views of some of the religious leaders. This may be due to some medical doctors' own anxieties regarding personal obstacles or cultural beliefs concerning domestic violence and their discomfort in exploring psychological issues (Dowrick et al., 2004; Epstein et al., 2006; Gerbert, 2002; Mai, 2004; Quill, 1985; Robbins et al., 1994; Salmon et al., 2004). However, some religious leaders, owing to their faith in God, may believe that whatever God wants must be, simply for reasons beyond their intelligibility (Levitt & Ware, 2006). They therefore have greater confidence that a higher being would be able to 'heal' the women. Consequently, they did not hold similar anxieties as some medical doctors, thereby possibly contributing to their optimism that they would be able to produce improvements for Indo- and Afro-Trinidadian women with somatization and experience of domestic violence.

These significant findings have added to the already existing international literature with regard to help-seeking for domestic violence experiences and somatization disorder as separate issues. However, what this present research has accomplished is that it has conglomerated these issues and highlighted help-seeking for both these issues. Thus, this present research has not only contributed to existing research but has added totally new information, which was absent from the literature regarding help-seeking for these intersecting issues. As a result, the international community will now have access to such information and hopefully be able to use these findings

as a basis for advance research into similar populations around to world to further their understanding regarding these topics, and thus find ways to improve their social services for these intersecting issues.

However, because the findings from this thesis are specific to Trinidad, the impact for this country is considerable. Now that it is known that medical doctors, for various reasons (such as, fear, anxiety) are apprehensive when treating women with somatic symptoms and domestic violence experiences, and whereas religious leaders are more willing but lack knowledge about these issues, training programs may now be implemented to help with this issue. For example, short courses facilitated by trained professionals may serve to educate both religious leaders and medical doctors on the topics of somatization disorder and domestic violence. It is anticipated that these courses may provide an environment to not only learn, but also enable these professionals to discuss their own concerns about treating women with these interesting issues, therefore, helping to reduce their own fears and anxieties. This may then lead to medical doctors screening more frequently and being more knowledgeable about how to treat with women with these issues. Thus, for example, when the medical doctor is more at ease about speaking to women about abusive situations he may further create an atmosphere in which the women are comfortable to disclose (as this was one issue spoken about by some women in study two: chapter 5). As a result, this may assist in reducing the amount of undetected cases of domestic violence. Furthermore, identifying and treating these women may in turn help in reducing some of the somatic symptoms being experienced by the women, as they now have an outlet to voice their agony consequently, also helping to reduce many of the women's distressing physical symptoms.

Moreover, with increase knowledge regarding somatization disorder and domestic violence, many religious leaders may also now be better equipped to counsel women with these issues. As noted in chapter 6 (study 3) many of the religious leaders in this research were not aware, or had never heard of the term somatization disorder however, they were in almost daily contact with women with symptoms associated with somatization. Additionally, many of the religious leaders were also not aware of the different forms of domestic violence or knowledgeable about the referral avenues available. Since in Trinidad religious leaders may be the first form of help some

women may seek (Maharajh, 2010), increasing their knowledge regarding these intersecting issues, better-quality help may be offered to the women. Thus, with improved skills to deal with somatic symptoms, further improvements in the women's overall health and coping strategies may be obtained.

Based on the conclusions of this thesis, several Government Ministries[76] within Trinidad may also benefit substantially from the findings from this research. These Ministries may now be able to use the data gathered to either implement or amend existing policies to assist women trying to cope with, and eventually overcoming these intersecting issues. Furthermore, it may be argued that the findings did encourage and challenge inter-disciplinary boundaries. Thus, it is anticipated that international, regional (Caribbean) and local (Trinidad) literature will have to be expanded, and much needed absent research provided by this thesis is presented with regard to specific theories regarding these issues. For example, the manifestation of psychological distress (abuse) as physical symptoms are interrelated, and these challenges are more commonly found among Indo-Trinidadian women. Additionally, these intersecting issues are definitely linked to both Indo- and Afro-Trinidadian women's experiences of help-seeking.

As noted, this thesis adopted a mixed-methods approach, thus, the following chapter addresses the issues of reflexivity.

[76] Ministries of Health; Gender, Youth and Child Development; Community Development; People and Social Development and Diversity and Social Integration

Chapter 8
Reflexivity

8: 1 Introduction:

Since this thesis is using a mixed methodology approach, it is important that I engage in reflexivity. Reflexivity is a confusing, yet central, topic for qualitative research (Lynch, 2000). In order to increase the trustworthiness and integrity of qualitative work, researchers have suggested that there is the need to evaluate how inter-subjective elements may influence the data collection process and analysis. Reflexivity, in which the researchers engage in the explicit self-aware analysis of their own role in data collection and analysis, offers the tool for such evaluation. The reflexive analysis is, however, difficult and its ambiguous and subjective nature is contested, and, in the face of these challenges, some researchers may retreat from this process (Finlay, 2002a; Macbeth, 2001 & Mauthner & Doucet, 2003). Still, for many researchers, the question is not whether to do it, but how to do it (Finlay, 2002b). According to Maslow (1966) "there is no substitute for experience, none at all" (p. 45), he was pointing researchers towards the value of self-dialogue and discovery. Therefore, researchers, who begin their research with the data of their experience, seek to "embrace their own humanness as the basis for psychological understanding" (Walsh, 1995: p. 335). Hence, this is what I have sought to accomplish with my own qualitative research through the process of reflexivity.

Finlay (2002a) stated that when it comes to reflexivity this process can be "full of muddy ambiguity and multiple trails" (p. 212). Thus, the researcher has to decide how much of one's methodological account of their research experience should be provided. Additionally, how much personal detail one should disclose and in what manner should these experiences be divulged. This chapter was extremely challenging for me to write; as many of the experiences encountered with participants were not new to me. As a result, I felt I had nothing 'emotional' to discuss, which seems that for some this aspect of critical reflexivity is crucial (D'Cruz, Gillingham & Melendez, 2007; Freshwater & Rolf, 2001). Additionally, as noted above, I also grappled with the notion of multiple strangers reading my personal thoughts. However, I have sought to best expound on my own personal reflections regarding the research process.

In order for this to be accomplished I will be adopting D'Cruz et al.'s (2007) approach to critical reflexivity. That is, they have sought to explain critical reflexivity as a skill that is developed to assist the researcher in enhancing their ability to recognize how their own behaviours and interpretations of events may influence the research process. Thus, I had to locate myself into the research process itself to fully appreciate how I may have influenced the research act (D'Cruz et al., 2007). Thus, it may be argued that critical reflection is the first step in uniting the participant with the researcher (Freshwater et al., 2001).

Additionally, Freshwater et al. (2001) and Cunliffe and Jun (2005) discussed two types of critical reflective processes: first, 'reflection-on-action', which is, one reflects after and away from the practice. Second 'reflection-in-action', where one reflects on the events, emotions and feelings experienced while conducting the research. For this thesis I engaged in both of these processes, which are highlighted throughout this chapter. Therefore, this chapter seeks to provide an in-depth view into my experiences, that is, the decision to apply for a PhD programme; data collection; how my own experiences (both professional and personal) may or may not have impacted on the entire PhD process and personal reflections. In order to accomplish this, I shall first present reflections regarding my decision to apply for a PhD, followed by reflections for study one, then, study two and finally provide a summary comparing how my experiences and perceptions have changed with each phase of this PhD.

8:2 The Beginning

According to D'Cruz et al. (2007), much insight may be gained by critically reflecting on why one will or will not have an emotional response to various situation(s). Thus, I now seek to share my journey into joining a PhD programme and the impact that this process had on me as a person. The thoughts about joining a PhD programme started (seriously) in 2004 after I completed my first Master's Degree in Clinical Psychology. Unfortunately, The University of the West Indies (UWI), St. Augustine campus (Trinidad) did not offer a PhD programme in psychology (clinical) at that time. I completed the MSc in Clinical Psychology at the UWI, Mona (Jamaica) but after living there for three years I did not have an interest continuing in that country, even though they had a PhD programme in Clinical Psychology. However, there was 'talk' that a programme would be introduced at UWI, St. Augustine very soon, therefore, I

decided to wait. During this waiting period my workplace at the time, started conducting pre-employment screening for police officers, and being one of the psychologists who conducted most of the psychological testing at that organization, I was asked to lead this venture. Additionally, as a psychologist I was also counselling people who were exposed to domestic violence and at times the perpetrators. While doing so, I gained an appreciation for work in criminology, and since the PhD programme in psychology still had not been introduced, I decided that a second master Degree would be very beneficial to my career. Thus, I successfully completed an MSc in Criminology and Criminal Justice at UWI, St. Augustine. For this programme my research paper was on 'protection order and procedural issues determining successful outcomes: an interpretative analysis.

During the completion of the second Master's degree I changed jobs and started lecturing at one of the local universities. However, even though I was no longer engaged in full-time counselling or psychological assessments, I still maintained an interest in psychology and criminology. Then in 2008, Professor Hari D. Maharajh was writing a book, 'Social Cultural Psychiatry Experience from the Caribbean Region' and asked if I would be willing to contribute a chapter on somatization disorder, I was delighted as this would be my first publication. My first master's degree thesis investigated 'Somatization Disorders among Indians in Jamaica and Trinidad and its association with Social and Cultural Factors', therefore, this was my input. Later when conducting literature searches, I realized that there have only been two studies on somatization disorder in Trinidad and mine was one of them; this made me feel very excited.

Ever since completing my first Master's degree I always wanted to pursue research into somatization disorder because of the lack of information regarding this topic in the Caribbean. Writing the chapter for Professor Maharajh's book reignited this desire, furthermore, I also now had more knowledge about domestic violence (from professional and educational experiences). Therefore, I decided to pursue further studies (PhD) combining aspects of both psychology and criminology, creating the topic investigated for this present thesis.

Nonetheless, the road to actually starting a PhD programme was a somewhat long and even emotional one. I was unsure in which country I should study, as UWI (St. Augustine) still had

not introduced a PhD programme, specific to my needs. Therefore, I gathered all application details in 2009 and started applying in countries such as the United States of America, the United Kingdom and Australia. Dr. Miranda Horvath from The University of Surrey was the first to contact me and we had a telephone interview which went well, as she agreed to supervise me. At this point in time I was also in communication with other potential supervisors at Manchester and Melbourne. After much consideration, I decided if I came to the UK it would be Surrey, therefore, eliminating the Manchester option.

I gained acceptance at the Universities of Melbourne and Surrey and decided to cease applying to other universities, as I was satisfied with these options. However, the world's financial crisis scared me; I was extremely concerned about being in a foreign country and not having enough financial support. Thus, I deferred my entry into both universities and started applying for financial assistance, mostly from the Government of Trinidad and Tobago. It took almost one year and many applications before I was finally granted a Development Programme Scholarship that would fund my studies anywhere in the world. While this was extremely good news for me, I was now also confined to the topic I submitted for the scholarship. Thus, I would have to fly back and forth to Trinidad for data collection at my own expense, since the scholarship only paid compulsory fees. Therefore, the UK was the most viable option financially compared to the cost of flying to and from Australia. Plus, I was very satisfied with Dr. Horvath's enthusiasm about my topic and her general helpfulness. Therefore, both these factors contributed to me choosing The University of Surrey. Unfortunately, when I contacted Dr. Horvath about starting the programme, she informed that she was leaving to work at Middlesex University and I was welcomed to join her. I still pursued the option of Surrey but they could not match with a supervisor for my topic. As a result, I came to Middlesex University. This University has proven to be an excellent choice, as I am very pleased with the support received.

Upon arriving in the UK my topic was solely to investigate Indo-Trinidadian women's experiences of somatization disorder and domestic violence as this was where my interest lay. After conversations with my supervisors they suggested that I include Afro-Trinidadian women. When I contemplated the benefits of such a comparative study and the population of Trinidad is almost equally divided among these ethnic groups I decided that this would be worth

investigating. Additionally, one of my supervisors suggested that I include religious leaders as part of my sample because Trinidad can be considered a religious/spiritual society. In reflecting, I am now of the opinion that I may have taken it for granted that in Trinidad we do not suffer religious persecution and I am essentially free to speak and express my spiritual views without fear of repercussions. Nonetheless, the idea to include religious leaders appealed to me because it drew to my attention to the possibility that Trinidad may indeed be considered a religious/spiritual society; thus, the birth of the present topics for this thesis. My thoughts regarding each of the studies conducted are explored below.

8: 3 Reflexivity for Study One (Occurrences of somatization disorder, domestic violence and help-seeking)

Study one of this thesis sought to report and compare occurrences of domestic violence and somatization disorder amongst Indo- and Afro-Trinidadian women living in Trinidad. The study also sought to map the routes of help the women employed. Therefore, data collection required me to interact with women in the general population in Trinidad who may be experiencing domestic violence. This was not a strange assignment for me, as I have experience in counseling with women in these situations. What was challenging was having a time frame of three months in which to find participants from all over Trinidad. Luckily for me, I had wonderful gatekeepers who really lived up to the task. Throughout the data collection process, participants, as well as myself, experienced various emotional and psychological reactions to the topics being investigated and the process in general; these will now be discussed in relation to the research process. Additionally, I kept a reflective journal (as noted in chapter 4; occurrences of somatization disorder and domestic violence (see appendix Hb). This enabled me to engage in 'reflection-on-action'. However, some researchers (Gill, 1995; White, 2001) have noted that utilizing this type of journal may only serve to act as 'confessionals' in which the researcher seeks to record information that is used to legitimize their own claims, rather than question them. Thus, throughout this research process I have tried not to do this, by exploring and acknowledging the research process as going beyond the 'traditional researcher/participant relationship' (2007, p. 78) and instead place myself in the participant's 'shoes' at times (D'Cruz et al. 2007; Freshwater et al, 2001).

Questionnaires

The questionnaire method was used to collect data for study one. Therefore, in order to fully understand the impact these questionnaires had on the study, it is important to not only examine the questionnaire itself, but also the construction of it. Firstly, it was stressful finding the appropriate assessment tools for somatization disorder and domestic violence, as these topics are very sensitive ones, and I would be meeting women who already live in a society where cultural traditions do not encourage women to openly express their emotions and feelings. At one point, I felt very discouraged that I would not be able to find any of the tools, especially when I emailed some researchers and university lecturers and had no response. But this changed when a researcher (Mary Dutton) in the United States of America responded, and provided me with an assessment tool for domestic violence. Even though I was pleased to now have this tool I still had to ensure that it was appropriate to the study. The questionnaire was very lengthy and included all aspects of domestic violence, such as, physical, sexual, financial abuse and it is a validated tool; therefore, this is the reason this specific tool was selected.

Once the required assessment tools were sourced, the questionnaire was compiled. The completed questionnaire had seven sections that comprised demographic information, general help seeking options that women seek, somatization assessment tool (Brief Symptom Inventory-18, developed by Derogatis, 2001), assessment tool for domestic violence (A modified version of the Coercive Control Measure for Intimate Partner Violence, developed by Dutton, Goodman and Scdmidt, 2005), and assessment questionnaires to determine the sources of help sought by the participants for somatic symptoms and domestic violence experiences if any and whether these sources were helpful or not. The questionnaire consisted of 23 pages and took between 30 minutes to one hour to complete, depending on the literacy level of the participant. That is, if they had only a primary school level of education these women may have taken a longer time to complete the questionnaire, compared to women with higher education. The length of the questionnaire caused a bit of concern, as I did not want participants to feel discouraged and not want to complete it. Additionally, this would mean that data collection would go on longer than the specified time and raise issues such as financial feasibility.

Upon the start of data collection one of the first issues raised by participants was that of "age". Some participants were a bit taken aback by the fact that they had to actually state their age instead of giving a category. I chose here, once again, to use my years of experience of counseling to reassure participants on the issue of confidentiality, and that this information will not be used in any way to single her out from the other participants. My past experience here helped me explain to the participants in a reassuring manner that their information would identify them. Therefore, at this point I further realized that my counseling experience was indeed a unique element to the research process and this would positively impact on my research. This would also serve to enrich the entire PhD thesis, as I was now conducting this research with the advantage of already meeting and treating women who had experiences of domestic violence and somatization disorder, and I knew how to speak with them, make them comfortable and as a result collect data that someone without this experience would not be able to do. I also reassured the participants the only reason that demographic information was required was for analytic purposes, such as to look for trends.

Following from the participants concern on the age issue was that I would "lose" participants and my time frame for data collection for study one would not be enough. Also even though I knew that participants were totally free to withdraw from the study at any point, I did not want an issue such as stating their age to cause them to do so. I felt that this would be an unfair analysis of the study by the participant. Nothing was done or said by me to coerce them to participate, but I just answered the questions that were asked to help put the participants' minds at ease. I looked at the issue of age as one of a gender issue as women in certain cultures are raised to feel inadequate or invisible as they get older and that it is especially shameful if they are not married or have biological children. Women are less tolerant of being labelled as an "old maid" but some women do still hold this belief and it may not have presented itself in an obvious manner in this study, but from the reactions of some women such as, "oh my yuh want to know meh age" or "huh I real ole" it seems that some of the residual cultural beliefs still exist.

For me it was a bit annoying that the women would define themselves so rigidly in terms of age. Personally, age is only a number and I have never considered myself to be any less of a person because I am getting older. It was less distressing to me, though, that it was the participants who

were over the age of 40 years that were taken aback by the question of age, and the younger participants did not bother and treated the age question like any other of the others. My feelings towards this did not seem to negatively impact on the research, as none of the participants voiced concerns that they noticed I was annoyed in any way. Additionally, even though the women were hesitant at first to indicate their age, they still did so. Therefore this had no significant impact on the data collection process. Additionally, since there were differences in the way participants approached the question of age, this may have impacted on the study by older women being less forthcoming with answers regarding their domestic violence experience. This is further discussed in the section later on older participants.

One should note that on presentation of the questionnaire to the participants, some of their initial reactions were that of shock as they commented "this is a book" or "this is an exam". I noticed the look of exhaustion already on the faces of participants, and some even showed signs of anxiety as they felt that they might give the "wrong" answer even though they were informed that there was no right or wrong answers. After completing a few questions, and realizing that it was mostly ticking the response, they were more cooperative as they may have felt less intimidated by the questionnaire or that it was more manageable.

This is where my experience as a lecturer impacted in a positive manner on the research process. I was now able to draw from being in front of a class and motivating them to do assignments or exams, and bring this to data collection. Again, this adds an affirmative element to the data collection that hopefully would have benefitted this thesis. If I did not have this experience I, too, may have become discouraged by the negative responses by participants, and this would show in my interactions with them. I was now able to take on the role of coach and encourage participants to complete the questionnaire. Additionally, in my past profession as a lecturer, and also doing part-time teaching at Middlesex University I also had students from different ages, ethnicities and backgrounds; therefore, I had the experience of ways to encourage them. For example, older persons might need more reassurance, whereas younger persons may need more motivation. Therefore, once again I was adding to the research process from my professional experience.

Now that data collection for study one has been completed, I am inclined to agree with the participants' point of view that the questionnaire was a bit too long and tedious, but from an academic standpoint it was necessary, as it yielded very vital information that will help those experiencing somatization disorder and domestic violence. Additionally, even though participants complained that the questionnaire was a bit lengthy, everyone still managed to complete it accurately. Additionally, my past experience as both psychologist and lecturer proved to be very beneficial because if I did not have these experiences, data collection may not have gone this well; therefore, my past professional experiences brought a level of proficiency to the data collection.

Gatekeepers

In order for this study to gain ethical approval and to access participants, gate keepers in each of the administrative counties in Trinidad needed to be located. Gatekeepers were chosen based on their familiarity with each county, that is, if they had spent enough time (either working or living) within that county to know participants. Sourcing gatekeepers, both male and female, who were from the respective county, or, at least, had spent enough time within that administrative county so that they knew the people living there, proved to be very beneficial. The gatekeepers knew the participants well enough that when they approached the women to participate there was already a level of trust between them, and this benefitted the study as none of the participants approached declined to take part.

This sense of trust between the gatekeeper and participant proved to be very beneficial to me, as by extension, the participants now also trusted me. Therefore, when I started the process of data collection, I noticed that some of the women already felt that they could relate their stories to me and not feel ashamed. I was delighted at this, and praised the women for their willingness, bravery and courage for participating in the study; it was a proud moment for me as a researcher, as I felt that I was not only using the women for information, but helping them to explore their own issues, and in turn, some of them were happy to get the debriefing information with the contact details of counseling agencies that handle domestic violence cases.

One of the downsides of gatekeepers knowing some of the participants was the issue of confidentiality; as some of the gatekeepers were friends with the participant. Even though the trust was there, there was also some mistrust, as a few of the participants had to be reassured that participation in the study was strictly confidential, and I would not release any information about them to the gatekeeper. Additionally, my brother being a gatekeeper could have been viewed as a negative. Since, he being male and having to recruit female participants who may have had experiences of domestic violence could be said to be placing some of the women in an awkward position. Some of the women being abused by a male partner could have easily viewed my brother as a treat and could have felt intimated by a male presence. Very fortunately for me the participants my brother recruited did not report any such experiences. Therefore, once this was established all went well with the data collection.

In my past jobs, I also had to build trust with clients, and this situation was similar, as, even though some of the women already seemed to have a sense of trust, I was now able to use various techniques to help with the participants who needed that extra reassurance. I was able to use verbal and non-verbal cues, such as facial expressions, and words such as "tell me more" to try to help the participants feel comfortable and therefore gain more trust from the participant.

One will notice from the information presented that the gender ratio for the gatekeepers was skewed, there were more females. The reason was that, initially, individuals who were asked to act as gatekeepers, were those whom I saw as having better access to participants, and then, as the study progressed, snowballing was used, and this had its negatives, such as: firstly, the male gatekeepers did not recommend any other persons to be gatekeepers, whereas the female gatekeepers did so freely. The gender gap among gatekeepers showed (at least to me) that males were less comfortable with recommending women whom they believed may have experienced domestic violence. The male gatekeepers showed less interest in the actual research topic as opposed to the female gatekeepers, for example, the female gatekeeper would ask questions about 'if women actually experienced some of the sexual violence' described in the questionnaire, and their tone of voice and facial expressions would convey that of concern. The male gatekeepers were mostly interested in what impact the study would have on the

medical/legal system, and also about my progress with achieving a PhD. Hardly ever was I asked by the male gatekeepers about the impact of domestic violence on the female victim.

For me, I would describe the male gatekeepers as somewhat insensitive to the topic and focusing only on the academic side of the study. I must admit that even though it felt insensitive it did not bother me as much as I thought at first, because the female gatekeepers compensated by actually focusing on the women and their comfort level with participating in a study of this nature. Additionally, because I do have experience in counseling with persons of different genders and age groups, I was able to deal personally with this. Self-debriefing was employed, a technique I used when I practiced as a counsellor, and therefore was able to move forward with data collection. If I did not have this experience maybe I would have been defensive with the male gatekeepers, and this would have negatively impacted on data collection.

The age range of gatekeepers played a crucial role in the data collection, as even though the gatekeepers' ages ranged from 25 to 71 years, the majority of gatekeepers would be considered 'old'. This yielded not a large number of participants which at first I thought this may be problematic, but I would later learn that this was actually beneficial, as my supervisors informed me that this might actually assist the study by providing a different perspective, which is, older participants would have different experiences from younger or middle aged women. I was very concerned that my sample would become skewed, but I asked some of the gatekeepers to select participants from the administrative counties from all age groups, if possible, and this sorted itself out as the gatekeepers had selected participants from other ages.

In thinking back at my experience with the chosen gatekeepers, I am extremely pleased with the level of support I gained from them, in terms of the level of assistance they provided in sourcing participants. The gatekeepers made a genuine effort to fulfil their roles. The gatekeepers own differences provided an avenue for a rich source of data to be collected, as I was now able to meet with participants from different backgrounds. This positively impacted on the research process as the sample now included a wide age group and background.

Gatekeepers Reflections

As mentioned, gatekeepers did an excellent job. Some stated that when they were informed about the number of participants needed, it sounded like a large number. This was the case for larger counties such as St. George and St. Patrick, but the gatekeepers were told that there was more than one gatekeeper in such counties where a larger sample size was required. The gatekeepers had a positive stance to their role, and, as a result, took their responsibility seriously; this stance contributed to the data collection process going smoothly. In terms of recruiting, because the gatekeepers lived or worked in the county, they had a lot of access to local people, and therefore were not at a loss for individuals to invite. Some observed that recruiting participants helped them get in touch with people they had not spoken with in a long time, and therefore helped them to reconnect.

Participants

In addressing the issues concerning the practicalities of the questionnaire, it is also important to address the persons completing the questionnaire. Participants for this study consisted of 150 females of East Indian (75) and African descent (75), third and fourth generation over the age of eighteen years from the general public in Trinidad. They were recruited from the eight administrative boundaries (counties) in Trinidad.

Older Sample

Firstly, the issue of having an older sample should be addressed. As mentioned, for study one there were a number of participants who were over the age of 65 years. Some of the older women seemed very happy to finally have someone asking them about themselves. I was able to show unconditional positive regard towards them, this Rogers (1967) stated is when there are "no conditions of acceptance, no feeling of "I like you only if you are thus and so"(p.98). This was especially important when they were completing the Brief Symptom Inventory-18 (BSI-18) as the women now had an avenue to open up to someone who was interested in their physical and emotional complaints that everyone else seemed to dismiss them for, or as one woman stated "take mi to deh psychiatrist for" instead of lending a listening ear. This would also encourage them to open up about their physical symptoms. Additionally, one of the BSI-18 questions asked how often they "felt blue" and many of the older participants did not understand what was meant

by this. I was a bit surprised by this as I took it for granted that everyone would know what "blue" in this context meant: that one is feeling sad or unhappy. One possible reason why the older participants may not have known what this meant was that of literacy or that they were probably never exposed to it because of their backgrounds such as, culture. Fortunately, this did not seem to have had a negative impact on the interview process, as when the participant understood what was being asked of them, they just answered the question and moved on.

Some of the older participants also felt that the questions were very personal, but then this was also voiced by the general sample. But specifically, the older participants expressed the view that the sexual questions on the Coercive Control Measure for Intimate Partner Violence were the most intrusive, for example, "*My partner refused to wear a condom during sex*" or "*I had sex because I was afraid of what might happen if I didn't*". I noticed hesitation on the participants' part in answering questions of this nature. Additionally, my age as the researcher could have also played a part here, as the older women had children who are my age, and in their generation issues of sexuality should not be discussed and more so not discussed with a younger person.

I did feel concern for the participants as I understood the culture and how uncomfortable it would be for them to express such "personal" information to someone they did not know. As for me, as the researcher, I have had many experiences with older persons and their hesitation with a younger person in the role of advisor. When I first started counseling some eight years ago, some older women in particular would express concern that I may not be capable to deal with their cases, because I was young; now these comments were not made after a counseling session with me, but before when I first introduced myself, they made assumptions based on physical appearance. I would often use this line in an effort to reassure them that *"it was not the years of experience but the experience within the years that counted"*. I used this technique with the older participants for this study and it proved to be beneficial, as after a while the women seemed comfortable to state the issues they were facing.

Therefore, at the end of data collection I felt I had a better understanding for women of this age group. In my years of counseling, I have always tried never to treat the older person as a baby or lacking in mental capacities, but now, having less time restriction for each interview (as opposed

to 50 minutes for a counseling session), it gave me a bit more time to spend with them; therefore, learning more and appreciating more their plights or happy moments.

Also, the differences across age ranges for this study were very insightful. If I compare the responses of the different age groups one will notice from a pragmatic viewpoint that these differences brought to the study rich data as experiences would not be the same for all. This, then, encourages me to want to conduct the interviews for study two of this thesis in order to gain even more insight and knowledge about women's experiences of somatization disorder, domestic violence and help-seeking.

Emotions

The topic under research is considered to be a sensitive one, which is domestic violence. The body of literature on critical reflectivity from a social constructionist point of view encourages the researcher to acknowledge how their own personal interpretations of the situation may impact on the meanings placed on the event. Thus, it is further encouraged that the 'self' be included as a part of the process of reflecting. Since the self includes cognitions and emotions, thus, much insight might be obtained by critically reflecting on why we might have certain emotional responses to situations (D'Cruz et al, 2007; Cunliffe at al., 2005). Throughout the data collection process there were women who were overcome by emotions when completing the questionnaire. I am of the opinion that despite some of the women experiencing emotional responses to recounting their abusive experiences, as the researcher I was able to experience 'controlled emotional involvement' (D'Cruz et al. 2007). As, according to the authors I possess what they termed 'reflexive and without feeling'. When I first read this term I felt it was very cold and how could I fit into this category, however upon reading the explanation offered I realized that it was appropriate. D'Cruz et al (2007) stated this form of critical reflection entails the researcher reflecting in her experiences but have already resolved any emotional reactions to the experiences. Thus, I believe this is the standpoint I adopted throughout this entire research process. In my past I have encountered domestic violence both at a professional level and family members experiencing such. Therefore, though the stories were terrible I have interacted with women in abusive situations and have somewhat resolved some of the emotional reactions I may have. However, for some of the women, the memories of abuse were too much for them and they

wept, I would say that I am very fortunate to have been trained as a psychologist, as I was now able to help the participant. I did this by providing them with an outlet to cry, in which they felt safe to do so and reassured. I was saddened that some of the women confessed that because of their financial situation they could not leave the relationship. But this revelation is in keeping with some international literature which states that "women's economic dependency plays a significant role in abuse risk and contributes to domestic-partner abuse" (Borstein, 2006, p. 595). Therefore, I felt the social services available in Trinidad, together with the society, had failed the participants, and hoped that my research would contribute to assist in promoting support for women with domestic violence experiences.

Additionally, from listening to the participants, I felt that some of them were minimizing their experiences of domestic violence, as some stated that "it was just a little push" or "it does not happen as often again" or "he does curse at me but only when he get mad". This suggests to me that the participants felt that because they did not have to go to the hospital for physical injuries that all was well with the relationship, and they should just be accepting of this behaviour towards them by their partner. As a psychologist and a woman this was difficult to hear, but I understood the participant's point of view. International studies, such as Dunham and Senn (2000) have reported that women often experience difficulties telling their stories about their abuse and when they do disclose they usually omit or minimize certain parts. Also, women who have a more accepting view of domestic abuse were more likely to minimize this abuse (Dunham & Senn, 2000). Thus, I used this opportunity to educate them on the different types of domestic violence that exist and hopefully this would encourage them to look at the situation from a different perspective and see that these behaviours should not be trivialized. Therefore, I was not only collecting data, but, hopefully, also providing some useful information for the women.

Also, many of the participants expressed surprise at the verbal and financial questions on the Coercive Control Measure for Intimate Partner Violence; many defined domestic violence as only physical violence, and did not realize that domestic violence entails much more than "hitting". This showed me that even though there are programmes to educate people in Trinidad (for example, free telephone hotlines, campaigns, and television advertisements) about domestic violence that maybe too much emphasis is being placed on only the physical/sexual violence,

and not much, if any, is being placed on the other aspects of domestic violence such as financial/verbal/psychological abuse even though these are defined in the Domestic Violence Act 27 of 1999.

One woman in particular stood out as she experienced what I would describe as a "breakdown". While she was completing the BSI-18 she indicated that she was experiencing extreme thoughts of suicide, and upon further investigation I found out that she had actually tried to commit suicide a week ago, and that she was still experiencing the thoughts; she was also currently in a very abusive relationship. All protocol was followed at this point and contact was kept with the woman to provide support and ensure that she received help. The experience of actually being able to speak about her situation seemed to be very cathartic for her, as, after she cried and told her story I could see a sign of relief in her face and she was somewhat relaxed. That day all other interviews had to be rescheduled, as, dealing with this one case took the majority of my time. I felt a bit guilty that I had to cancel my other appointments because those participants would have taken time from their busy schedules to be there and now I was asking them to adjust their lives once again to accommodate the research for which they were not being compensated.

This did not negatively impact on the data collection process as I was able to re-schedule the other participants and none of them stated that this caused distress to them. I adapted my attitude to this change in scheduling by looking at it as a learning experience and was able to continue with the others on the rescheduled dates. As for me, I felt very saddened that this person was in such a situation of domestic violence and felt she did not have avenues to sources for help. Again, my previous experience in the field of counseling proved to be very beneficial as I have dealt with such cases before and knew what should done, and, as a result, I was not shaken up by it; I was able to successfully complete the interview. Also, this situation presented me with the opportunity to show the participant that I was not only telling about my counseling experience, but my past role as one had now become evident in the research process. But at the same time I had to remind myself that this was not a counseling session and respond accordingly.

Literacy

Another topic that arose was the literacy level of the participants. Some of the women in study one had obtained only a primary school level of education, but were still very willing to participate in the study. As a result I now had to read the information sheet, informed consent and even the questionnaire for them. At first, this was very tiring for me, as I felt that it was too time- consuming as I could be meeting two or three women in the time I took to help this one person. I had to be very careful of counter- transference as I was starting to feel irritated. As data collection progressed my attitude changed and the process did not seem so long and bothersome. Some of the women felt ashamed by their level of literacy and I had to reassure them. Then there were some who, even though they had low literacy skills, were still willing to participate and, in turn, I had to spell some of the words for them to write. This was again very time-consuming, but I could see that this helped boost the self-confidence of the women. I then started to feel that I was helping the women in some way.

From a practical viewpoint, the differences in literacy among participants meant that the data gathered would now show scope, that is, data would not only reflect on socio-economic class but a variety of factors; thereby helping to fill gaps in the literature in Trinidad about women who have experienced domestic violence, somatize their distress and the help they sought.

Summary

The research process for any chosen topic can be a very challenging task; as not only the pressures of time, but also meeting with individuals who are experiencing a broad range of troubling issues. This study required me to meet with women who would be experiencing various symptoms associated with somatization disorder, such as, feelings of anxiety, depressive feelings and physical symptoms. It also required that I meet with women who would have been, or still be, in a situation of domestic violence.

I would say that meeting with participant one was very different from meeting with participant two for me as the researcher. In the beginning of the research process for this study I was somewhat more anxious, and the theme that kept presenting itself to me was that of time. I felt that I would not have enough time to complete the task at hand, and, in turn, when some of the

participants asked many questions, even though I took time to answer, I felt within myself that I was wasting time. By the middle of the data collection process these feelings of anxiety were partly subsiding, and by participant 140 I was much more relaxed and hopeful that I would indeed complete on schedule.

The stories that participants related to me were not shocking as in my professional and personal life I have heard some of these. Therefore, I am fortunate that throughout the data collection process I did not experience emotional/psychological distress with which I could not deal maybe when data collection for study two starts this may change as I would now be hearing the participant's detailed experiences of domestic violence, somatic symptoms and help seeking. My past professional experiences have indeed helped positively with this phase of the research process, as I was able to bring to the research strategies for treating with participants who are considered vulnerable. I was able to use these experiences to also improve and add a difference to my PhD research, and the research process. This was accomplished by my having the knowledge to enable me to interact with persons of certain backgrounds, ages and ethnicities, and encourage them to feel a sense of comfort to provide valuable information. This has also contributed to the research process by helping it go smoothly.

Overall, the research process for study one has helped me put into perspective my PhD, as before I knew where I wanted to be, but was not clear on the path that should be taken to reach that destination. I now have a clearer picture about what needs to be done in order to complete the task at hand and feel more confident that I will be able to complete it. Professionally, this exercise added to my knowledge as a psychologist, as I have gained experience that will help me later in my career. Even though there were times I felt annoyed, I always kept in mind that the participants were indeed doing me a huge favour by taking part in the study. Personally, this experience has helped me mature as an individual by, providing me with a different perspective to women's experiences of help-seeking. That is, throughout data collected I tended to draw a lot from professional experiences but now the women not being in a 'clinical' setting enabled me to interact with them in a less rigid manner.

It is hoped that these experiences will assist me when data collection for study two, by providing me more confidence to conduct the interviews and, therefore I will be able to obtain valuable and rich information and help the research process move along.

8:4 Reflexivity for Study Two (IPA analysis of help-seeking for Indo- and Afro-Trinidadian women)

8:4a Introduction

Study two of this thesis sought to report and compare experiences of help seeking for those women who had experiences of domestic violence and somatization disorder amongst Indo and Afro Trinidadian women living in Trinidad. It mapped the routes to help the women take and explore the impacts these had on their outcomes. Therefore this phase of the research process required that I interact in a more personal manner with the women than in study one as I would now be verbally asking the women various questions about their lives, instead of their completing a questionnaire as they had done in study one.

8:5 The Middle

At this point my PhD programme was almost half way completed. I had finished one and a half years and was about to collect data for study two. Unfortunately, prior to this I had some personal upheavals. In January 2012 I had to return home to Trinidad unexpectedly because my aunt, who has always been such a source of support for me passed away suddenly. This was a very tragic experience for me, as she was considered healthy and vibrant and we were very close. I was also the one who read the eulogy at her funeral and obviously this would have had an emotional toll on me. During this time in Trinidad my mother also had a minor heart attack; fortunately there was no permanent damage to her heart. However, I did have to extend my stay in Trinidad for another week; therefore I stayed in Trinidad for three weeks. Upon my return to the UK, it was becoming more evident to me that my professional relationship with my then Director of Studies was on a steady decline. From 2011 our relationship was not a satisfactory one, and after many meetings in an attempt to sort the issues out, I decided that I needed a change. I was also tired from what I felt was a constant struggle in communicating with my other supervisors. Therefore, there was a change in the supervisory team, and I now had a new Director of Studies and additional supervisor. While all these events were occurring, my past

supervisor, and co-author, Professor Hari. D. Maharajh succumbed to a long-term illness and passed away. However, despite these tragic circumstances the PhD proceed as they should, in terms of being on track to return to Trinidad for data collection for study two, which I will now elaborate on.

Since this phase of data collection comprised interviews instead of questionnaires, I have chosen to write the reflexivity for study two as a separate section, but still making comparisons between studies one and two where appropriate. This stage of data collection for my thesis was not as tiring physically, because, I interviewed twelve women, compared with locating 150 women to complete questionnaires in study one. What was exhausting mentally and psychologically was listening to the women tell their stories and not being able to provide them with continued assistance, such as continued psychological counseling. Throughout the data collection process, the women, as well as myself, experienced various emotional and psychological reactions to the topics being investigated and the process in general; these will now be discussed, using the main areas of the data collection process: gatekeepers, participants, the interview itself, financial and reflections in relation to the research process.

Participants

Firstly, the participants will be discussed, as in this study they were my initial contact, that is, for study one I contacted gatekeepers first, but now I was the one contacting the women directly to participate in the study. The method used to collect data for this study was the semi-structured interviews. This method was chosen because study two of this thesis sought to identify and learn how the women deal and cope with their somatic symptoms, domestic violence experiences and how they interconnect. Therefore, the interview method proved to be the most efficient and effective, as I was able to learn how the women deal and cope with these issues and gain insight into personal experiences that the questionnaire method may not have been able to elicit.

As mentioned the women for this study consisted of 12 females of East Indian (n=7) and African descent (n=5), third and fourth generation over the age of eighteen years from the general public in Trinidad. They were recruited from study one if they fit the criteria for having experienced somatization disorder, domestic violence or both. During the interview the women experienced

various reactions to the process which will be discussed below. The interview schedules for all categories served their purpose, as the women responded to the questions and prompts which in turn gave them the opportunity to speak in detail about their experiences of somatization disorder, domestic violence and help- seeking, providing me with rich data that I felt would really benefit analysis.

Again, in this study, as with study one, my past professional experiences had a very positive impact on the data collection process. As mentioned, since I have many years of experience as a practicing psychologist, I was very accustomed to interviewing people and, in particular, women who had experiences of domestic violence and somatization disorder. Therefore, I was now able to add to the research process, and, by extension, the PhD thesis. However, I also now possessed more personal insights into the women's experiences and this also greatly increased by skills with regards to interacting with the women. For example, I was now able to not view help-seeking as purely 'counselling' but not I was beginning to understand the emotional component to help-seeking. That is, the effort and courage it took these women to seek out assistance and actually continue with the help they sought. As a result of my personal and professional experiences, I was able to provide an atmosphere that encouraged the women to speak freely about their experiences; as one will note this was successfully accomplished as each interview lasted approximately 45 minutes. This then serves to gather rich, detailed information about the chosen topics and, therefore, provide this thesis with insight.

I also noticed subtle difference between interviews. These differences included the manner in which participant one would speak about her domestic violence experiences, compared with participant three. The women who were still in the vulnerable situation were more emotional, as might be expected; compared to the women who had left, they were much more relaxed when relating their stories. From a practical viewpoint, this served to confirm what I already had experienced in counselling; that women who experience abuse at different stages need different levels of assistance; therefore, much different data would be obtained from each of them. Hence, these differences serve to add richness to the data collected, and in return produce information for the thesis that would be very beneficial. As for me, these differences in interviews helped me to modify my approach to the women. That is, after a while in the interview, I was able to adapt

to the women's stories, such as, my body language or verbal prompts. This then leads into the emotions the women would have experienced during the interviews which is discussed next.

Emotional

One aspect of data collection for this study that needs special attention is that of the emotional issues of the women. The majority of the women stated that having to speak about their domestic violence experiences brought back memories that they either chose to bury or had not thought about in a while. One of the women cried and the interview had to be stopped for approximately fifteen minutes while she gathered her emotions together; I offered her emotional comfort in the form of talking and the interview continued. It was at this point I was able to comprehend what D'Cruz et al. (2007) spoke about; that is, 'reflection-in-action' (as discussed earlier). As, at this point I now had to reflect on the situation and respond accordingly at that moment. This woman was one who was still with her abusive partner, and helps illustrate the point made above that women still in the abusive situation tended to be more emotional. These reactions were similar to those expressed by the women in study one of this thesis, as some of the women did get emotional and cried. Therefore, the experience of data collection in study one helped to prepare me for these reactions. I went into this phase of data collection expecting emotional reactions and was therefore equipped to treat with them. As a result of these reactions, each of the women was reminded that she did not have to continue the interview if she did not want to, but I really admired that even though the interview did evoke some negative memories and emotions the women were still willing to share their experiences with me for the sake of research.

The women who were interviewed because they were identified as having somatization disorder, did not have any emotional reactions such as crying, but they did seem to be blocking out their physical health problems; they stated that they needed to be reminded about what symptoms they ticked in the questionnaire last year, and then tried to trivialize their symptoms by stating that the symptoms were not as bad or they had "short-term memory" problems which hindered them from remembering their physical ailments. From their facial reactions, I could tell they were a bit embarrassed to have had those health issues. This encouraged me to continue with this research and hope that the results will help in the formulation of some sort of educational program about somatization disorder; that it is nothing to be ashamed about, and to try and

eradicate the stigma attached to the symptoms, as I feel this is the reason some of the women were embarrassed.

One of the women had an experience of being sexually abused some years ago, which she did not disclose to me during data collection for study one (approximately one year prior to this study). She appeared to be coping well but when she revealed certain things to me, such as approximately 3 weeks ago seeing her abuser and her angry reaction, I suggested that she seek additionally counselling as there seemed to be some unresolved issues. I gave her contact information for counselling centers, such as the Rape Crisis Center that was not on the debriefing sheet; she made the decision to go. Overall, she is doing well and her past counseling did help her a lot. The revelation showed me that the fact that I took the personal time to do all the data collection for study one myself, now the women felt more comfortable to tell their stories; they were now familiar with me; my role as researcher had now become more apparent.

Additionally, as mentioned, the women had now become a bit familiar with me from study one, therefore more willing to divulge information to me. Study one then served to really help build study two by providing this familiarity, and as a result, more valuable information from the women. As I was able to build on this familiarity by using various techniques to further help the women be comfortable and talk about their situations. Thus, my emotional response was used to assist and promote a deeper understanding between the women and myself and as a result, enhance the quality of our interaction. Thus, some researchers have argued that this type of critical reflection is desirable, in that, by embracing my own emotional response and not suppressing it, this enhanced the interview process (D'Cruz et al. 2007; Macbeth, 2001; Lynch, 2000). As some of the women may have felt more comfortable and I also acknowledged my own emotions. All of this has positively contributed to adding literature about the chosen topics, and, therefore, shed light on the topic which is helping to make a positive and novel contribution to the field of psychology and specifically somatization disorder, domestic violence and help seeking.

Gatekeepers

Gatekeepers also had an important role in this phase of data collection as with study one. Study two required the help of various gatekeepers but not as much as in study one. Again, I was very pleased with the gatekeepers, as their assistance proved to be beneficial to the research process. They ensured that the venue for the interview was prepared beforehand, and, therefore, when I arrived at the site I just had to welcome the participant. This level of organization also showed the participant that the process was being conducted in a very professional manner and encouraged them to open up about their experiences. The fact that gatekeepers thus far have shown such enthusiasm in their role gives me encouragement, because I now feel that persons in the general public are also interested in the well-being of others, even though they may not be affected by any of the research topics. One of my recommendations that I can already see emerging from this thesis is that of further education of the general public about somatization disorder, domestic violence and help seeking. Since gatekeepers played such a vital role in the research process, it is important to acknowledge their thoughts and reflections as I did in study one.

Gatekeepers Reflection

As mentioned above, for study two the same gatekeepers were used. Many stated that serving as gatekeepers at this phase of data collection was much easier as there were fewer participants to contact, and, therefore, fewer arrangements to be made in terms of allocating times for the interviews. Additionally, study two was with pre-identified women; therefore, the two gatekeepers who had to assist in contacting some participants stated that it was also easier to access the participants as they knew exactly whom they were approaching. As a result, it was not as tiring and their role ended sooner than when they assisted in sourcing participants for study one.

The gatekeepers were not informed about the reason(s) why I was contacting these specific people, and they did not ask. They were not told the reason(s) in order to maintain confidentiality; they were only informed that it was for my follow-up study. For the women who the gatekeepers did contact directly, they informed the women that I (the researcher) wanted to

speak with then regarding participating in a follow-up study from the year before and if they would be willing to speak with me.

Overall, I would say that the gatekeepers seemed to be more comfortable this time with carrying out their roles. This may have been as a result that this time they were not asked to actually source participants, but mostly assist with arrangements for accessing the location for the interview to be conducted. Therefore, as with study one, with study two there was no negative impact on the data collection.

Summary

I chose for study two to write more in-depth notes about how I felt before, during and after the data collection, transcription and data analysis process, because this study required one on one contact with the women and therefore reflections on the research process was different from study one. I will now summarize these experiences according to the categories of before, during and after data collection.

Before data collection: I was a bit more anxious about this phase of data collection; I do not believe I was actually anxious about the data collection itself, but it was preparation and events leading up to the data collection that proved to be challenging. Firstly, some of the anxiety arose out of the fact that I had many challenges in formulating the interview schedule, as I felt that I should have been able to complete this in less time than it actually took. Secondly, I would not describe it as anxiety, but more so feelings of being psychologically tired at the point of preparation for data collection as mentioned prior my mother had suffered a minor heart attack, my very close paternal aunt suddenly passed away and an extremely good past supervisor to me also passed away, and this had taken an emotional toll on me. Additionally, after numerous attempts, I realized that I could no longer work with my then Director of Studies and a change was made.

During data collection: Fortunately for me I did not experience many challenges getting the women to participate in study two; some remembered that I would be contacting them, while others, when approached, were willing. Only three of the women approached declined, citing

such reasons as; they did not have the time or they just did not want to. The women's stories were interesting, and I deeply admired their willingness to speak to me about such personal matters; when I spoke with the women who had experienced domestic violence I felt a little remorseful that I might be using these women for information. There I was asking them to divulge information that evoked such strong emotions from them, and all I could offer at the end was some comfort and contact numbers in case they needed more counseling. I believe that my experiences as a counsellor had an impact, because I was accustomed to being able to work with people and help them gain some sort of peace of mind, but here I had to close and not be able to offer further assistance to them; the memory of this is still on my mind. I know from having members of my extended family who have experienced domestic violence, that the woman needs some sort of social support to either leave the relationship, or, at least learn coping skills if they decide to stay, and at this point, I was not able to provide this. The only thing I can hope is that through telling their stories to me and receiving the debriefing sheet, they would be encouraged to seek our help. Thus, the only statement that may be helpful with helping me to explain my own experiences with this aspect of data collection is summed up by Alvesson and Skoldberg (2000)

> *"there is no on way street between the researcher and the object of study; rather, the two affect each other mutually and continually in the course of the research process" (p.79)*

Thus, it was at this point that I realized that even though I was indeed trying to maintain a 'controlled emotional involvement', I was able to but only to a certain extent. As, even though I had much experience with treating with women with experiences of domestic violence, I still felt that I could do more but was not able to at this point. As a result, the data collection process, at this point, also served to further reinforce my own aims of educating the public about what somatization disorder is and seeking help. As mentioned in the section "emotional," the women did not even know about somatization disorder, and, therefore, do not tend to seek help for it, and results from study 1 showed that Indo- Trinidadian women were three times more likely to have this disorder. Therefore I believe with the proper education both Afro and Indo Trinidadian women will be able to seek treatment for their physical ailment.

After data collection (transcription and data analysis): Despite experiencing these feelings of using the women and not being able to help them, I now have to focus on the fact that my research may not have helped the women there and then, but, hopefully, when I make recommendations to the Government of Trinidad and Tobago they will implement the necessary changes to the various social services and this will, maybe help these same women and even more. This gives me a sense of fulfilment that at the end it would have helped many others. After the data collection I am also able to even more appreciate my family and friends, as I always knew they were concerned for me. Ever since I can remember my family has always been a strong support for me, being there when I needed them the most. At this point in their lives they are all married, work full-time and have young children, and yet they take time out of their busy life to accommodate me in ways that others do not. I feel truly blessed in every way.

As mentioned in chapter two (IPA analysis of help-seeking for Indo- and Afro-Trinidadian women) because of the experiences I had as a counsellor the women's stories were not 'shocking'. These experiences assisted me with data analysis and write-up of the findings. For example, as a counsellor, I have had an abusive partner of a client threaten to 'find me' because his partner was seeking assistance. For these reasons the entire data collection process was not an overwhelming experience for me. The process of transcribing the interviews was an interesting one, as previously I had never audio recorded therapy sessions with clients. Now, I had the privilege of listening to the women's stories and an in-depth examination of their words and what they meant. This assisted in data analysis and write-up; many of the domestic violence case were very similar, for example, the cultural impact of disclosure. That is, for many of the women (both Indo- and Afro-) they were apprehensive of telling their stories because they felt that it was a private matter and should be dealt with accordingly. Thus, as noted in the discussion chapter, culture had a powerful impact on the women's disclosure (help-seeking). This then reignited past memories of women whom I met as a counsellor. Some of these women were attending counseling sessions and chose to keep it a secret that they were seeking assistance for their abusive situations; they never disclosed their challenges to a family member nor a friend.

From my previous counselling experiences I held the opinion that domestic violence was not exclusion to any ethnic group. I would counsel with a range of ethnic groups and some forms of

abuse were present in all ethnic groups. This opinion has now changed as study one (occurrence of somatization disorder, domestic violence and help-seeking) and this study has shown me (through statistics and interviews) that indeed domestic violence does occur more frequently among Indo-Trinidadian women. This has now piqued my interest in investigating possible reasons why this occurs. I must admit if I did not have previous counselling experiences my react to some of the women (their domestic violence and somatization disorder challenges) in this thesis may have been very different. That is, I could easily envision many persons being shocked at what some of the women experienced. Therefore, I attribute my past experiences to me not reacting in astonishment or horror to some of the stories. I am of the opinion that I am extremely fortunate and blessed that I came into this PhD programme with such professional experiences, as this greatly assisted me in every area. For example, in counselling sessions I would have to shift from a clinical stance to a less rigid position. That is, when speaking with clients I would show sympathy, and then when writing up session notes and formulating treatment plans I would then return to a more clinical perspective. I was now also able to do this when conducting the interviews and listening to the women's experiences. After data analysis and writing-up of the findings I was now able to approach the interviews from both clinical and compassionate perspectives. That is, through IPA analysis I now read the interviews and was almost experiencing the women's emotions. Thus, I was able to write-up the findings in an academic manner while at the same time highlighting the emotional plight of many of the women. However, it could also be argued that I rely too much on my clinical experiences to the point where it may mask any 'real' feelings from being shown. As my supervisors have often told me that I needed to express more emotion when writing this chapter; this will be explored in the "The End" section of this chapter.

In conclusion, the research process for study two was a pleasant and educating experience for me, as I was able to fully appreciate the women and their experiences and what it meant for them. The differences identified between participants, the data collection process for studies one and two and that it is a mixed methods thesis, have significantly propelled this thesis and set it up to be an important piece of work that not only will present data in terms of statistics, but also express the women's lived experiences for other readers to gain a more personal and emotional insight into somatization disorder, domestic violence and help seeking. All of this, together with

my experience, has hopefully added to the originality of this research and hence stand out from other similar research projects.

As a result, my experiences from studies one and two invigorated me to continue to strive for excellence when it comes to data collection. Study three of this thesis requires me to administer questionnaires to medical doctors and religious leaders. Therefore, it may not be as much as a personal experience as studies one and two, but again, hopefully my experiences and reflections of the research process thus far would have built and fostered even better data collection for study three. Therefore, I will be making a novel and unique contribution to this field of study, not just from the data collected, but from what my experience adds to the process of data collection, thereby gathering richer data.

8:6: Reflexivity for Study three (Religious leaders and medical doctors intervention)

8:6a Introduction

This phase of the research process sought to investigate medical doctors and religious leaders' knowledge, resources, willingness to explore and intervention strategies they employ when meeting with women who may have domestic violence experiences and somatization disorder. Even though for this study I was not directly surveying women who may have somatic symptoms or domestic violence experiences, there was still the possibility that I could have come into contact with some; but throughout data collection none of the participants disclosed any such challenges. Since this is the final study for this thesis, reflections will incorporate comparisons of the research process between all of the studies.

Gatekeepers

As opposed to study two, I had to rely on the gatekeepers to first locate some of the participants for this study before I contacted them; this process was very similar to study one. Once again, I was extremely pleased with the gatekeepers' assistance. Additionally, since the gatekeepers contacted potential participants before I met with them, the participants already knew about the study and expected me at a certain time. Thus, when I arrived at the pre-arranged location, I was met with enthusiasm. Although I did have to contact some of the participants myself, this was not a problem. For study two, I had to do this, and thus I had experience and practice in

contacting potential participants, helping the process to go smoothly. I was able to draw from my experience of contacting participants for study two and as a result knew what to say to potential participants in this study.

Gatekeepers' Reflections

As mentioned, the majority of gatekeepers used in this study was already very familiar with this thesis and knew this was the final study. They said that they were delighted to have helped in this process, and it also educated them about research. That is, they now have personal insight into what data collection entailed. Some of them confessed that before they were of the opinion that 'handing out a few questionnaires' were 'no big deal', but now they realize the ethics and thoroughness that is involved, and now look at the process differently. Some also stated that before when persons would approach them to participate in a study they would hesitate, and felt it would take too much of their time. Now, they realize that participation is important and try not to decline participation, unless absolutely unavoidable.

Additionally, some of the gatekeepers stated that, prior to their role in this study, they were not familiar with somatization disorder, and now they had learnt about it, in terms of what it is and occurrences. When some of the gatekeepers revealed this to me, I was very pleased to know that this thesis was already making a difference. It served to educate others, not only in terms of the topics being investigated, but also the research process.

Questionnaires

Similar to study one, this study utilized questionnaires to collect the required data. A total of 100 questionnaires (50 religious leaders' and 50 medical doctors) were collected over a three month period. I did not encounter challenges with administering the questionnaires, as all the participants had some level of education and were therefore able to read and understand what was being asked of them. One of the participants expressed the view that he felt this was an 'excellent' topic and he 'enjoyed' completing the questionnaire. They all stated that because of the design of the questionnaire, it was easy to complete, as the questions required either ticking or circling the answers. As a result, completing the questionnaire was not tiring or time consuming; this was quite different from study one, as many of the participants stated that the

questionnaire was too lengthy. Again, my past experience of data collection from studies one and two helped. I was able to use this experience to help the participants feel comfortable, and thus they completed the questionnaire satisfactorily. Therefore, this experience positively contributed to the data collection process. I was also very pleased that participants positively received the questionnaire, as much time went into the construction. Thus, I felt delighted that all the hard work paid off and, that my supervisors' time and effort in assisting was also recognized.

Participants

As mentioned, participants for this study consisted of religious leaders' (50) and medical doctors (50). Their ages ranged between 18 to 70 years and over, they from all ethnicities and were both males and females. For the previous studies males were involved, but only at the gatekeeper level, but now, this was the first time that males were included as part of the sample. This did not pose a problem to me as the researcher, as I already had experience counseling and teaching persons of the opposite sex. This experience not only helped with the religious leaders, but also with the medical doctors. Throughout my career as a psychologist, I often had to interact with medical doctors either in a hospital or private setting, as I practiced as a clinical psychologist. Thus, before approaching this sample, I was already aware that many of them would state that they did not have the time to complete the questionnaire. Therefore, upon introducing the study I ensured I stressed that the questionnaire took approximately 15 minutes to complete. This seems to have encouraged the medical doctors to consider participating, and contributed to data collection being accomplished. Therefore, once again my experience positively contributed to the data collection process.

I started data collection with the pre-conceived notion that medical doctors would be less willing to participate than religious leaders. To my surprise, this was not the case, as many of the medical doctors showed just as much enthusiasm; they agreed readily, and recommended other doctors to me. They showed an interest in the topic and even asked about previous research on the topic of somatization disorder in Trinidad. I was able to identify with the medical doctors professionally, as, when I was asked to take part in research (as a participant) I too was often delighted to be able to contribute, and add to my knowledge about the topic being investigated.

Moreover, it was not only interested in the medical doctors who were interested in occurrences of somatization disorder in Trinidad, but some of the religious leaders, after completing the questionnaire also asked for more information about somatization disorder. Here I drew on my past experience as a lecturer and also a psychologist, as many times when diagnosing clients, I often had to educate them about the ailment. I then proceed to inform them about the limited research in this area in the Caribbean and about the studies conducted by Kassiram and Maharajh (2010) and Maharajh et al., (2010). Thus, having published work on the topic contributed to the research process and also helped my role as a researcher to be more explicit.

Emotions

Data collection for this study was very different compared to studies one and two: as none of the participants stated that they had either somatic symptoms or domestic violence experiences. What some participants did divulge to me was their encounter with women whom they met who had either somatic symptoms or domestic violence experiences. It was mostly the religious leaders who spoke about this. For example, one of the pundits (Hindu Priest) spoke about his role in assisting women in abusive relationships to 'escape'. He stated that he would often refer women to 'safe houses', by finding appropriate housing for them or provide counselling to both the women and/or family. He was very passionate about helping women in this situation and spoke at length; it appeared to me that he was pleased to have someone with a background with work in domestic violence to speak with. Thus, I provided support by listening to his experiences. I adopted the body position, facial expression and verbal cues necessary for him to feel comfortable to talk, while at the same time not allowing too much, as I was not the psychologist but researcher in this context. Therefore, I listened and then referred him to some of the agencies listed on the debriefing sheet in the event he needed to speak further with someone about his experiences.

Additionally, I was pleased to hear a religious leader speak about domestic violence as something that should be addressed, and not 'swept under the rug' or seen as a 'private matter'. I felt encouraged that with more research and educational programs that someday more people will be willing to deal with such matters (e.g. calling the police); by so doing help individuals who are in abusive situations. Therefore, according to some experts in critical reflexivity, while

it may be expected for the researcher to distance his/her self emotionally from the situation in some cases, in order to be 'objective', it may be beneficial to acknowledge their own feelings and emotions (D'Cruz et al. 2007). By so doing, the researcher gains insight into the formulation of their own interpretation and influences of the situation and is therefore better able to critically reflect on the process. Thus, I believed I was able to achieve this by acknowledging my own role in the religious leader telling his story, while at the same time recognizing my effect on the situation.

Summary

The research process for study three was similar in some ways to studies one and two, but very different in other respects. This study utilized questionnaires as with study one, and also required that I draw on the interviewing skills I employed in study two. However, the questionnaire for this study was much shorter and thus, participants did not seem overwhelmed. Importantly, it did not require participants to divulge personal information as with studies one and two. As a result of collecting data for studies one and two personally, data collection for this study, even though for 100 participants, was more relaxed. I now had a better understanding of what the process entailed.

8:7 Discussion

Now that all three studies are complete, I shall now reflect upon how the entire process has impacted on me. Having to critically reflect on this entire research process has helped me to understand the deeper domains of human experience (Freshwater et al., 2001). Thus, successful data collection would not have been possible without the help of all the gatekeepers; they truly worked to ensure that it was accomplished. Actually, in reflecting, I felt blessed as I knew I was surrounded by people who cared about me, although I did not realize how much. Also, some of the gatekeepers did not know me personally, but they helped me as if they did; this made me feel really fortunate. The data collection process not only assisted in me learning about somatization disorder and domestic violence, but also that I have people on whom I can depend. Additionally, data collection also enabled me to put into practice some of my skills as a psychologist and lecturer out of the designated settings. I was able to use these skills in an area that I had not anticipated.

Additionally, critical reflexivity is a process of watching outward to the cultural pieces and social situations that contribute to the formation of our thoughts, while at the same time challenging the processes we use to make sense of the world we live in (Cunliffe at al., 2005; D'Cruz et al., 2007; Finlay 2002a; Freshwater et al., 2001). Thus, I realized that even though previous research and this present thesis have shown that Indo-Trinidadian women do experience more domestic violence and tend to somatize their distress more than Afro-Trinidadian women, I am undecided if this is as a result of Afro-Trinidadians having been traditionally taught to be strong, independent, assertive and outspoken, whereas Indo-Trinidadians have been raised to be passive, obedient and conscientious and are seen as docile, submissive and clandestine (Maharajh, 2010). In my personal experiences, I have grown up among assertive and independent Indo-Trinidadian women, who have taken a stance against domestic violence. Thus, I believe that this opinion may be flawed in many ways; I endeavor to investigate if this premise might be true. Furthermore, being an Indo-Trinidadian female and growing up in an environment where independence was taught I am of the opinion that there are many other Indo-Trinidadians who are being socialized in a similar manner. Also, many of my female Indo-Trinidadian relatives and friends have similar upbringings as myself, therefore, this stirs the impression in me that the belief that Indo-Trinidadian women are more docile, was a traditional one. This perception may change in the future as a new generation of Indo-Trinidadian women teaching their children different values.

Also, I believe that there are various factors that have contributed to my thinking regarding my views about persons of different ethnicities. First, that I have grown up in an environment that did not promoted racial discrimination (family), having many relatives and friends of different ethnicities and my own spiritual beliefs. I have many relatives who are of mixed ethnicity, Afro-Trinidadian, as well as other ethnicities and they are not aggressive, as suggested my Maharajh (2010); therefore, I am further inclined to refute his comment. Afro-Trinidadians in general that I know either at a personal or professional level have been very kindhearted and patient with me. Thus, I am further persuaded to state that the findings of this thesis are accurate that both Indo- and Afro-Trinidadian women do in fact experience not only somatization of distress or experiences of domestic violence in a similar manner; but also general issues.

Also, I am also of the opinion that my own faith in God has also positively impacted on my views of people in general. Growing up I was thought that God views all persons as equal regardless of their social status, ethnicity, educational level etc. I have taken this teaching to heart and have practiced this in my daily life. The peace that I have obtained from this has resounded throughout all aspects of my life and I am confident that it shall continue. This may be one of the reasons that the suggestion to include religious leaders as part of this thesis appealed to me. I believe that my own personal opinions did not negatively impact on the research process, but it did serve to strengthen my faith in God. For example, in study two (IPA analysis of help-seeking) many of the women expressed that it was their faith in God that helped them through their challenging times. Thus, re-confirming my own experiences that faith helps a person at many levels. Several researchers have also reported that faith in a higher being assists individuals cope with stressful situations and experiences (e.g. Coyle, 2001; Giesbrecht & Sevcik, 2000; Sisley et al., 2011).

Thus, the entire research process served to further educate me about women who have somatization disorder and domestic violence experiences. I gained more in-depth knowledge about their experiences, and how they cope. Also, I gained even more respect for women with these experiences. As noted in study two, I became very appreciative of the women. They did not come to an office for help, but instead told their stories to a stranger for the sake of research. Thus, I close data collection being more knowledgeable about not only the topics being studied, but also the personal everyday challenges some women experience and how religious leaders and medical doctors devote their lives to helping others. Additionally, the process of having to reflect on the research process has indeed opened my way of thinking. According to Cunliffe and Jun (2005) reflection is "an act of reason turned inward" (p. 229). Consequently, reflecting has helped to show me how my own personal feelings may impact on others. Moreover, the process of self-reflection has enabled me to make more sense of my lived experiences and examine my own responses to others (Cunliffe & Jun, 2005).

8:8 The End

Having completed this thesis and by extension my PhD, I have grown in many ways. Through experiences, such as, having to wake up and get to university in the freezing cold weather to

dealing with the actual writing of this thesis. My experiences professionally of counseling women who have somatic symptoms and domestic violence experiences helped me tremendously throughout my PhD. I would admit that nothing occurred that was surprising to me. That is, my interactions with the women and other professionals who participated were 'comforting'. I used the word comforting because I felt that it was an extension of my previous job experiences. While I may view this as a positive, many may be inclined to state otherwise, as I have often been told that I may be 'hiding' behind my professional experiences and not being forthcoming about my 'real' personal feelings; I tend to disagree. As mentioned above nothing happened throughout data collection that was shocking or disturbing to me. Additionally, I am of the opinion that I should be the one who decides what and to whom I should disclose certain information to. Thus, I have tried my best to manage this and produce reflexivity that may be helpful to others reading. I also do believe that I have to a great extent 'opened up' more regarding this; whether this is enough I am not inclined to say at this point.

However, if you asked if this PhD has changed me in anyway - my answer would be yes! The reason being, my maturity in dealing with people in general has developed, I gained a deeper understanding of experiences of somatization disorder and domestic violence. Importantly, I now have a better understanding of the true effect I may have on person seeking assistance for these intersecting issues. I am now (especially through IPA) able to appreciate the entire process of help-seeking for women, as through IPA I had to view the women's experiences through their lens. Previously I would have concentrated mostly on the issues for which the women came for assistance. Now, I am mindful of the entire process and truly believe this will significantly help me in the counselling field, should I decide to pursue this option again. Additionally, I have also learnt many things about myself, in terms of, how to meet and treat with persons both professionally and personally. Consequently, having to critically reflect on this entire PhD process enabled me to generate "theory from one incident that is generalizable to other incidents and situations" (D'Cruz et al., 2007, p. 83). Thus, I have also been able to reconstitute how I act and reshape the manner in which I view others and interact with them (Ferguson, 2003). Moreover, reflexivity may be viewed as an alternative method of achieving 'ethical and intellectually sound research' ((D'Cruz et al., 2007). Thus, I am of the opinion that by engaging in this "muddy and (sometimes) ambiguous" (Finlay, 2002a) task, I have achieved transparency

and have enabled others and myself the ability to make sense of themselves in relation to others (Cunliffe & Jun, 2005) ensuring that this research is indeed "ethical and sound'.

Overall, I am satisfied with my decision to pursue a PhD, and specifically with the topic investigated as I am of the opinion that these findings will positively impact on the overall health and social services available in Trinidad for these intersecting issues.

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Appendices

Appendix A: Calculation of Number of Participants for each Administrative Boundary (County)

Administrative Boundary (County)	Total Female Population for that County	Total Female Population for Trinidad	Persons per County to be surveyed	Persons per County to be surveyed (rounded up)
St. George	*276,087	**601,999	68.79	69
Caroni	114,807	601,999	28.61	29
Victoria	73,506	601,999	18.32	18
St. Patrick	90,167	601,999	22.46	22
Nariva/Mayaro	15,501	601,999	3.86	04
St. Andrew/St. David	31,931	601,999	7.95	08
TOTAL				150

*An example illustrating how the number of participants was calculated for each county:

276,087 ÷ 601,999 × 100 = 45, 8617

45, 8617 ÷100 × 150 = 68.79

** Total female population for Trinidad = 601,999

Appendix Ba: Questionnaire: Section A (Demographics)

SECTION A

This section is designed to gather some general information about you. This information will not be used to identify you but instead look for trends, for example among women of different ages.

Please tick the appropriate answer or write you answer where indicated.

1. Please state your age.

_____

2. Which ethnic group do you belong to?

1. Afro – Trinidadian ☐
2. Indo – Trinidadian ☐
3. Other, please specify _____

3. What is your current marital status?

1. Married ☐
2. Single ☐
3. Divorced ☐
4. Widowed ☐
5. Common-Law ☐
6. Visiting ☐
7. Other , please state_____

4. Please indicate how long you have been in the above relationship:

1. Zero to six months
2. Seven months to one year
3. One to five years
4. Six to ten years
5. Eleven to twenty years
6. More than twenty years

5. How many children do you have?

1. None
2. One
3. Two
4. Three
5. Four
6. More than four

6. In which of the counties below do you live?

1. St. David	
2. St. Andrew	
3. Nariva	
4. Mayaro	
5. St George	
6. Caroni	
7. Victoria	
8. St. Patrick	

7. Level of education achieved (please tick all that apply)

1. Primary	
2. Secondary	
3. Tertiary	
4. None	

8. Are you currently employed?

1. Yes	
2. No	

9. Briefly state what type of job you currently do:

_____

_____

10. How much money do you earn per year?

1. Less than $10,00.00	
2. $10,000 to $20,000	
3. $21,000 to $40,000	
4. $41,000 to $60,000	
5. $61,000 to 80,000	
6. $81,000 to $100,000	
7. More than $100,000	

11. Which religion do you belong to?

1. Hindu	
2. Muslim	
3. Presbyterian	
3. Baptist	
4. Roman Catholic	
5. Pentecostal	
6. Anglican	
7. None	
8. Other	

Please state_____

12. What is your sexual orientation?

1. Heterosexual
2. Lesbian
3. Bisexual

Appendix Bb: Questionnaire: Section B (General Help-Seeking Sources)

SECTION B
The following questions are designed to find out about your general help seeking options.

Please indicate your answer by ticking the appropriate box or writing your answer where required.

1. In general when you experience any problems do you more often than not seek help from another individual/institution?

1. Yes ☐
2. No ☐

If your answer is yes please continue to question two. If you answered no please continue to section C of this questionnaire.

2. If you have sought help please indicate ALL the sources by ticking yes or no and write in the space a brief description of the problem, for example, medical, spiritual etc.

Source of help	Yes	No	Reason for seeking help
Religious Leader (For example, priest, pundit, Imam)			
Medical Doctor			
Police			
Family/Relative			
Government Organization (for example, hospital)			
Non-Governmental Organization (for example, Families in Action)			
Counselor			
Other, Please specify_____			

3. If you sought help from a religious leader please indicate from which religious background the leader was from.

1. Christian ☐
2. Hindu ☐
3. Muslim ☐
4. Other, please specify _____

4. From all of the sources of help above please explain which was the most helpful to you and why.

_____

_____

_____

5. From all of the sources of help you sought which do you think was the least helpful and why?

_____

_____

_____

_____

6. Do you think the help you received influenced whether you decided to seek further assistance?

If yes, please explain _____

_____

_____

If no, please explain _____

_____

Appendix Bc: Questionnaire: Section E (Coercive Control Measure For Intimate Partner Violence)

SECTION E

This section will be made up of the items from the coercive control scale that will be used to measure women's experience of domestic violence

Answer the following questions in relation to your current intimate partner if you have one - or your most recent intimate partner if you are not currently in an intimate relationship.

Sometimes people demand things from their intimate partners even without saying it in words. We are interested in knowing what your partner has demanded from you.
Please shade the appropriate answer

Question: In the last 12 months of your current or most recent relationship, did YOUR PARTNER demand something related to		
Personal activities/Appearance		
1. Leaving the house (e.g. not want you to leave).---------->	O Yes	O No
2. Eating.---------->	O Yes	O No
3. Sleeping in certain places or at certain times.---------->	O Yes	O No
4. Wearing certain clothes.---------->	O Yes	O No
5. Maintaining a certain weight.---------->	O Yes	O No
6. Using TV, radio, or the internet.---------->	O Yes	O No
7. Viewing sexually explicit material.---------->	O Yes	O No
8. Bathing or using the bathroom---------->	O Yes	O No
9. Answering the phone.---------->	O Yes	O No
10. Reading certain things.---------->	O Yes	O No

Support / Social life / Family

11. Talking on the phone.----------> O Yes O No

12. Spending time with friends or family members.----------> O Yes O No

13. Going to church, school, or other community activities.---------> O Yes O No

14. Talking to a counselor, clergy, or someone else about personal or family matters.----------> O Yes O No

15. Taking care of dependent relatives.----------> O Yes O No

16. Taking care of pets.----------> O Yes O No

Question: In the last 12 months of your current or most recent relationship, did YOUR PARTNER demand something related to

Household

17. Taking care of the house.----------> O Yes O No

18. Buying or preparing foods.----------> O Yes O No

19. Living in certain places.----------> O Yes O No

Work / Economic / Resources

20. Working.----------> O Yes O No

21. Spending money, using credit cards or bank accounts.----------> O Yes O No

22. Learning another language.----------> O Yes O No

23. Going to school.----------> O Yes O No

24. Using the car or truck.----------> O Yes O No

Health

25. Using street drugs.----------> O Yes O No

26. Using alcohol.----------> O Yes O No

27. Going to the doctor.----------> O Yes O No

28. Taking medication or prescriptions drugs.----------> O Yes O No

Intimate Relationship

30. Spending time with your partner.----------> O Yes O No

31. Separating or leaving the relationship.----------> O Yes O No

29. Talking to your partner.----------> O Yes O No

32. Having sex.----------> O Yes O No

33. Using birth control/condoms.----------> O Yes O No

34. Doing certain sexual behaviors.----------> O Yes O No

35. Having sex in exchange for money, drugs, or other things.------> O Yes O No

36. Photographing you nude or while having sex.----------> O Yes O No

Question: In the last 12 months of your current or most recent relationship, did YOUR PARTNER demand something related to

Legal

37. Talking to police or lawyer.----------> O Yes O No

38. Doing things that are against the law.----------> O Yes O No

39. Carrying a gun or knife.----------> O Yes O No

40. Talking to landlord or housing authorities.----------> O Yes O No

Immigration (Answer only if you are an immigrant to this country)

41. Filing citizenship papers.----------> O Yes O No

42. Talking to the immigration authorities.----------> O Yes O No

43. Immigration sponsorship.----------> O Yes O No

Children / Parenting *(If no children skip to question #49)*

44. Taking care of children.----------> O Yes O No

45. Disciplining the children.----------> O Yes O No

46. Making every day decisions about the children.----------> O Yes O No

47. Making important decisions about the children.----------> O Yes O No

48. Talking to child protection authorities.----------> O Yes O No

Please list any other expectations or expectations by your partner.

49. _____

50. _____

In the last 12 months of your current or most recent relationship, did YOUR PARTNER make you think that he/she MIGHT do the following IF you didn't do what he/she wanted?

Please shade the appropriate answer

Harm to you

1. Say something mean, embarrassing or humiliating to you.-------> O Yes O No
2. Keep you from seeing or talking to family or friends.---------> O Yes O No
3. Tell someone else personal or private information about you---> O Yes O No
4. Keep you from leaving the house.-----------------------------> O Yes O No
5. Limit your access to transportation.-------------------------> O Yes O No
6. Physically hurt you.---> O Yes O No
7. Try to kill you.---> O Yes O No
8. Scare you.---> O Yes O No
9. Have sex with someone else.----------------------------------> O Yes O No
10. Leave the relationship or get a divorce.--------------------> O Yes O No
11. Not let you take medication.-------------------------------> O Yes O No
12. Put you in a mental hospital.------------------------------> O Yes O No
13. Cause you to lose your job.--------------------------------> O Yes O No
14. Keep you from going to work.-------------------------------> O Yes O No
15. Cause you to lose your housing.----------------------------> O Yes O No
16. Hurt you financially.--------------------------------------> O Yes O No
17. Cause you legal trouble.-----------------------------------> O Yes O No

18. Have you arrested.----------> O Yes O No

19. Threaten to have you deported.----------> O Yes O No

20. Force you to engage in unwanted sex acts.----------> O Yes O No

21. Force you to participate in or observe sex acts with others.--> O Yes O No

22. Destroy legal papers.----------> O Yes O No

23. Destroy or take something that belongs to you.----------> O Yes O No

In the last 12 months of your current or most recent relationship, did YOUR PARTNER make you think that he/she MIGHT do the following IF you didn't do what he/she wanted?

Please shade the appropriate answer

Harm to you

24. Physically hurt or kill your pet or other animal.------> O Yes O No

25. (Skip if no children) Not let you see your child or take your children from you.----------> O Yes O No

Harm to Partner

26. Threaten to commit suicide.----------> O Yes O No

27. Actually attempt to harm or kill himself/herself.------> O Yes O No

Harm to others

28. Say something mean or hurtful to your friends or family members.----------> O Yes O No

29. Physically hurt a friend or family member----------> O Yes O No

30. Try to kill a friend or family member.----------> O Yes O No

31. Destroy property of family members or friends----------> O Yes O No

Please list any other things that your partner lead you to believe he/she might do if you did not do what he/she wanted.

32.Other_____

Question: During the last 12 months of your current or most recent relationship has YOUR PARTNER made you think that he or she would get anyone to help him/her to enforce a demand?

Please shade the appropriate answer

O Yes If yes, who (e.g. Friends, Kids)

O No

In this section, you will be asked questions about whether you may have experienced the following during the last 12 months of your current or most recent intimate relationship. Please shade "yes" or "no"

1. My partner grabbed me.----------> O Yes O No

2. My partner pushed or shoved me.----------> O Yes O No

3. My partner threw something at me that could hurt----------> O Yes O No

4. My partner slapped me.----------> O Yes O No

5. My partner twisted my arm or hair.----------> O Yes O No

6. My partner kicked me ----------> O Yes O No

7. My partner punched or hit me with something that could hurt.----------> O Yes O No

8. My partner slammed me against a wall.----------> O Yes O No

9. My partner choked or strangled me.----------> O Yes O No

10. My partner burned or scalded me on purpose.----------> O Yes O No

11. My partner beat me up.----------> O Yes O No

12. My partner used or threatened to use a knife or gun.----------> O Yes O No

13. My partner forced me to have sex.----------> O Yes O No

14. My partner used threats to make me have sex.----------> O Yes O No
O Yes O No

15. My partner refused to wear a condom during sex.----------> O Yes O No

16. I had sex because I was afraid of what might happen if i didn't.----------> O Yes O No

17. I felt physical pain that still hurt the next day because of my partner's abuse.----------> O Yes O No

18. I had a sprain, bruise, or small cut because of my partner's abuse.----------> O Yes O No

19. I passed out from being hit on the head by my partner.----------> O Yes O No

20. I had a broken bone from my partner's abuse.----------> O Yes O No

21. I went to a doctor because of my partner's abuse.----------> O Yes O No

22. When was the FIRST time you experienced ANY of these types of abuse from ANY intimate partner?
☐ years ago (if less than 1 year ago, shade this circle in ---> O

In the last 12 months of your current or most recent relationship has your partner done the following.

Pleases shade "yes" or "no"

Question: In the last year…

1. My partner called me names.----------> O Yes O No

2. My partner swore at me.----------> O Yes O No

3. My partner yelled and screamed at me.----------> O Yes O No

4. My partner treated me like I was less than he or she is.-------> O Yes O No

5. My partner watched over my activities and insisted I tell him or her where I was at all times.----------> O Yes O No

6. My partner used our money or made important financial decisions without talking to me about----------> O Yes O No

7. My partner was jealous or suspicious of my friends.----------> O Yes O No

8. My partner accused me of having an affair.----------> O Yes O No

9. My partner interfered with my relationships with other family members.----------> O Yes O No

10. My partner tried to keep me from doing things to help myself.----------> O Yes O No

11. My partner controlled my use of the telephone.----------> O Yes O No

12. My partner told me my feelings were crazy.----------> O Yes O No

13. My partner blamed me for his/her problems.----------> O Yes O No

14. My partner tried to make me feel crazy.----------> O Yes O No

Appendix Bd: Questionnaire: Section D (Help-Seeking Sources for Experiences of Domestic Violence)

SECTION F

Please continue to think about the questions you have just answered, the following questions relate to the issues covered in those questions. Specifically the following questions are designed to find out more about whether you sought any help for those experiences and if so where from.

Please indicate you answer by ticking the appropriate box or writing your answer where required.

1. Have you ever experience any of the behaviours described in the above questionnaire you just completed?

3. Yes ☐
4. No ☐

If your answer is yes please continue to question two. If you answered no, you have finished this survey and thank you very much for your participation.

2. Please list ALL the behaviours that you have experienced.

_____

_____

_____

_____

_____

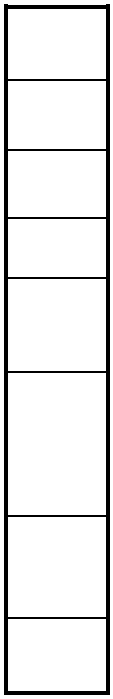
3. Have you ever sought help for any of the above?

1. Yes ☐
2. No ☐

If your answer is yes please continue to question four. If you answered no, you have finished this survey and thank you very much for your participation.

4. If you have sought help please indicate ALL the sources by ticking the appropriate box:

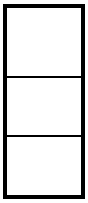
1. Religious Leader
2. Medical Doctor
3. Police
4. Family/relative
5. Government Organization
   (For example, Hospitals)
6. Non-Governmental Organization
   (For example, Trinidad and Tobago Coalition
   For Domestic Violence)
7. Counselor
8. Other



Please state to other source(s)
_____

5. If you sought help from a religious leader please indicate from which religious background the leader was from.

5. Christian
6. Hindu
7. Muslim



8. Other, please specify _____

6. From all of the sources of help above please explain which was the most helpful to you and why.

_____

_____

_____

7. From all of the sources of help you sought which do you think was the least helpful and why?

_____

_____

_____

_____

8. Do you think the help you received influenced whether you decided to seek further assistance?

If yes, please explain _____

_____

_____

If no, please explain _____

_____

9. Have you ever heard about Domestic Violence?

1. Yes ☐
2. No ☐

10. If yes, please briefly explain what this is

_____

_____

_____

_____

Appendix Be: Questionnaire: Section F (Help-Seeking Sources for Somatization Disorder)

SECTION D

Please continue to think about the questions you have just answered, the following questions relate to the issues covered in those questions. Specifically the following questions are designed to find out more about whether you sought any help for those symptoms and if so where from.

Please indicate you answer by ticking the appropriate box or writing your answer where required.

1. Have you ever experienced symptoms described in the last 18 questions you just completed?

1. Yes ☐
2. No ☐

If you answered yes to the above question please go to question 2 below. If you answered no, please go to section D of this questionnaire.

2. Did you seek help for any of these symptoms?

1. Yes ☐
2. No ☐

If you answered yes to the above question please go to question 3 below. If you answered no, please go to section D of the questionnaire.

3. If yes, which symptoms did you seek help for? (please list all that apply)

_____

_____

_____

_____

4. For each symptom please tick where you sought help from.

Symptom	**Source of help sought**							
	Religious Leader	Medical Doctor	Police	Family/ Relative	Government Organization (e.g. Hospital)	Non-Government Organization (e.g.T&T Coalition for Domestic Violence	Counselor/ Psychologist	Other (please specify)
Faintness/ Dizziness								
Nervousness or shakiness								
Pains in the heart or chest								
Feeling no interest in things								
Feeling lonely								
Feeling tense								
Nausea/ upset stomach								
Feeling blue								
Trouble getting your breath								
Scared for no reason								
Feelings of worthlessness								
Spells of sudden terror or panic								

4 con't: For each symptom please tick where you sought help from.

Symptom	**Source of help sought**							
	Religious Leader	Medical Doctor	Police	Family/ Relative	Government Organization (e.g. Hospital)	Non-Government Organization (e.g.T&T Coalition for Domestic Violence	Counselor/ Psychologist	Other (please specify)
Numbness/ tingling in parts of your body								
Feelings of hopelessnes s about the future								
Feeling so restless that you can't sit still								
Feeling weak in parts of your body								
Thoughts of ending your life								
Feeling fearful								

5. If you sought help from a religious leader please indicate from which religious background the leader was from.

1. Christian ☐
2. Hindu ☐
3. Muslim ☐
4. Other, please specify _____

6. From all of the sources of help above please explain which was the most helpful to you and why?

_____

_____

_____

_____

7. From all of the sources of help you sought which do you think was the least helpful and why?

_____

_____

_____

_____

8. Do you think the help you received influenced whether you decided to seek further assistance?

If yes, please explain _____

_____

If no, please explain _____

_____

9. Have you ever heard the term "Somatization Disorder"?

1. Yes ☐
2. No ☐

10. If yes, please state what it might be.

_____

_____

Appendix C: Administrative Boundaries and Gate Keepers

Administrative Boundary (Counties)	Gate Keeper
1. St. David	Corporal Sheldon Kassiram
2. St. Andrew	Mrs. Margaret Gopaul - Mohammed (Teacher)
3. Nariva	Mrs. Florence Nunu (Teacher)
4. Mayaro	Corporal Sheldon Kassiram
5. St. George	Mrs. Margaret Chatoor(Counselor)/ Professor Hari Maharajh
6. Caroni	Professor Hari Maharajh
7. Victoria	Mr. Nero Doonath (Retired Teacher)
8. St. Patrick	Mrs. Sita Singh (Retired Teacher)

Appendix D: Information Sheet

Middlesex University School of Health and Social Sciences

Psychology Department

Information Sheet

Somatization and Domestic Violence

Your participation is appreciated.

Participation Number: _____

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

Who am I?

My name is Astra Kassiram and I am conducting this research as part of my doctoral studies with Middlesex University, London.

What is the title of research?

Indo and Afro- Trinidadian women's experience of domestic violence, somatization disorder and help seeking: A mixed methodological analysis.

What is the purpose of this study?

This study will seek will seek to report and compare experiences of domestic violence and somatization of distress amongst Indo and Afro Trinidadian women living in Trinidad. The study is also interested in the general types of help and support woman look for and how helpful they find any help or support they receive. A study like this one has never been done in Trinidad before, therefore the different Ministries in Trinidad will be informed and hopefully makes changes to Health Care, Education and Social Services to provide better services.

What will the study involve?

You will be required to complete a questionnaire which has five sections. The sections ask questions about your age, ethnicity, educational level, general and specific help seeking options, various symptoms such as, stomach aches you may have experienced and your encounter with domestic violence.

It should take you no longer than one hour to complete; there are no right or wrong answers; I simply want your opinion. When you have finished the questionnaire there will be an opportunity for you to further discuss the study with me, in order to fully address any questions or concerns you may have.

Why should I take part?

Not only will you be helping me personally with my PhD, but you will also be contributing to the collection of human knowledge about this topic, and so benefiting society as a whole. A study of this kind has so far never been done in Trinidad and therefore you will be helping in the growth of the nation.

Additionally, you may also find the experience of participating in an academic study to be personally interesting.

Why shouldn't I take part?

Participating in the study will use up some of your time, for which you will not receive any financial compensation. Additionally, whilst the questionnaires will not specifically ask about topics of a sensitive nature, there is some possibility that you may find recounting certain events to be emotionally troubling.

What if I decide not to take part?

Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decide to take part you may withdraw at any time without giving a reason.

What if I change my mind part way through the survey?

You are totally free to withdraw your participation at this point without prejudice.

What if I change my mind after the interview?

You can withdraw any data that has not yet been published at any point following completing the questionnaire, via the contact details below. You just need to make sure you remember your participation number and you information will be completely destroyed.

Will this study be properly conducted?

I am doing my PhD at Middlesex University in England and all proposals for research using human participants are reviewed by an Ethics Committee at this university before they can proceed. The Middlesex Psychology Department's Ethics Committee has reviewed this proposal. The risks in participating in this study are minimal as no identifying information about you will be released to the public. All data collected will coded to protect the identity of participants and the coded information securely stored in a password protected file on a password protected computer

Informed Consent prior to participation?

Before you participate you will be asked to sign a consent form (like the one on the next page) which will show that you understand what you are taking in part in and what the information you provide will be used for.

What if I have further questions or concerns?

If you have any questions about participating in this study please do not hesitate to contact Ms. Astra Kassiram at 07931718288 (UK) or 18687801336 (T&T); a.kassiram@mdx.ac.uk or my supervisor Dr. Miranda Horvath (m.horvath@mdx.ac.uk).

Thanking you for your time.

Yours sincerely,

Ms. Astra Kassiram
Doctoral Student
Department of Psychology
Middlesex University
United Kingdom

Appendix E: Informed Consent

Middlesex University School of Health and Social Sciences
Psychology Department

Written Informed Consent

Participation Number: _____

Title of study: **Indo- and Afro-Trinidadian women's experience of domestic violence, somatization disorder and help seeking: A mixed methodological analysis.**

I have understood the details of the research as explained to me by the researcher and in the information sheet, confirm that I have consented to act as a participant.

I have been given contact details for the researcher in the information sheet.

I understand that my participation is entirely voluntary, the data collected during the research will not be identifiable, and I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.

I further understand that the data I provide may be used for analysis and subsequent publication, and provide my consent that this might occur.

_____ _____

Print name Sign Name

Date: _____

To the participants: Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Social Sciences Ethics committee of Middlesex University, if required by institutional audits about the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you do not wish your data to be included in audits: _____

If you have any questions about participating in this study please do not hesitate to contact Ms. Astra Kassiram at 07931718288 (UK) or 18687801336 (T&T); a.kassiram@mdx.ac.uk or my supervisor Dr. Miranda Horvath (m.horvath@mdx.ac.uk).

Appendix Fa: Debriefing Sheet for Non-Returning Participants

Debriefing Information

Research on Indo- and Afro-Trinidadian women's experience of domestic violence, somatization disorder and help seeking: A mixed methodological analysis.

Participation Number: _____

Thank you very much for taking part in my study, I hope you found it an interesting experience.

What if I want to know more about the study?

If you have any further questions or concerns about this study then I would be happy to discuss them now.

Alternatively, if you would like to discuss any aspect of the study at some point in the future then please contact either myself or my supervisor as detailed below.

What if I change my mind later?

You can partially or completely withdraw your data from this study at any point in the future, provided it has not yet been published. To do so please contact either myself or my supervisor as detailed below.

What if I found the study troubling?

In the event that you find any of the issues raised by this study to be troubling then you may wish to contact one of the following individuals listed below for assistance or contact either The Trinidad and Tobago Coalition Against Domestic Violence at 624 - 0402 or Families in Action at 628 - 2333 for free counselling. Additionally, you can contact the Ministry of Community Development and Gender Affairs at 623 - 6621 or 800-SAVE for information on any of the free counselling drop-in centres in your area.

Research Contacts:

Ms. Astra Kassiram (PhD Researcher)
a.kassiram@mdx.ac.uk
Telephone Numbers: 07931718288
18687801336

Dr. Miranda Horvath (Supervisor)
m.horvath@mdx.ac.uk

Dr. Joanna Adler (Director of Studies)
j.adler@mdx.ac.uk

Dr. Susan Hansen (Supervisor)
s.hansen@mdx.ac.uk

All of whom are located in the School of Health and Social Science, Psychology Department, Middlesex University, Hendon, London, NW4 4BT

Appendix Fb: Debriefing Sheet for Potential Returning Participants

Debriefing Information

Research on Indo- and Afro-Trinidadian women's experience of domestic violence, somatization disorder and help seeking: A mixed methodological analysis.

Participation Number: _____

Thank you very much for taking part in my study, I hope you found it an interesting experience.

What if I want to know more about the study?

If you have any further questions or concerns about this study then I would be happy to discuss them now.

Alternatively, if you would like to discuss any aspect of the study at some point in the future then please contact either myself or my supervisor as detailed below.

What if I change my mind later?

You can partially or completely withdraw your data from this study at any point in the future, provided it has not yet been published. To do so please contact either myself or my supervisor as detailed below

What if I found the study troubling?

In the event that you find any of the issues raised by this study to be troubling then you may wish to contact one of the following individuals listed below for assistance or contact either The Trinidad and Tobago Coalition Against Domestic Violence at 624 - 0402 or Families in Action at 628 - 2333 for free counselling. Additionally, you can contact the Ministry of Community Development and Gender Affairs at 623 - 6621 or 800-SAVE for information on any of the free counselling drop-in centres in your area.

What if I change my mind about participating in study two?

You can totally withdraw your participation in this phase of data collection by contacting the researcher through the details listed below or when you are contacted by the researcher during March 2012 you can verbally withdraw at this point without any negative consequences.

Research Contacts:

Ms. Astra Kassiram (PhD Researcher)
a.kassiram@mdx.ac.uk (can be accessed at anytime)
Telephone Numbers: 011 44 7931718288(UK) during the months of October 2011 to March 2012
1 868 780 1336 (Trinidad) during the months of July to September 2011 and April to June 2012.

Dr. Miranda Horvath (Supervisor)
m.horvath@mdx.ac.uk

Dr. Joanna Adler (Director of Studies)
j.adler@mdx.ac.uk

Dr. Susan Hansen (Supervisor)
s.hansen@mdx.ac.uk

All of whom are located in the School of Health and Social Sciences, Psychology Department, Middlesex University, Hendon, London, NW4 4BT

Appendix G: Verbal Protocol

Middlesex University School of Health and Social Sciences

Psychology Department

Verbal Protocol

Somatization and Domestic Violence

Who will be given this information?
Participants from the first study who have agreed to participate in the second phase of data collection for this thesis.

How will participants gain access to the researcher?
Participants will be given a debriefing sheet containing email and telephone numbers for the researcher outlining the various months the researcher will be in Trinidad and the United Kingdom.

What if the participant decides not to take part?

Participation in this research is entirely voluntary. The participant does not have to take part if she does not want to. If she decides to take part she may withdraw at any time without giving a reason by contacting the researcher with their participation number through the details given on the debriefing sheet.

What if the participant changes her mind part way through the survey?

The participant is totally free to withdraw her participation at this point without prejudice, she just needs to contact the researcher via one of the identified options with her participation number and her information will be destroyed.

What if the participant changes her mind after the interview?

The participant can withdraw any data that has not yet been published at any point following completing the questionnaire, via the contact details below. She just needs to make sure you remember your participation number.

How will the researcher keep in contact with the participant?

It will be agreed upon during the initial data collection phase that the researcher will call the participant during the month of March 2012 on her personal mobile, if the participant does not answer no voice message will be left and the researcher will try again at a later date within the same month. If the participant answers the phone but indicates she is unable to speak at this time the researcher will contact her again the following day.

What will the researcher say to the participant during the phone call?

The research will use the following dialogue:

"Hello, I am Astra Kassiram, the PhD student you had you interview with last July/August/September 2011at the community center/church hall, is this a good time to speak with you?" If the participant states this is not an appropriate time then the researcher will follow the agreed protocol above but if the

participant agrees to speak then the researcher will then ask *"I would like to ask if you are still willing to participate in the second part of the study that we discussed?"*

If the participant says no, then the researcher will thank her for her time and contact another participant. If the participant agrees to continue in the study then she will be asked the following:

"Can you please let me know when at the beginning of April (2012) it will be convenient to contact you to arrange another meeting for the interview".

After this date has been agreed upon, when the researcher arrives in Trinidad at the beginning of April 2012 she will contact the participant with the potential location, date and time of the interview. Again, if the participant cannot speak freely at this point she will be contacted the following day. At this point the participant still free to withdraw from the study without any negative consequences.

Appendix Ha: Ethics Approval Forms for Study One

PSY.OFFICE:Study Reference Number 189/JG 1

Middlesex University, Department of Psychology

REQUEST FOR ETHICAL APPROVAL (STUDENT)

Applicant (specify): *UG PG (Module:* ***MPhil/PhD*** *Date submitted:...12th DECEMBER 2012.....*

Research area (please circle)				
Clinical	Cognition + Emotion	Developmental	**Forensic**	Health
Occupational	Psychophysiological	Social	Sport + Exercise	
Other _____			**Sensitive Topic☒**	
Methodology:				
Empirical/Experimental	**Questionnaire-based**	Qualitative	Other _____	

No study may proceed until this form has been signed by an authorised person indicating that ethical approval has been granted. For collaborative research with another institution, ethical approval must be obtained from all institutions involved.

This form should be accompanied by any other relevant materials (e.g. questionnaire to be employed, letters to participants/institutions, advertisements or recruiting materials, information and debriefing sheet for participants[1], consent form[2], including approval by collaborating institutions).

- Is this the first submission of the proposed study? **Yes**/No
- Is this an amended proposal (resubmission)? Yes/**No**
  Psychology Office: If YES, please send this back to the original referee
- Is this an urgent application? (To be answered by Staff/Supervisor only)[1] **Yes**/No

Supervisor to initial here ____S.H._____

Name(s) of investigator: Ms. Astra Kassiram

Name of Supervisor (s) :
Dr. Miranda Horvath; Dr. Susan Hansen; Dr. Paul de Mornay Davies

Title of Study:
Help agencies understanding and intervention for women with somatization disorder and domestic violence

Results of Application:

REVIEWER – please tick and provide comments in section 5.

[1]See Guidelines on MyUnihub

[1,2,3,4,5,6,7]**Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

PSY OFFICE:Study Reference Number _____ 2

APPROVED	APPROVED SUBJECT TO AMENDMENTS	APPROVED SUBJECT TO RECEIPT OF LETTERS	NOT APPROVED

SECTION 1

1. Please attach a brief description of the nature and purpose of the study, including details of the procedure to be employed. Identify the ethical issues involved, particularly in relation to the treatment/experiences of participants, session length, procedures, stimuli, responses, data collection, and the storage and reporting of data.

SEE ATTACHED PROJECT PROPOSAL

2. Could any of these procedures result in any adverse reactions? YES/NO

If "yes", what precautionary steps are to be taken?

respondent will be given an information sheet describing the nature of the study, risks involved in participating and they are free to withdraw from the study at any point without prejudice.They will then be presented with an informed consent to sign; online participants will be required to tick a box on the informed consent page. On completion of the questionnaire each participant will be given a debriefing sheet which includes free help agencies in Trinidad if they feel distress about anything that may have presented during the study. The information sheet, informed consent and debriefing sheet are all attached to this proposal.

3. Will any form of deception be involved that raises ethical issues? YES/**NO**

(Most studies in psychology involve mild deception insofar as participants are unaware of the experimental hypotheses being tested. Deception becomes unethical if participants are likely to feel angry, humiliated or otherwise distressed when the deception is revealed to them).

Note: if this work uses existing records/archives and does not require participation per se, tick here ..... and go to question 10. (Ensure that your data handling complies with the Data Protection Act).

4. If participants other than Middlesex University students are to be involved, where do you intend to recruit them? *(A full risk assessment must be conducted for any work undertaken off university premises)*[5,7]

Participants will be medical doctors and religious leaders from the eight administrative counties in Trinidad. For a detailed explanation about recruitment please see the attached proposal.

5a. Does the study involve:

Clinical populations	YES/**NO**
Children (under 16 years)	YES/**NO**
Vulnerable adults such as individuals with mental or physical health problems, prisoners, vulnerable elderly, young offenders?	YES/**NO**
Political, ethnic or religious groups/minorities?	YES/**NO**
Sexually explicit material / issues relating to sexuality	YES/**NO**

[1,2,3,4,5,6,7]**Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

5b. If the study involves any of the above, the researcher may need CRB (police check) Staff and PG students are expected to have CRB – please tick UG students are advised that institutions may require them to have CRB please confirm that you are aware of this by ticking here _____ Since this study is being conducted in Trinidad W.I. a CRB is not required but I have obtained the equivalent from Trinidad; a Certificate of Character	YES/NO
6. How, and from whom (e.g. from parents, from participants via signature) will informed consent be obtained? (*See consent guidelines[2]; note special considerations for some questionnaire research)* Participants completing a written questionnaire will be asked to sign an informed consent form (attached)after when they are satisfied they have obtained enough information about the study. Participants completing an online questionnaire will be required to tick a box indicating they are satisfied and understand the information provided.	
7. Will you inform participants of their right to withdraw from the research at any time, without penalty? (*see consent guidelines[2]*)	**YES**/NO

8. Will you provide a full debriefing at the end of the data collection phase? (*see debriefing guidelines[3]*)	**YES**/NO
9. Will you be available to discuss the study with participants, if necessary, to monitor any negative effects or misconceptions? If "no", how do you propose to deal with any potential problems?	**YES**/NO
10. Under the Data Protection Act, participant information is confidential unless otherwiseagreed in advance. Will confidentiality be guaranteed? (*see confidentiality guidelines[5]*) If "yes" how will this be assured *(see[5])* All data collected will coded to protect the identity of participants and the coded information securely stored in a password protected file on a password protected computer. If "no", how will participants be warned? *(see[5])* (*NB: You are not at liberty to publish material taken from your work with individuals without the prior agreement of those individuals*).	**YES**/NO
11. Are there any ethical issues that concern you about this particular piece of research, not covered elsewhere on this form? If "yes" please specify:	YES/**NO**
12. Is this research or part of it going to be conducted in a language other than English?	YES/**NO**

[1,2,3,4,5,6,7]**Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

If YES – Do you confirm that all documents and materials are enclosed here both in English and the other language, and that each one is an accurate translation of the other?	N/A

(NB: If "yes" has been responded to any of questions 2, 3, 5, 11, 12 or "no" to any of questions 7-10, a full explanation of the reason should be provided – if necessary, on a separate sheet submitted with this form).

SECTION 2 (to be completed by all applicants – please tick as appropriate)

	YES	NO
13. Some or all of this research is to be conducted away from Middlesex University	X	
If "yes" tick here to confirm that a Risk Assessment form has been submitted	X	
14. I am aware that any modifications to the design or method of this proposal will require me to submit a new application for ethical approval	X	
15. I am aware that I need to keep all the materials/documents relating to this study (e.g. consent forms, filled questionnaires, etc) until completion of my degree / publication (as advised)	X	
16. I have read the British Psychological Society's *Ethical Principles for Conducting Research with Human participants*[1] and believe this proposal to conform with them.	X	

SECTION 3(to be completed by STUDENT applicants and supervisors)

Researcher: (student signature) Ast- Kan- date 17th Dec 2012

CHECKLIST FOR SUPERVISOR – please tick as appropriate

	YES	NO
1. Is the UG/PG module specified?	X	
2. If it is a resubmission, has this been specified and the original form enclosed here?	N/A	
3. Is the name(s) of student/researcher(s) specified?	X	
4. Is the name(s) of supervisor specified?	X	
5. Is the consent form attached?	X	
6. Are debriefing procedures specified? If appropriate, debriefing sheet enclosed – appropriate style?	X	
7. Is an information sheet for participants enclosed? appropriate style?	X	
8. Does the information sheet contain contact details for the researcher and supervisor?	X	
9. Is the information sheet sufficiently informative about the study?	X	

[1,2,3,4,5,6,7]**Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

10. Has Section 2 been completed by the researcher on the ethics form?	X	
11. Any parts of the study to be conducted outside the university? If so a Risk Assessment form must be attached – Is it?	X	
12. Any parts of the study to be conducted on another institution's premises? If so a letter of acceptance by the institution must be obtained – Letters of acceptance by all external institutions are attached	N/A*	
13. Letter(s) of acceptance from external institutions have been requested and will be submitted to the PSY office ASAP.	N/A*	
14. Has the student signed the form? If physical or electronic signatures are not available an email endorsing the application must be attached.	X	
15. Is the proposal sufficiently informative about the study?	X	

*Some participants may complete the questionnaire in their place of work while the researcher is present; however their signature on the informed consent form is sufficient. List of premises to be visited will be added to Risk Assessment form (cleared by Chair of Ethics Team).

Signatures of approval:

PSY OFFICE received

Supervisor: Smith date: 14/12/12 date:

Ethics Panel: [signature] date: 18/12/12 date:

(signed pending approval of Risk Assessment form) date:

If any of the following is required and not available when submitting this form, the Ethics Panel Reviewer will need to see them once they are received – please enclose with this form when they become available:

- letter of acceptance from other institution
- any other relevant document (e.g. ethical approval from other institution):_____

PSY OFFICE received

Required documents seen by Ethics Panel: _____ date: _____ date:

[1,2,3,4,5,6,7]**Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

PSY OFFICE:Study Reference Number _____ 6

SECTION 4 (to be completed by the Psychology Ethics panel reviewers)

		Recommendations/comments
1. Is UG/PG module specified?	✓	
2. If it is a resubmission, has this been specified and the original form enclosed here?	NA	
3. Is the name(s) of student researcher(s) specified? If physical or electronic signatures are not available has an email endorsing the application been attached?	✓	
4. Is the name(s) of supervisor specified? If physical or electronic signatures are not available, has an email endorsing the application been attached?	✓	
5. Is the consent form attached?	✓	
6. Are debriefing procedures specified? If appropriate, is the debriefing sheet attached? Is this sufficiently informative?	✓	
7. Is an information sheet for participants attached?	✓	
8. Does the information sheet contain contact details for the researcher?	✓	
9. Is the information sheet sufficiently informative about the study? Appropriate style?		Please add that participants responses are confidential and anonymous
10. Has Section 2 (points 12-15) been ticked by the researcher on the ethics form?	✓	
11. Any parts of the study to be conducted outside the university? If so a fully completed Risk Assessment form must be attached – is it?	✓	
12. If any parts of the study are conducted on another institution/s premises, a letter of agreement by the institution/s must be produced. Are letter/s of acceptance by all external institution/s attached?	NA	
13. Letter/s of acceptance by external institution/s has/have been requested.	NA	
14. Has the applicant signed? If physical or electronic signatures are not available, an email endorsing the application must be attached.	✓	
15. Is the proposal sufficiently informative about the study? Any clarity issues?	✓	
16. Is anyone likely to be disadvantaged or harmed?	No	
17. If deception, protracted testing or sensitive aspects are involved, do the benefits of the study outweigh these undesirable aspects?	N/A	
18. Is this research raising any conflict of interest concerns?	No.	

[1,2,3,4,5,6,7]**Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

INDEPENDENT FIELD/LOCATION WORK RISK ASSESSMENT FRA1

This proforma is applicable to, and must be completed in advance for, the following field/location work situations:

1. *All field/location work undertaken independently by individual students, either in the UK or overseas, including in connection with proposition module or dissertations. Supervisor to complete with student(s).*
2. *All field/location work undertaken by postgraduate students. Supervisors to complete with student(s).*
3. *Field/location work undertaken by research students. Student to complete with supervisor.*
4. *Field/location work/visits by research staff. Researcher to complete with Research Centre Head.*
5. *Essential information for students travelling abroad can be found on www.fco.gov.uk*

FIELD/LOCATION WORK DETAILS

Name ...Astra Kassiram

Student No

Research Centre (staff only).....

Supervisor Dr. Miranda Horvath

Degree course ...MPhil/PhD Psychology

Telephone numbers and name of next of kin who may be contacted in the event of an accident

NEXT OF KIN

Name Mrs. Carla Kassiram – Lackhai

Phone 1 868 642 5466

Physical or psychological limitations to carrying out the proposed field/location work

.....NONE.....

Any health problems (full details) Which may be relevant to proposed field/location work activity in case of emergencies.

.....NONE.....

Locality (Country and Region)

...TRINIDAD, W.I.EIGHT ADMINISTRATVE BOUNDARIES (COUNTIES), which includes the following regions: Sangre Grande; Arima; St. Augustine, Port or Spain; San Fernando; Sipiara; Chaguanas; Mt. Hope; Couva; Penal; Diego Martin; Tunapuna; Curepe; Tacarigua; Valencia; Mayaro

Travel Arrangements

PERSONAL CAR

NB: Comprehensive travel and health insurance must always be obtained for independent overseas field/location work.

PERSONAL INSURANCE IN TRINIDAD

Dates of Travel and Field/location work **FEBRUARY TO MAY 2013**

.....

.....

PLEASE READ THE FOLLOWING INFORMATION VERY CAREFULLY

Hazard Identification and Risk Assessment

List the localities to be visited or specify routes to be followed **(Col. 1)**. For each locality, enter the potential hazards that may be identified beyond those accepted in everyday life. Add details giving cause for concern **(Col. 2)**.

Examples of Potential Hazards :
Adverse weather: exposure (heat, sunburn, lightening, wind, hypothermia)
Terrain: rugged, unstable, fall, slip, trip, debris, and remoteness. Traffic: pollution.
Demolition/building sites, assault, getting lost, animals, disease.
Working on/near water: drowning, swept away, disease (weils disease, hepatitis, malaria, etc), parasites', flooding, tides and range.
Lone working: difficult to summon help, alone or in isolation, lone interviews.
Dealing with the public: personal attack, causing offence/intrusion, misinterpreted, political, ethnic, cultural, socio-economic differences/problems. Known or suspected criminal offenders.
Safety Standards (other work organisations, transport, hotels, etc), working at night, areas of high crime.
Ill health: personal considerations or vulnerabilities, pre-determined medical conditions (asthma, allergies, fitting) general fitness, disabilities, persons suited to task.
Articles and equipment: inappropriate type and/or use, failure of equipment, insufficient training for use and repair, injury.
Substances (chemicals, plants, bio- hazards, waste): ill health - poisoning, infection, irritation, burns, cuts, eye-damage.
Manual handling: lifting, carrying, moving large or heavy items, physical unsuitability for task

If no hazard can be identified beyond those of everyday life, enter 'NONE'.

1. LOCALITY/ROUTE	2. POTENTIAL HAZARDS
1. ADVERSE WEATHER	1. FLOODING

The University Field/location work code of Practice booklet provides practical advice that should be followed in planning and conducting field/location work.

Risk Minimisation/Control Measures

PLEASE READ VERY CAREFULLY

For each hazard identified **(Col 2)**, list the precautions/control measures in place or that will be taken **(Col 3)** to **"reduce the risk to acceptable levels"**, and the safety equipment **(Col 5)** that will be employed.

Assuming the safety precautions/control methods that will be adopted **(Col. 3)**, categorise the field/location work risk for each location/route as negligible, low, moderate or high **(Col. 4)**.
Risk increases with both the increasing likelihood of an accident and the increasing severity of the consequences of an accident.

An acceptable level of risk is: a risk which can be safely controlled by person taking part in the activity using the precautions and control measures noted including the necessary instructions, information and training relevant to that risk. The resultant risk should not be significantly higher than that encountered in everyday life.
Examples of control measures/precautions:

Providing adequate training, information & instructions on field/location work tasks and the safe and correct use of any equipment, substances and personal protective equipment. Inspection and safety check of any equipment prior to use. Assessing individuals fitness and suitability to environment and tasks involved. Appropriate clothing, environmental information consulted and advice followed (weather conditions, tide times etc.). Seek advice on harmful plants, animals & substances that may be encountered, including information and instruction on safe procedures for handling hazardous substances. First aid provisions, inoculations, individual medical requirements, logging of location, route and expected return times of lone workers. Establish emergency procedures (means of raising an alarm, back up arrangements). Working with colleagues (pairs). **Lone working is not permitted where the risk of physical or verbal violence is a realistic possibility.** Training in interview techniques and avoiding /defusing conflict, following advice from local organisations, wearing of clothing unlikely to cause offence or unwanted attention. Interviews in neutral locations. Checks on Health and Safety standards & welfare facilities of travel, accommodation and outside organisations. Seek information on social/cultural/political status of field/location work area.
Examples of Safety Equipment: Hardhats, goggles, gloves, harness, waders, whistles, boots, mobile phone, ear protectors, bright fluorescent clothing (for roadside work), dust mask, etc.

If a proposed locality has not been visited previously, give your authority for the risk assessment stated or indicate that your visit will be preceded by a thorough risk assessment.

3. PRECAUTIONS/CONTROL MEASURES	4. RISK ASSESSMENT (low, moderate, high)	5. SAFETY/EQUIPMENT
1. USUALLY LOCALIZED FLOODING THAT WOULD QUICKLY SUBSIDE AFTER THE RAIN STOPS; THIS IS A USUAL OCCURANCE FOR CITIZENS OF TRINIDAD.	1. LOW	1. PROPER SHOES 2. UMBRELLA

PLEASE READ THE FOLLOWING INFORMATION AND SIGN AS APPROPRIATE

DECLARATION: The undersigned have assessed the activity and the associated risks and declare that there is no significant risk or that the risk will be controlled by the method(s) listed above/over. Those participating in the work have read the assessment and will put in place precautions/control measures identified.

NB: Risk should be constantly reassessed during the field/location work period and additional precautions taken or field/location work discontinued if the risk is seen to be unacceptable.

Signature of Field/location worker (Student/Staff) Ark-Kai ..... **Date** 17th Dec 2012

Signature of Student Supervisor Smith ..... **Date** 14/12/12 .....

APPROVAL: (ONE ONLY)

Signature of Director of Programmes (undergraduate students only) ..... **Date** .....

Signature of Research Degree Co-ordinator or ..... **Date** .....

Director of Programmes (Postgraduate)

Signature of Research Centre Head (for staff field/location workers) ..... **Date** .....

FIELD/LOCATION WORK CHECK LIST

1. Ensure that **all members** of the field party possess the following attributes (where relevant) at a level appropriate to the proposed activity and likely field conditions:

X Safety knowledge and training?

X Awareness of cultural, social and political differences?

X Physical and psychological fitness and disease immunity, protection and awareness?

X Personal clothing and safety equipment?

X Suitability of field/location workers to proposed tasks?

2. Have all the necessary arrangements been made and information/instruction gained, and have the relevant authorities been consulted or informed with regard to:

n/a Visa, permits?

n/a Legal access to sites and/or persons?

n/a Political or military sensitivity of the proposed topic, its method or location?

X Weather conditions, tide times and ranges?

X Vaccinations and other health precautions?

n/a Civil unrest and terrorism?

X Arrival times after journeys?

X Safety equipment and protective clothing?

X Financial and insurance implications?

X Crime risk?

X Health insurance arrangements?

X Emergency procedures?

X Transport use?

X Travel and accommodation arrangements?

Important information for retaining evidence of completed risk assessments:

Once the risk assessment is completed and approval gained the **supervisor** should retain this form and issue a copy of it to the field/location worker participating on the field course/work. In addition the **approver** must keep a copy of this risk assessment in an appropriate Health and Safety file.

Principal: Mr. Kendall John
Telephone: 670-8261
Date: 24th May, 2011

Toco Secondary School
Galera Road
Toco

Forensic Psychological Services
Middlesex University
School of Health & Social Services
Town Hall
The Burroughs
London NW 44BT.

Re: Approval for Use of School

Dear Madam,

Approval is given to Ms. Astra Kassiram to use Toco Secondary School to conduct interviews for the period between11th July – 2nd September 2011.

Thank you.

Yours respectfully,

Verona Davis – Modeste
Principal II (Ag)

PRINCIPAL
TOCO SECONDARY SCHOOL
GALERA ROAD
TOCO

GUAICO PRESBYTERIAN SCHOOL
EASTERN MAIN ROAD, GUAICO
TELEPHONE: 668-0644
MOTTO: *'LABOUR CONQUERS ALL THINGS'*

16th May, 2011

Ms. Astra Kassiram,
Middlesex University.
School of Health and Social Sciences,
The Town Hall The Burroughs London NW4 4BT

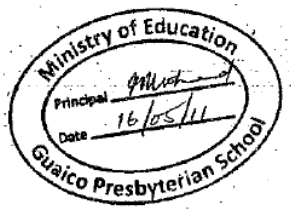
Dear Madam,

I acknowledge receipt of your letter dated 18th April, 2011 seeking permission to use the above named school in order to conduct interviews with some women of this country. Please be advised that permission has been granted and we are fully supportive of your project as we encourage advances in education.

I look forward to meeting you when we will make the necessary arrangements for the use of the school. I would be happy to assist so please feel free to contact me for any further information you may require.

Yours respectfully,

Indira Rambaran-Mohammed
Principal Primary



Plum Mitan Presbyterian School

#6 Settlement Road

Plum Mitan

Telephone / Fax : 668 9743

Principal : Mrs. Jenny Kowlessar

SCHOOL MOTTO : HARD WORK BRINGS REWARD

Astra Kassiram,

Middlesex University,

School of Health and Social Sciences,

The Town Hall, The Burroughs London NW44BT.

Dear Madam,

I acknowledge receipt of your letter dated 18th April, 2011 seeking permission to use the above named school in order to conduct interviews with some women of this country.

Please be advised that permission has been granted and we are fully supportive of your project as we encourage advances in education.

I look forward to meeting you, where we will make the necessary arrangements for the use of the school. I would be happy to assist, so please feel free to contact me for any further information you may require.

Yours Respectfully,

Jenny Kowlessar

(Principal Primary)

MINISTRY OF EDUCATION MITAN PRESBYTERIAN SCHOOL SANGRE GRANDE

Principal: Philip Allard
Phone: 630-4506, 497-0496
E-mail: mayarocomposite@gmail.com

Mayaro Secondary School
Guayaguayare Road
Mayaro

Specialist School for P.E. & Sport

24th May 2011.

TO: Ms. Astra Kassiram
PhD Candidate
Middlesex University
U.K

Dear Miss Kassiram,

The above school is please to inform you that permission is granted for you to use the school compound to conduct your interviews. We hope that your studies will be a resounding success and we are happy to have been a part of your endeavor.

Date (s) approved for use of school compound: **July 11th to September 2nd 2011**.

Yours sincerely,

Philip Allard
Principal

PRINCIPAL
MAYARO SECONDARY
SCHOOL

MAYARO SECONDARY
Specialist School for P.E. & Sports
Est 1989
SCHOOL

St. Augustine Secondary School
Corner Warren & Gordon Street
St. Augustine, Trinidad W.I.
Tel: 662-5882, Fax: 662-9447
Email: staugustinesec@gov.tt

19th May, 2011

Dr. Miranda Horvath
Supervisor
Middlesex University School of Health and Social Sciences
The Town Hall
The Burroughs London
NW4 4BT.

APPROVAL FOR USE OF THE SCHOOL PREMISES

I wish to inform you that permission has been granted to Ms. Astra Kassiram for use of the above-named school premises to conduct interviews on somatization disorder, domestic violence and help seeking from the 11th July – 02nd September, 2011.

Yours faithfully,

.....
Principal
ST. AUGUSTINE SECONDARY SCHOOL

ST. AUGUSTINE SECONDARY SCHOOL
MAY 27 2011
DESPATCHED

MINISTRY OF EDUCATION
Caroni Education District

Longdenville Presbyterian Primary School

Main Road, Longdenville
Telephone No: 671 - 5338

ESTABLISHED: 1957
Principal: Ms. Susan Ram

MOTTO: *Per Ardua ad Astra*
Through Toil To The Stars
Tuesday 24th May, 2011.

Ms. Astra Kassiram
Middlesex University
School of Health and Social Science
The Townhall, The Burroughs London NW4 4BT.

Dear Madam,

Re: Permission to use School Building.

I acknowledge receiving your letter requesting permission to use the School building for your research project. Permission is granted to use the same. Please contact me at 463 – 3495, so that we can make final arrangements.

I look forward to further communication with you.

Yours Respectfully,

Susan Ram
Principal Primary

MINISTRY OF EDUCATION
MAY 25 2011
LONGDENVILLE P.S.
PRIMARY

San Fernando Central Secondary School
Todd Street. Les Efforts West.
San Fernando
Trinidad West Indies
Tel:/Fax 1-868-657-7169

11th May, 2011

Dr. Miranda Horvath
Forensic Psychological Services
Middlesex University
School of Health and Social Sciences
The Town Hall
The Burroughs
London NW4 4 BT

RE: Approval for use of School

Dear Madam,

Approval is given to Ms. Astra Kassiram to use San Fernando Central Secondary School to conduct interviews for the period between 11th July, 2011 and 2nd September, 2011.

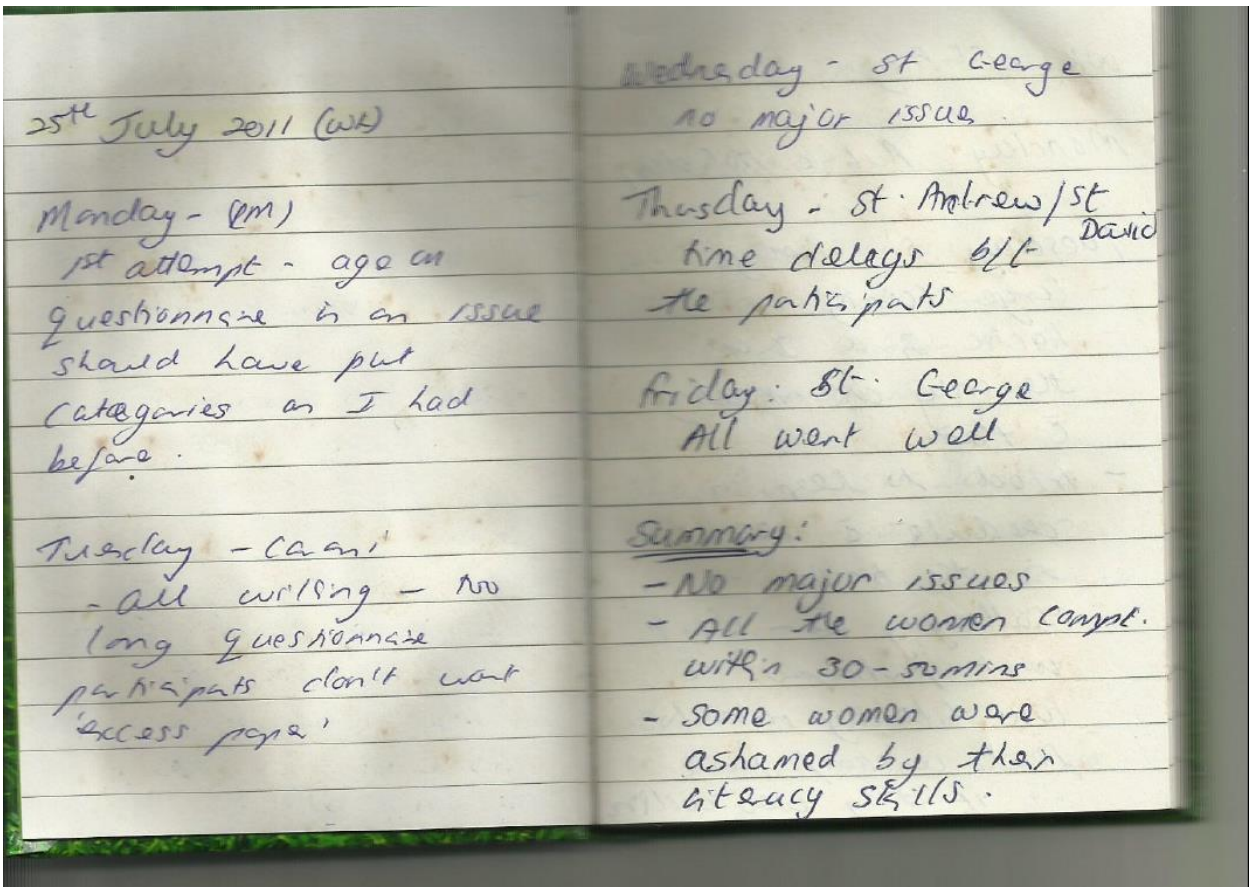
I wish Ms. A. Kassiram success in the research undertaken and in her thesis.

Yours respectfully,

Ms. Farial Ali
Principal (Secondary)

PRINCIPAL (SEC.)
SAN FERNANDO CENTRAL SECONDARY SCHOOL

Appendix Hb: Excerpt from Reflective Journal for Study One



25th July 2011 (Wk)

Monday - (PM)
1st attempt - age on questionnaire is an issue should have put categories as I had before.

Tuesday - Cairns
- All writing - too long questionnaire participants don't want 'excess page'

Wednesday - St George
no major issues

Thursday - St. Andrew/St David
time delays b/t the participants

Friday: St. George
All went well

Summary:
- No major issues
- All the women comp. within 30-somins
- Some women were ashamed by their literacy skills.

Appendix I: Help-Seeking Sources for General Problems by Ethnicity

Sources of Help Sought		*Indo-Trinidadian Women (%)*	*Afro-Trinidadian Women (%)*	*Entire Sample (%)*	*Statistic*
Religious Leader	Yes	40.0	44.0	42.0	
	No	38.7	32.0	35.3	
	Not Applicable	21.3	24.0	22.7	
Medical Doctor	Yes	72.0	49.3	60.7	p<.05*
	No	9.3	26.7	18.0	
	Not Applicable	18.7	24.0	21.3	
Police	Yes	21.3	14.7	18.0	
	No	53.3	50.7	52.0	
	Not Applicable	25.3	34.7	30.0	
Family/Relative	Yes	69.3	66.7	68.0	
	No	16.0	9.3	12.7	
	Not Applicable	14.7	24.0	19.3	
Government Organization (e.g. Hospital)	Yes	34.7	22.7	28.7	
	No	42.7	49.3	46.0	
	Not Applicable	22.7	28.0	25.3	
Non-Government Organization (e.g. Private Hospital)	Yes	5.3	1.3	3.3	
	No	69.3	65.3	67.3	
	Not Applicable	25.3	33.3	29.3	
Counselor	Yes	24.0	13.3	18.7	
	No	54.7	53.3	54.0	
	Not Applicable	21.3	33.3	27.3	

* $\chi^2(1,N=150)=10,p<.05$ Cramer's V = .007

Appendix J: Help-Seeking according to Religious Affiliations

Religious Leader's Affiliation	***Indo-Trinidadian Women (%)***	***Afro-Trinidadian Women (%)***	***Entire Sample (%)***
Christian	22.7	40.0	31.3
Hindu	8.0	0.0	4.0
Muslim	1.3	0.0	0.7
Christian/Hindu/Muslim	1.3	0.0	0.7
Christian/Hindu	4.0	0.0	2.0
Christian/Muslim	1.3	0.0	0.7
Not applicable	61.3	60.0	60.7

Appendix K: 'Other' Sources of Help for General Problems by Ethnicity

Other sources of help	*Indo -Trinidadian Women (%)*	*Afro-Trinidadian Women (%)*	*Entire Sample (%)*
Friend	18.7	26.7	22.7
Spouse	66.7	33.3	4.0
Psychiatrist	8.0	0.0	4.0
Friend/Spouse	1.3	2.7	2.0
God	1.3	2.7	2.0
Not Applicable	65.3	65.3	65.3

Appendix L: Reasons given for Seeking Help from the Various Sources

Sources of Help	***Reasons for seeking General Help***	***Indo-Trinidadian Women (%)***	***Afro-Trinidadian Women (%)***	***Entire Sample (%)***
Religious Leader	Spiritual	21.3	20.0	20.7
	Emotional/Psychological	5.3	4.0	4.7
	Personal	5.3	6.7	6.0
	Medical	4.0	2.7	3.3
	Marital	2.7	6.7	4.7
	Other	0.0	1.3	0.7
	Not Applicable	61.3	58.7	60.0
Medical Doctor	Spiritual	1.3	0.0	0.7
	Emotional/Psychological	1.3	0.0	0.7
	Personal	0.0	1.3	0.7
	Medical	64.0	44.0	54.0
	Physical Need	1.3	0.0	0.7
	Not Applicable	32.0	54.7	43.3
Police	Personal	4.0	0.0	2.0
	Martial	1.3	0.0	0.7
	Legal	8.0	9.3	8.7
	Physical Need	2.7	0.0	1.3
	Other	4.0	4.0	4.0
	Not Applicable	80.0	86.7	83.3
Family/Relative	Spiritual	1.3	1.3	1.3
	Emotional/Psychological	8.0	16.0	12.0
	Financial	4.0	2.7	3.3
	Personal	34.7	30.7	32.7
	Medical	1.3	4.0	2.7
	Marital	9.3	6.7	8.0
	Legal	1.3	0.0	0.7
	Other	1.3	1.3	1.3
	Not Applicable	38.7	37.3	38.0
Non-Government Organization (e.g. Private Hospital)	Emotional/Psychological	2.7	0.0	1.3
	Medical	1.3	0.0	0.7
	Other	1.3	1.3	1.3
	Not Applicable	94.7	98.7	96.7

***Appendix* L con't: Reasons given for Seeking Help from the Various Sources**

Sources of Help	***Reasons for seeking General Help***	***Indo-Trinidadian Women (%)***	***Afro-Trinidadian Women (%)***	***Entire Sample (%)***
Government Organization (e.g. Public Hospital)	Spiritual	1.3	0.0	0.7
	Financial	1.3	0.0	0.7
	Personal	2.7	1.3	2.0
	Medical	21.3	18.7	20.0
	Legal	2.7	0.0	1.3
	Physical Need	1.3	0.0	0.7
	Marital	0.0	6.7	0.7
	Other	2.7	0.0	1.3
	Not Applicable	66.7	78.7	72.2
Counselor	Emotional/Psychological	2.7	5.3	4.0
	Personal	9.3	4.0	6.7
	Medical	1.3	0.0	0.7
	Marital	5.3	0.0	2.7
	Other	2.7	1.3	2.0
	Not Applicable	78.7	89.3	84.0

Appendix Ma: Interview Schedule for Somatization Disorder

Schedule 1

1. Last time we spoke you mentioned that you had some health problems; can you please tell me more about that?

a) How were you feeling at that time?

2. What was going on for you in your life when you were feeling this way?

a) Can you please tell me some more about that?

Prompts:

i. What about your family, what was happening?
ii. What about you relationship at the time, what was happening?
iii. Or tell me what was happening with your job at that time?
iv. Were you experiencing any other stress in your life at this time? Tell me more

3. Did you speak to anyone about what you were feeling?

a) How did they respond?

b) How did you feel about their response?

c) If you did not speak to anyone, please tell me why?

d) How did you cope with your health problems?

4. Did you draw on your faith to get you through this time?

a) How did this help you through this time in your life?

Prompts:

i. Did you draw on your religious leader, prayer, and/or support from other members of this community?

Appendix Mb: Interview Schedule for Domestic Violence Experiences

Schedule 2

1. Last time we spoke you mentioned that you were experiencing some problems in your relationship; can you tell me some more about this?

   a) How do you feel about the way he acted towards you?

   b) Do you think the way he acted towards you impacted on your health in any way?

   c) If yes, how?

2. What else was going on for you in your life when your partner acted like this?

   b) Can you please tell me some more about that?

Prompts:

v. What about your family, what was happening?
vi. Or tell me what was happening with your job at that time?
vii. Were you experiencing any other stresses in your life at this time? Tell me more

3. Did you speak to anyone about what was happening?

   e) If yes, how did they respond?

   f) How did you feel about their response?

   g) (If no) Since you did not speak to anyone, please tell me why?
      a. What else did you do to cope with what was going on?

   h) (If any) How did you cope with your health problems?

4. Did you draw on your faith to get you through this time?

   a) How did this help you through this time in your life?

Prompts:

i. Did you draw on your religious leader, prayer, and or support from other members of this community?

5. Did you tell your medical doctor what was happening/did your doctor ask you what was going on?

   a) If you didn't tell them, why was this?

Appendix Mc: Interview Schedule for Somatization Disorder and Domestic Violence Experiences

Schedule 3

1. Last time we spoke you mentioned that you had some health problems; can you please tell me some more about that?

a) How were you feeling at that time?

2. What was going on for you in your life when you were feeling this way?

c) Can you please tell me some more about that?

Prompts:

viii. What about your family, what was happening?
ix. What about your relationship at the time, what was happening?
x. Or tell me what was happening with your job at that time?
xi. Were you experiencing at stress in your life at this time? Tell me more

3. Did you speak to anyone about what you were feeling?

i) How did they respond?

j) How did you feel about their response?

k) If you did not speak to anyone, please tell me why?

l) How else did you cope with your health problems?

4. Did you draw on your faith to get you through this time?

a) Tell me what source of faith did you turn to at this time?

Prompt:

ii. Did you draw on your religious leader, prayer, and/or support from other members of this community?

b) How did this help you through this time in your life?

5. Also the last time we spoke you mentioned that you were experiencing some problems in your relationship; can you tell me more about this

d) How do you feel about the way he acted towards you?

e) Do you think the way he acted towards you impacted on your health in any way?

f) If yes, how?

6. What was going on for you in your life when your partner was acting like this?

a) Can you please tell me some more about that?

Prompts:

i. What about your family, what was happening?
ii. Or tell me what was happening with your job at that time?
iii. Were you experiencing any other stresses in your life at this time? Tell me more

7. Did you speak to anyone about what was happening?

a) If yes, how did they respond?

b) How did you feel about their response?

m) (If no) Since you did not speak to anyone, please tell me why?

a. What else did you do to cope with what was going on?

Did you draw on your faith to get you through this time?

a) How did this help you through this time in your life?

Prompts:

i. Did you draw on your religious leader, prayer, and/or support from other members of this community?

9. Did you tell your medical doctor what was happening/did your doctor ask you what was going on?

a) If you didn't tell them, why was this?

Appendix N: Information Sheet

Middlesex University School of Health and Social Sciences

Psychology Department

Information Sheet

Somatization and Domestic Violence

Your participation is appreciated.

Participation Number: _____

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

Who am I?

My name is Astra Kassiram and I am conducting this research as part of my doctoral studies with Middlesex University, London.

What is the title of research?

Indo and Afro- Trinidadian women's experience of domestic violence, somatization disorder and help seeking: A mixed methodological analysis.

What is the purpose of this study?

This study will seek will seek to report and compare experiences of domestic violence and somatization of distress amongst Indo and Afro Trinidadian women living in Trinidad. The study is also interested in the general types of help and support woman look for and how helpful they find any help or support they receive. A study like this one has never been done in Trinidad before, therefore the different Ministries in Trinidad will be informed and hopefully makes changes to Health Care, Education and Social Services to provide better services.

What will the study involve?

You will be interviewed by me on a one-to-one basis to discuss your experiences of somatization disorder and/or domestic violence and your help seeking options. This should take around an hour, depending on how much you have to say. The interview will be audio recorded, and you will be asked to agree to this by signing a consent form prior to it taking place. Following the interview there will be an opportunity for you to further discuss the study with me, in order to fully address any questions or concerns you may have.

Will I get paid for taking part?

Reasonable expenses to cover the cost of travel to the location of the interview will be met.

Why should I take part?

Not only will you be helping me personally with my PhD, but you will also be contributing to the collection of human knowledge about this topic, and so benefiting society as a whole. A study of this kind has so far never been done in Trinidad and therefore you will be helping in the growth of the nation. Additionally, you may also find the experience of participating in an academic study to be personally interesting.

Why shouldn't I take part?

Participating in the study will use up some of your time, for which you will not receive any financial compensation. Additionally, whilst the questions will not specifically ask about topics of a sensitive nature, there is some possibility that you may find recounting certain events to be emotionally troubling.

What if I decide not to take part?

Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decide to take part you may withdraw at any time without giving a reason.

What if I change my mind part way through the survey?

You are totally free to withdraw your participation at this point without prejudice.

What if I change my mind after the interview?

You can withdraw any data that has not yet been published at any point following completing the questionnaire, via the contact details below. You just need to make sure you remember your participation number and you information will be completely destroyed.

Will this study be properly conducted?

I am doing my PhD at Middlesex University in England and all proposals for research using human participants are reviewed by an Ethics Committee at this university before they can proceed. The Middlesex Psychology Department's Ethics Committee has reviewed this proposal. The risks in participating in this study are minimal as no identifying information about you will be released to the public. All data collected will coded to protect the identity of participants and the coded information securely stored in a password protected file on a password protected computer

What will happen to the recording?

The original recording will be stored as a computer file, which will be password protected or physically secured, as appropriate, and only be accessible to me. It will subsequently be transcribed (converted to written form) by me, and analysed, together with those of other participants, to form the basis of my research report. The original recording will be destroyed by the end of the project. Anonymised audio copies and anonymised transcripts derived from the original recording may be published to illustrate my analysis, or retained by me for potential future analysis.

How will my identity be protected?

Prior to the interview you will be asked to choose a unique pseudonym (made-up name). All audio recordings, transcripts and extracts will only be identified by this pseudonym. I will not retain any link between your real name and pseudonym, or between the pseudonyms of partners who both participate in this study. Names of potentially identifying third-parties, companies, locations, and so on, will be 'bleeped out' to produce anonymised audio copies of the original interview recording. Similarly, such names will be substituted with pseudonyms to produce anonymised transcripts. Having done this, the original recording will be destroyed, so there will therefore be no means of identifying you or anyone else from data that is published or retained by me after the end of the project.

Informed Consent prior to participation?

Before you participate you will be asked to sign a consent form (like the one on the next page) which will show that you understand what you are taking in part in and what the information you provide will be used for.

What if I have further questions or concerns?

If you have any questions about participating in this study please do not hesitate to contact Ms. Astra Kassiram at 07931718288 (UK) or 1868 780 1336 (T&T); a.kassiram@mdx.ac.uk or my supervisor Dr. Miranda Horvath (m.horvath@mdx.ac.uk).

Thanking you for your time.

Yours sincerely,

Ms. Astra Kassiram
Doctoral Student
Department of Psychology
Middlesex University
United Kingdom

Appendix O: Informed Consent

Middlesex University School of Health and Social Sciences
Psychology Department

Written Informed Consent

Participation Number: _____

Title of study: **Indo- and Afro-Trinidadian women's experience of domestic violence, somatization disorder and help seeking.**

I have understood the details of the research as explained to me by the researcher and in the information sheet and confirm that I have consented to act as a participant.

I have been given contact details for the researcher in the information sheet.

I understand that my participation is entirely voluntary, the data collected during the research will not be identifiable, and I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.

I further understand that the data I provide may be used for analysis and subsequent publication, and provide my consent that this might occur.

I consent to be interviewed by the researcher on a one-to-one basis for around an hour, and agree that the interview should be audio recorded.

I consent to publication of extracts from the audio recording and corresponding transcripts, provided they are fully annoymised so that I cannot be personally identified.

I consent to retention by the researcher of the audio recording and corresponding transcripts for potential future analysis; provided they are fully annoymised to that I cannot be personally identified.

_____ _____

Print name Sign Name

Date: _____

To the participants: Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Social Sciences Ethics committee of Middlesex University, if required by institutional audits about the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you do not wish your data to be included in audits: _____

If you have any questions about participating in this study please do not hesitate to contact Ms. Astra Kassiram at 07931718288 (UK) or 1868 780 1336 (T&T); a.kassiram@mdx.ac.uk or my supervisor Dr. Miranda Horvath (m.horvath@mdx.ac.uk).

Appendix P: Debriefing Sheet

Debriefing Information

Research on Indo- and Afro-Trinidadian women's experience of domestic violence, somatization disorder and help seeking.

Participation Number: _____

Thank you very much for taking part in my study, I hope you found it an interesting experience.

What if I want to know more about the study?

If you have any further questions or concerns about this study then I would be happy to discuss them now.

Alternatively, if you would like to discuss any aspect of the study at some point in the future then please contact either myself or my supervisor as detailed below.

What if I change my mind later?

You can partially or completely withdraw your data from this study at any point in the future, provided it has not yet been published. To do so please contact either myself or my supervisor as detailed below.

What if I found the study troubling?

In the event that you find any of the issues raised by this study to be troubling then you may wish to contact one of the following individuals listed below for assistance or contact either The Trinidad and Tobago Coalition Against Domestic Violence at 624 - 0402 or Families in Action at 628 - 2333 for free counselling. Additionally, you can contact the Ministry of Community Development and Gender Affairs at 623 - 6621 or 800-SAVE for information on any of the free counselling drop-in centres in your area.

Research Contacts:

Ms. Astra Kassiram (PhD Researcher)
a.kassiram@mdx.ac.uk
Telephone Numbers: 07931718288
18687801336

Dr. Miranda Horvath (Supervisor)
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Dr. Susan Hansen (Director of Studies)
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Appendix Qa: Anonymized Transcript

I: Interviewer

P: Participant

I: So Good Afternoon **** How are you?

P: I'm fine thanks.

I: Okay thank you for coming. The last time we spoke you mentioned you had some health problems. Can you please tell me some more about that?

P: Well I don't really have any umm serious health problems. Umm regular problems for me would be ever so often might be head-headache. Umm oh actually health problems I find… not last time but recently more like something called gastritis, problems with your stomach like umm I'll feel upset umm like nausea but it's like a stomach burning so apparently it's called gastritis. And you know, I could take medication for that. So I've taken Nexium and umm I've also had another medication that's a-a fizzy medication that is effervescent, I forget what it's called, it starts with 'r', I forget the name. Umm so that's one, headaches, umm other than that I think I'm okay.

I: Did you go to the doctor for that?

P: No I did not. I know somebody very well who could prescribe so I don't need to actually…

I: Oh this is a doctor you know other than that?

P: Yes.

I: Okay so you umm indirectly saw a doctor [laughs].

P: Yes I did, yes I did. I saw a doctor for that yes, you could say so.

I: Okay. Alright so were you satisfied with the advice that he or she gave you?

P: Umm yes the cert−sometimes the medication worked, sometimes I find it didn't work. And umm I had to be on the Nexium for like a week before to see it working. But sometimes like certain things will happen and I will get that pain. If I don't eat on time that's fine but like okay so I'm sleeping and I get woken up, I find I get that like I think it's a little mixture of anxiety. So you wake up and you like you f−get that pain or stomach… it's an upset feeling it's not pain. It's like this burning sensation in your stomach.

I: Okay. I don't know if you remember last year you completed the questionnaire for me.

P: I remember completing it but I have a terrible memory so I'm not sure what I would've completed. Whatever it was it wasn't difficult for me to complete.

I: Okay and you would've ticked different umm health concerns on there. Umm is it anything… you mentioned headaches and upset stomach, is it anything like feeling sad, anxious umm…

P: Umm maybe as I… some anxiety because umm ever so often I think I'll have anxiety. Like umm I think it's generally anxiety yes. I would call it a trait anxiety, I think I-I have anxiety in me. Umm so a situation could come up and I'll get anxious in terms of like on timing, waiting for people or being waited on especially being waited on. More than being waited on, I don't like when people waiting on me. Umm anxiety and time usually… time gives me anxiety. It's sometimes it-it's something that I don't have to… I shouldn't be worried about because it's like a lot of people get… you know, they late or… so they don't even study those things so I don't know why I take it on so much. Umm other than that umm anxiety… I don't really feel any sort of depressed. Sometimes I'll have that but not like anything long-longstanding. No depressed feelings. Ever so often you might have the moods so I might be moody so I'll have my moods, yes.

I: What about like your heart pounding or anything like that?

P: Umm no in normal situations, if for example you want to talk to somebody and or you want to stand up in a crowd. Last time I felt that was when I wanted to say something in a crowd and well I think that's normal. So no heart pounding.

I: Okay how were you feeling at that time like last year?

P: Back then?

I: Yes.

P: Well I'm trying to remember umm I was in the in… not employed umm so I had now graduated and I think that I was fine. I-I thought that you know, I didn't really have any serious issues with respect to the umm doing the questionnaires and I-I think I was okay. I don't think I… I don't recall being in any sort of stressful situation other than normal life problems.

I: What-what were some of the life problems that you had? What was going on for you in your life when you were feeling that way?

P: Like umm looking for a job umm and I think that's about it.

I: What was happening at... in terms of looking for a job?

P: Umm yes I had just finished graduated so that's what happened. It's umm… finish with university and so like and research. So I think umm I was like now out there and I think that's if I remember it correctly.

I: Were you feeling… how were you feeling about looking for this job?

P: Umm sometimes I wouldn't [laughs] feel that motivated. Umm it's-it's work, it's stress to actually just go out and look for something and apply for jobs and so on. And thinking about it

now it's been… July is again one exact year and I don't have any sort of steady employment but there is some kind of employment but probably back then it was less. Yes.

I: Less employment?

P: Yes because I, I mean I don't have a full time job but I still do stuff during the… during the day and I keep busy.

I: How did that make you feel about looking for the job and not having as much job as you said there. How do you think that impacted on your life?

P: Hmm umm hmm I wonder if I-I have signs of depression. I-I-I don't think it would really umm it would… I don't think it really bothered me so much, I just knew it was just the next step to... the next step to take. I really didn't stress over it. I, I don't think I stressed over it.

I: Okay. Umm what about your family? Was anything happening with your family at the time?

P: Hmm I think one year later was the death anniversary of my father so that means it's two years now. But it was not anniversary, it was April that was the anniversary so it was probably after you know, you know after one year you have a lot of things to do. So umm that's about it as well in terms of family situation. And that was one year later so it wasn't *such* a big impact.

I: Anything else was going on with your family? Like the persons who were there with you?

P: Hmm no I don't think anything I could remember going on, no.

I: Okay what about your relationship at the time? Did you have one?

P: At the time I didn't have a relationship so I, I think I might have… I might have been up, up and down or [kisses teeth] in and out of a relationship. But no I wasn't... I was single.

I: Yes when you say in and out of a relationship?

P: Umm with somebody but not really in committed relationship so that was I would say me being single. It wasn't… it wasn't a big impact as well so it was there but really not there at the same time.

I: [Laughs] okay. How did that make you feel?

P: Well if I could remember… so I have really bad memory with respect to how I felt at that time so I forget things easily and therefore I could repeat the same thing because I forget the feeling. So that happens to me so July 2011 is really hard for me to try to remember but I'm sure I had a lot of up and down in the relationship. So sometimes it'll be good, sometimes it'll be bad but even so, even though at the time it would've been stressful I would've gotten over it in about two days or so.

I: Okay. Two days or so.

P: Yes actually one day but you know, let me just say two days for safety.

I: Okay.

P: Yes.

I: How did you cope with what was happening?

P: Umm well yes I have other things in my life that keeps me busy so I have a good social life even then and now. Umm being busy with family and family responsibilities, umm ever so often having other things to do work related. So I keep busy, I don't have any… I don't dwell on it, I wouldn't dwell on it for too long.

I: Okay so you wouldn't say it affected you that much?

P: No.

I: Umm were you experiencing any other stresses at the time? Minor, major…

P: Umm I don't think I can remember if I was going through any other stress. Nope, I don't think I could remember.

I: You mentioned that you had just finished university.

P: Yes.

I: How was that time for you?

P: Umm well I finished the two years but I had to take a little extra time to do my umm thesis. But it finished as well just a couple months after. Umm it was… I should've graduated in 2010 but the, the graduation certificate says 2011. I… overall it was okay. I find the system or the programme itself could've been a bit frustrating so I'm a bit nonchalant about the whole umm the-the programme itself and getting out of it and then looking for a job and not really feeling… I don't know if it's prepared. I think I was prepared but not really caring so much because of how the-the programme was. It wasn't umm something… I don't think like the people in the programme, the administration umm the whole thing was properly cared for so we weren't really umm… we were like treated as if we were on the side-line, the students in the… in my class at least.

I: Okay so you didn't feel the programme was well executed?

P: Umm no. I-I know I got some out, some things out of it but it felt so lackadaisical so I come out of it feeling lackadaisical about things and not really feeling motivated to-to stay into

psychology even though I'm still in it. I'm still in it and I try to do other things other than staying in psychology so just in case I might have to you know, not be in it in the long haul.

I: So when you were completing the-the thesis…

P: Yes.

I: Umm it would've been last year about the…

P: It would've been completed December twenty-ele−2010, December 2010. So I think umm at between January to… I may… I think January to May I was not really, not sure what was my status until I think I-I… because I remember my certificate saying April 2011 I knew that I would've gotten that by then. So I know by July I know that I was already graduated.

I: You said that the programme did not encourage you to want to do school.

P: Yes it wasn't encouraging, yes.

I: How do you feel about… you know, you spend two years in a programme and then you don't feel encourage to do anything further?

P: Right so I wish that I didn't do it or if I could've got−gotten the chance to do it part time because I lost my job in-in doing so because I had to resign my teaching job. If I didn't do it then I would've still been at my teaching job.

I: You taught at the secondary schools?

P: Yes.

I: Okay. So how come you made the decision to go full-time and maybe not part-time?

P: I had su−I had support to-to-to… well I didn't need the financial support so much so I could've afforded to do the-the-the full time. I wanted to get something more than my degree because I guess yes, it's no longer… a degree is no longer that feasible. I'm actually still thinking about doing a second Master's or a PhD in the future so it's still going to happen like… Now a M−a Master's is not even imp−that important anymore. So that's why I left it.

I: So being graduated with this degree and now not being able to get a job and then don't like the programme, how did you cope with all those feelings that you were having?

P: Umm well I still, I guess I still coping because I-I-I'm still in the situation. Umm hmm I was going to say something but I can't remember. Umm let me think… the… I… hmm… Like I said I've actually reapplied to…because I, I… Okay right, the thing I wanted to say is that sometimes after having a Master's is like a real big joke for… not just for me but for a lot of people who do their Master's. So people who'll do their Masters, what I've learnt in the process is that you need to do your Master's that it will actually accentuate your job and perhaps give you a better pay.

Umm s−sometimes some people actually… after a Master's they actually not just me alone, they actually don't find jobs, it's more difficult. In fact, I have had interviews where I've been overqualified but… and-and under experienced. So umm it's actually… it's actually a big joke really in-in the world out there that Master's students… Why you doing Master's if you not going to get somewhere? Unless you know… because you might as well get a job basically. So I should've stayed in the job but again the support was there and-and good. But I guess I was thinking I would have had something after doing the Master's in Clinical Psych but didn't realise that the market is very small and the government doesn't realise that there is umm a need for it. So there isn't space for that even though we need it so much.

I: So how are you managing now?

P: Umm okay so I keep very busy even though I don't get the satisfactory pay that I should be getting umm so right now I'm trying to manage that. That's like my dis−dissonance right now. So umm keeping busy is all good and everything but the pay isn't eh? And only for so long I guess I could do that. And I'm still looking for something umm I-I-I'm… I could just say that I'm managing. I am… the-the keeping busy part is good. Having a little bit of money is good but it's nothing to say I could save or anything like that. So again fall back on… I have a boyfriend and family for-for extra help if I need it.

I: Okay so you rely on your boyfriend and your…

P: Family yes.

I: Family members.

P: Yes.

I: Umm tell me about that support you receive from them. It doesn't have to just be financial but also other…

P: Well they take up my time [laughs]. I mean it doesn't pay me but actually it-it's not bad. I…

I: Tell me about your family first.

P: Alright so with my family, it's just me and my mom. So umm I find that because I don't have a full-time job I'm actually able to tend to her with certain things like doing errands because she doesn't drive, I drive. And like sometimes I do… other than a lot of things that I do, one thing that I do is actually while I was doing the, doing the-the balloons… I do deliveries for somebody else, they do fruit arrangements. So sometimes I'll go to far areas−Couva, South or so−and my mom will go with me and in the process when we coming back we might go to the grocery or you know, so she'll get that done. So I'll take her to, to wherever she needs to go. Once in a blue moon something social and umm that's with my mom. There's also my umm sisters and I have

nieces and nephews so they could keep me occupied too. So if my niece is home I-I have a whole day with her and I really don't do much if-if I have the child with me. [Laughs]

I: So do you go to them for like other issues also? When you're experiencing other challenges in life?

P: No I wouldn't. I don't think I'd go to them. I don't think the challenges that I have would require them to intervene so I'm fine.

I: So who do you normally go to?

P: I have other friends, like I have different friends for different situations.

I: Okay so tell me a little bit about that.

P: Okay well that's difficult because… okay so maybe if I have… now I don't really have financial problems. Umm I have social… friends for-for being social with which is like everybody and then some of them will… I guess will have certain sort of strengths that I could get. But again I don't say that I'm… What kind of dilemmas I might have? Umm they-they just have different varie−… like one might be in terms I could talk to her about relationships and she could talk to me about relationships. I have another who I might want to just go by and just visit and-and enjoy their family time because they have a child and we have a good intellectual relationship. So some will give me that intellectual relationship, some will give me a social, some will give me a food… like going out to eat, so I have people who I could go and actually lime with because they take me out for food or I'll go out with them and eat with them because they appreciate food, those kinds of things. And I also have friends that I will hike with so I have friends for exercise and so on.

I: So you look to them for support in different ways.

P: In different ways yes.

I: How are you pleased or not pleased with the support you get from them?

P: Yes, yes, yes. I'm pleased with them but I find sometimes I guess I get so much support from the boyfriend that I don't really need to be with them and I have to actually now make the… make more effort to see them because I don't really make the effort to see them. I would eh but because it's so many of them for so much different things and I wouldn't meet everybody at the same time because everybody's so different, I'll have to try and make that time. But these days I'm just okay with… I'll-I'll do the… like sometimes I guess it's like default or the-the what you have to do you know, to keep the relationship there because you might have to go out with them. Umm or I might go and visit somebody but it would be very few, very infrequent.

I: Tell me about your boyfriend. How is he there to support you?

P: I think he is understandable so he could actually be a friend and kind of ex−umm say a perspective that's not like typically male. He'll get a… he'll give you a perspective that's kind of different. Actually not different, like a, like a girlfriend [laughs] but it's not like… it's just very… he's just very understanding. So he could understand things, see things in a different manner and be supportive, be empathic I guess.

I: What about like with your little health concerns? When you had them? Who did you go to besides the medical doctor? Did you discuss it with anyone?

P: My boyfriend's a doctor so that's why I have that…

I: Oh so that's who you went to. [Laughs]

P: [Laughs] yes.

I: So you got medical advice and umm…

P: Right! So he gives me that medical advice too and he's very practical and he also has an intellectual side of him so he's an all-round…you know, give-gives me that. Umm we're still in the process of still trying to meet friends with each other because we like to spend time with each other but also we know we have to meet up with his friends and my friends so that's a bit time consuming because it's not to say that he's not busy and I'm-I'm also not busy so we have to find that time.

I: So prior to you starting to date him, umm when you had experienced these health problems like last year, did you ex−go to another doctor or something?

P: No I don't think I went to any doctors for any sort of… especially for that stomach problem because I never really took it on as something like a big deal. And umm I think he was the one who prescribed the Nexium and I didn't realise Nexium is quite a popular umm medication.

I: What about the little anxiety and stuff you spoke about? Did you talk to anyone about it?

P: I never really talked to anybody about the anxiety. I think it's umm, it's not some kind of anxiety that I, that will go…that is out of hand. Umm I think it's manageable.

I: Tell me how do you cope with it then?

P: I not sure if I cope with it in a g−… I-I'm not sure. I, I rush [laughs] if I have to… in terms of timing. Umm I relax myself. I have my t−, my time for myself so if I in a like feeling strung out, I need some time for myself. So these days how I like to spend my time is doing a crossword, watching something on the computer like a television show and reading.

I: And reading.

P: Yes.

I: Okay and that will calm you down?

P: Yes that-that-that's like when I need my time alone like I just don't want to see anybody, I just want to relax if I not sleeping, those are the things I will do to just keep me… I don't know it's-it's just a nice time to spend by yourself. So I do like spending time by myself and just trying to recharge myself.

I: Okay so when you were going through all like the ups and downs with the jobs and stuff and-and you probably would've been experiencing the anxiety at all this time, did you still employ those same sort of coping mechanisms or you did something…?

P: No I think that was recently. Umm I started reading umm this volume of books, Game of Thrones which was in December 2010 which is just recently. And umm every time I'm done with whatever it is, workwise or even social−socializing, I look forward to just coming home and reading the book.

I: But you said that was recently?

P: Right.

I: Could you think back like maybe last year when you were… you know, when you filled out the questionnaire or something? What kind of coping did you…?

P: Yes. Most I would've done was socialize or spend time with the family. That would be like keeping your mind occupied.

I: Did you tell any of the friends or family how you were feeling at that time?

P: No because I wouldn't say that I had any sort of like situation where it required me to tell them anything. I-I-I guess it was just… for me I would think that it was just a regular level and if I needed to go out or to do something I'll-I'll just have that time. I-I don't think it was anything that I… that was im−, hmm significant for me to say 'okay I need help.'

I: So and how did you… umm now that you're still looking for the job and all of these things, have you seen like maybe a difference in… because you said it's much better now, have you seen like a difference in maybe the anxiety experience, the stomach problems or the headaches? Did you have headaches you mentioned?

P: But the headaches are if it's like hungry headaches or so on. So…

I: Okay, alright. Did you see a difference in it now that umm I'm hearing that you might be a little more settled?

P: Umm I find that I'm more aware that I have this… the-the-the medical issue because of the fact that I have medical advice but umm I don't think so. I don't think so.

I: Did… You're just more aware of it?

P: Yes, yes I think it's more, being more aware and not really thinking that if I, I've improved on certain things. Because it's not that I have anxiety you know, maybe I have anxiety but I actually present it as aggressiveness because I could be aggressive or I could be short. So if I have something that I want to do I lose my patience, I actually lose my patience. That is actually more of… I don't know if that's a symptom of a-anxiety or [inaudible].

I: When you say lose your umm your patience what do you do?

P: Umm I could get really impatient with people if they're speaking and especially family. Family and then relationship, people who I'm in relationships with. So I'll be snappy, quick umm to-to-to want to get a response, shout. Yes those things.

I: How do they react to that?

P: Umm not really good, not really good. [Laughs]

I: So when they don't react good and...what is your reaction to them?

P: Well then I feel bad afterwards and I realise I have to really find ways to find out how to be aggres−… umm to-to-to be less aggressive. Umm I don't know if it's anxiety but it could be like a lot of things. It could be that I might be hungry; it could be that I'm fed up of like having a long day with the person or something, umm things like that. But I find sometimes I could be really just I-I'm so impatient.

I: [Laughs] have you found ways of dealing with it?

P: I'm still, I'm still trying. I'm still in the process of trying to figure out well what to do because sometimes I speak my mind, I'm very direct and I shouldn't, I shouldn't really be that direct. I shouldn't be like tell my boyfriend 'no I don't want you to come over.' I should be saying it in a better way. [Laughs]

I: [Laughs] do you hurt his feelings sometimes?

P: Well it's not nice. You know, he-he's fine because I was tired. Like one time I would've been tired and like I spent the whole day with him and he wanted to come over. I want to spend the time with him too but I'm like so tired that I can't really accommodate that. I was thinking I'll just go home get myself... by myself, be alone and then eventually fall asleep. And he said he was going to come over and I basically said straight-straight off 'no I think I want to go home and I don't want you to come over.' Saying that 'I don't want you to come over' could've been done in a better manner. I just have to figure out what to do or how to say it.

I: How do you think that has affected your relationships?

P: Umm that's the major thing that might affect my relationship in terms of my… because it's my personality as well which I'm actually… because it's my personality to change it will be a difficult task. I'm aware of it, that's a good start and only after I react then I realise I could do something differently. So while being in the situation it's such a biological situation that takes place that umm what-what happens is that you can't control yourself at the time but you really have to utilise your cognitions and I have to practice that and I'm still working on it.

I: You still wor−self-improvement. [Laughs]

P: Yes still working on that.

I: Have you ever been to like umm anything religious to help with any of your issues?

P: No. [Laughs] no actually during after I met you I think I would've started yoga in some time period after July 2011 which would've been sometime last year maybe before the year ended be-before December. And I tried it, it was really good but I don't think it really… it was, it was not Hatha yoga it was Kundalini yoga and I was involved in breathing umm exercise and some sort of the positions and so on, it's a variety. Umm I honestly, I-I-I did the-the ten sessions that was… I-I had committed to do and then I-I didn't want to continue because I, even though afterwards I'll feel good, I don't know it just, it wasn't a long term kind of feeling. I think I'll rather do the Hatha yoga but I haven't done any type of yoga.

I: What prompted you to go do the yoga?

P: Oh a friend of mine I met while I was hiking, she was telling me about it so I was interested and to check it out. So I checked it out and I did it for the ten, for the ten.

I: Is it just an interest or because of what was happening in your life?

P: No, interest, not because of what was happening. But it was helpful in terms of like okay so you had a hard day or something, you go, that would be good a-after.

I: Okay.

P: Umm but you know what, actually hiking really helps. So umm hiking is a… is-is-is okay it's not religious but it's actually a form of meditation. Umm I'm not religious so I will not do anything like go to temple or pray or anything like that to help any kind of thing. It wouldn't really matter to me so I don't think it'll work.

I: Has anybody ever advised you to?

P: No. Some people might say pray but I just don't take them on [laughs]. And my boyfriend I think he's a bit on the… not religious side but he understands that side and he doesn't really push. But actually I've been more into cultural things because of him and umm that's been good in terms…

I: When you say cultural what do you mean?

P: Cultural as in Indian cultural stuff. So umm things that might be in terms of like umm going to a performance to watch people sing or dance, umm plays, those sort of things. So I get a little bit better understanding of that but I wouldn't consider that as anything to do with religious so that's just a new add-addition but it just helps me to I guess learn or understand things better.

I: So prior to your boyfriend and you having the stomach issues and stuff−I think I asked you and we went off into a different topic−umm did you seek medical help for it?

P: No.

I: How come you didn't umm…?

P: Because I didn't see it as something that was a-a burning issue to do.

I: Oh you were doing self-management or…?

P: What I would've done is have ice-cream if my stomach was burning. I didn't think it was something that was like a-a serious issue but apparently if you, if you let that happen it's a possibility of ulcers and even cancer so you have to be careful.

I: When do you see it happening more often?

P: [Sighs] perhaps if I'm hungry or I'm not having… if I don't eat on time. Yes, that's basically it.

I: What about like if you're experiencing something stressful in your life? Do you see…?

P: Thing is I'm not sure if I'm aware of it if… because of something stressful and a-another thing is I don't know, some people different levels of stress differ. My level of stress could be just the fact that I'm working on a time, on a-a time constraint. And that's what could cause it, I'm not sure but that's possibly one.

I: Okay.

P: Right so I don't have any, I don't have any stressful situations. I don't, I don't go through stress as much as other people.

I: Okay well that's good. [Laughs]

P: Yes I don't.

I: That's good because we live in a stressful umm stressful world. Okay and is there anything else that you would like to talk about in terms of your health or your umm help seeking?

P: So help seeking, it's good to have medical advice. Oh actually if I was looking for any other help I might go online and look for it. So…

I: Okay. Have you gone online before?

P: Yes I would go online and look up like information whether it's something biological umm or something medical or just even find out things about relationships I'll go online and get information.

I: Okay so in terms of biological and medical what have you looked up?

P: Looked up? Umm things on pregnancy, umm sexual health, umm relationships, understanding people, friendships, things actually related to psychology as well so it might not necessarily be for myself but generally so that would help other people. Things like that.

I: Did you look up that stomach thing on the internet?

P: Not really, no.

I: [Laughs] okay I was going to ask you what advice did they give you in the internet.

P: No I didn't, I never really looked at it. Sometimes you see what happens is that okay so belief, my belief is that I didn't even think the medication was working so I think it was like one minute it works and next minute I don't even have that problem. So it's not even ongoing, it's not even chronic so I don't know really yet what is the problem, what's causing it. What so far I think it's like it could be like a jolt of anxiety if somebody wakes you up. Like you don't want to wake up and you-you feel that pain immediately, it goes away or if you have bad eating habits.

I: Okay you think it's one of the two.

P: It could, it could be both. Definitely the eating habits in terms of not eating on time as well as eating greasy foods, yes.

I: [Laughs] alright umm so **** is there anything else you'd like to let me know?

P: No, I'm-I'm good.

I: Okay well thank you so much for coming.

P: Okay, you're welcome.

I: Thank you.

Appendix Qb: ***Generating Codes and Themes (super-ordinate themes) for Study Two***

Initial Codes For All Interview	Searching For Themes (Emergent)	Initial Themes	Final Super-Ordinate Theme
"Well actually for my health at that time I, sometimes I used to be sick, sometimes I used to be healthy, going to work. Sometimes I had fever, sometimes I had cold, cough. I used to more be sickly sick" *"Yes of course. And I feel umm one part is that when I was pregnant I feel… And the trauma with what I told you before where they wanted me to throw away the child, I feel it affect my child eh. I, it affect my child because he umm is ADHD"* *"Well I used to get headaches umm like, I think I used to get fever too. But I used to like cry a lot and like be down. Headaches never used to go, I used to feel dizzy, you know?"* *"Umm it started manifesting itself like headaches. Umm and umm gastric problems, problems with my stomach. Umm I didn't know what to make of it initially. The stomach problems, umm it got worse and worse and I went to the doctor and they diagnosed me with Irritable Bowel Syndrome. Umm and why I know that it was… I felt that it was directly related to that issue with my… you know, with the, the stresses I was having at home, is when I left and divorced him, it almost stopped entirely"*	*"Yes of course. And I feel umm one part is that when I was pregnant I feel… And the trauma with what I told you before where they wanted me to throw away the child, I feel it affect my child eh. I, it affect my child because he umm is ADHD"* *"Well I used to get headaches umm like, I think I used to get fever too. But I used to like cry a lot and like be down. Headaches never used to go, I used to feel dizzy, you know?"* *"I felt that it was directly related to that issue with my… you know, with the, the stresses I was having at home, is when I left and divorced him, it almost stopped entirely"*	"My symptoms were linked" Or "My stressors manifested itself as somatic symptoms"	The manifestation of abuse as physical symptoms as a means of coping: 'My physical symptoms are linked to my abuse'

Appendix Qc: ***Generating Codes and Themes (sub-themes) for Study Two***

Initial Codes For All Interviews	Searching For Themes (Emergent)	Initial Themes	Final Sub-Theme
"I felt that it was directly related to that issue with my… you know, with the, the stresses I was having at home, is when I left and divorced him, it almost stopped entirely" *"Yes and I said to him umm he-he's the one… I say 'I believe you-you is the one that have me umm… that I have high blood pressure now' because all the stress and you know, not being able to express it how you want"* *"Well I used to get headaches umm like; I think I used to get fever too. But I used to like cry a lot and like be down. Headaches never used to go, I used to feel dizzy, you know?"* *"Yes it used to impact on my health because umm I used to take it on so much that I used to be in the hospital most of the time. You know at one point in time I went to the hospital and I remember the nurse asking me if I wanted to kill myself because I was getting so sick and then I was getting so small and you know? It was really frustrating and everything so it was really impacting my health"*	*"you know, with the, the stresses I was having at home, is when I left and divorced him, it almost stopped entirely"* *… I say 'I believe you-you is the one that have me umm… that I have high blood pressure now' because all the stress"* *"Yes it used to impact on my health because umm I used to take it on so much that I used to be in the hospital most of the time"*	"My abusive experiences and somatic symptoms were/are linked" Or "My somatic symptoms were/are cause by my domestic violence experiences"	"Past abusive experiences caused symptoms"

Appendix R: Ethics Approval Forms for Study Two

dis

Astra Kassiram
Susan Hansen; Paul De Mornay Davies
ject: letter from external organisation

Dear Astra,

I am pleased to inform you that your recent Ethics application has been approved subject to amendments and PENDING receipt of the letter from the External Organisations which you will be using to conduct any part of the study. Therefore please ensure that you contact formally the External Organisations and obtain a letter of approval from them prior to commencing your data collection. Once you have obtained the letter please bring it into the Psychology Curriculum office for us to attach it to your application.

Formal written contact with the organisation must be done under the guidance of your supervisor and must indicate the name and contact details of both student-researcher and supervisor.

In addition to this we await information regarding your CRB/police check from Trinidad.

Kind regards,

Judy Mattis
Department and Programme Administrator
Psychology Department
TEL: +44 (0)20 8411 4283
FAX: +44 (0)20 8411 4259
EMAIL: j.mattis@mdx.ac.uk

work pattern: Monday and Wednesday

Judy Mattis

From: Judy Mattis
Sent: 23 May 2012 08:07
To: Astra Kassiram
Cc: Susan Hansen; Paul De Mornay Davies; Sonia Dubois
Subject: RE: letter from external organisation

Dear Astra,

The reviewer has noted that there is a typo error to be corrected on the information sheet Also, they have asked you to add some more information regarding the 'telephone call to arrange the interview' section - please see notes made on the form which I will leave on my desk.

Kind regards,

Judy.

-----Original Message-----
From: Astra Kassiram
Sent: 21 May 2012 18:56

CRB - to start the process ASAP

In the meantime: equivalent police check from Trinidad

RA to be signed → I signed it as PDMD (RDC) is involved in the supervision FF

Davies; Sonia Dubois
organisation

: The letters from the various organizations from
oximately the end of this week to early next week. Also,
lication has been "approved subject to amendments and
to know what amendments need to be made ?

School of Health & Social Sciences
Middlesex University
Hendon Campus
The Burroughs
London NW4 4BT
020 8411 4581
Email: a.kassiram@mdx.ac.uk

From: Judy Mattis
Sent: Monday, May 21, 2012 3:54 PM
To: Astra Kassiram
Cc: Susan Hansen; Paul De Mornay Davies; Sonia Dubois
Subject: letter from external organisation

Dear Astra,

I am pleased to inform you that your recent Ethics application has been approved subject to amendments and PENDING receipt of the letter from the External Organisations which you will be using to conduct any part of the study! Therefore please ensure that you contact

Judy Mattis

From: Judy Mattis
Sent: 23 May 2012 08:07
To: Astra Kassiram
Cc: Susan Hansen; Paul De Mornay Davies; Sonia Dubois
Subject: RE: letter from external organisation

Dear Astra,

The reviewer has noted that there is a typo error to be corrected on the information sheet Also, they have asked you to add some more information regarding the 'telephone call to arrange the interview' section - please see notes made on the form which I will leave on my desk.

Kind regards,

Judy.

-----Original Message-----
From: Astra Kassiram
Sent: 21 May 2012 18:56
To: Judy Mattis
Cc: Susan Hansen; Paul De Mornay Davies; Sonia Dubois
Subject: RE: letter from external organisation

Dear Judy

Thank you very much for the email. The letters from the various organizations from Trinidad will be with you by approximately the end of this week to early next week. Also, you mentioned that the ethics application has been "approved subject to amendments and PENDING receipt...." I would like to know what amendments need to be made ?

With Thanks

Astra Kassiram
PhD Candidate
Psychology Department
School of Health & Social Sciences
Middlesex University
Hendon Campus
The Burroughs
London NW4 4BT
020 8411 4581
Email: a.kassiram@mdx.ac.uk

From: Judy Mattis
Sent: Monday, May 21, 2012 3:54 PM
To: Astra Kassiram
Cc: Susan Hansen; Paul De Mornay Davies; Sonia Dubois
Subject: letter from external organisation

Dear Astra,

I am pleased to inform you that your recent Ethics application has been approved subject to amendments and PENDING receipt of the letter from the External Organisations which you will be using to conduct any part of the study1 Therefore please ensure that you contact

formally the External Organisations and obtain a letter of approval from them prior to commencing your data collection. Once you have obtained the letter please bring it into the Psychology Curriculum office for us to attach it to your application.

Formal written contact with the organisation must be done under the guidance of your supervisor and must indicate the name and contact details of both student-researcher and supervisor.

In addition to this we await information regarding your CRB/police check from Trinidad.

Kind regards,

Judy Mattis
Department and Programme Administrator
Psychology Department
TEL: +44 (0)20 8411 4283
FAX: +44 (0)20 8411 4259
EMAIL: j.mattis@mdx.ac.uk

work pattern: Monday and Wednesday

Astra Kassiram

PSY OFFICE: Study Reference Number 167/JG 1

Middlesex University, Department of Psychology

REQUEST FOR ETHICAL APPROVAL (STUDENT)

Applicant (specify): *UG PG (Module: **MPhil/ PhD*** *Date submitted: ...14th May 2012.....*

Research area (please circle)				
Clinical	Cognition + Emotion	Developmental	**Forensic**	Health
Occupational	Psychophysiological	Social	Sport + Exercise	
Other _____			**Sensitive Topic** ☒	
Methodology:				
Empirical/Experimental	Questionnaire-based	**Qualitative**	Other _____	

No study may proceed until this form has been signed by an authorised person indicating that ethical approval has been granted. For collaborative research with another institution, ethical approval must be obtained from all institutions involved.

This form should be accompanied by any other relevant materials (e.g. questionnaire to be employed, letters to participants/institutions, advertisements or recruiting materials, information and debriefing sheet for participants[1], consent form[2], including approval by collaborating institutions).

- Is this the first submission of the proposed study? **Yes**/No
- Is this an amended proposal (resubmission)? Yes/**No**
  Psychology Office: If YES, please send this back to the original referee
- Is this an urgent application? (To be answered by Staff/Supervisor only)[1] Yes/(No) *

* However, Astra will be travelling to Trinidad in early June to commence data collection

Supervisor to initial here S.H.

Name(s) of investigator: Ms. Astra Kassiram

Name of Supervisor (s):
Dr. Miranda Horvath; Dr. Susan Hansen; Dr. Paul De Mornay Davies

Title of Study:
Indo and Afro – Trinidadian women's experience of domestic violence, somatisation disorder and help seeking.

Results of Application:

REVIEWER – please tick and provide comments in section 5

[1] **See Guidelines on MyUnihub**

[1,2,3,4,5,6,7] **Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

PSY OFFICE: Study Reference Number _____ 2

APPROVED | APPROVED SUBJECT TO AMENDMENTS | APPROVED SUBJECT TO RECEIPT OF LETTERS | NOT APPROVED

Trinidad

SECTION 1

1. Please attach a brief description of the nature and purpose of the study, including details of the procedure to be employed. Identify the ethical issues involved, particularly in relation to the treatment/experiences of participants, session length, procedures, stimuli, responses, data collection, and the storage and reporting of data.

SEE ATTACHED PROJECT PROPOSAL

2. Could any of these procedures result in any adverse reactions? **YES**/NO

If "yes", what precautionary steps are to be taken?
Participants for this study previously took part in study one (conducted between July to September 2011) and have agreed to be contacted by me (the researcher) to participate in this phase of data collection, this is further highlighted in the attached proposal. Each respondent will be given an information sheet describing the nature of the study, risks involved in participating and they are free to withdraw from the study at any point without prejudice. After they will be presented with an informed consent to sign and on completion of the interview each participant will be given a debriefing sheet which includes free help agencies in Trinidad if they feel distress about anything that may have presented during the study. The information sheet, informed consent and debriefing sheet are all attached to this proposal.

3. Will any form of deception be involved that raises ethical issues? YES/**NO**

(Most studies in psychology involve mild deception insofar as participants are unaware of the experimental hypotheses being tested. Deception becomes unethical if participants are likely to feel angry, humiliated or otherwise distressed when the deception is revealed to them).

Note: if this work uses existing records/archives and does not require participation per se, tick here ..... and go to question 10. (Ensure that your data handling complies with the Data Protection Act).

4. If participants other than Middlesex University students are to be involved, where do you intend to recruit them? *(A full risk assessment must be conducted for any work undertaken off university premises)*[6,7]

Participants will be women aged 18 years or older who were identified from study one of this thesis as having somatization disorder and experienced domestic violence behaviours. For a detailed explanation about recruitment please see the attached proposal.

5a. Does the study involve:

Clinical populations	YES/**NO**
Children (under 16 years)	YES/**NO**
Vulnerable adults such as individuals with **mental** or physical health problems, prisoners, vulnerable elderly, young offenders?	**YES**/NO
Political, ethnic or religious groups/minorities?	YES/**NO**
Sexually explicit material / issues relating to sexuality	YES/**NO**

[1,2,3,4,5,6,7] **Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

5b. If the study involves any of the above, the researcher may need CRB (police check) Staff and PG students are expected to have CRB – please tick UG students are advised that institutions may require them to have CRB please confirm that you are aware of this by ticking here _____ This is not relevant as the study is being conducted in Trinidad, West Indies.	YES/**NO** Required
6. How, and from whom (e.g. from parents, from participants via signature) will informed consent be obtained? *(See consent guidelines[2]; note special considerations for some questionnaire research)* **Participants will be asked to sign an informed consent form after they are satisfied they have obtained enough information about the study.**	
7. Will you inform participants of their right to withdraw from the research at any time, without penalty? *(see consent guidelines[2])*	**YES**/NO

8. Will you provide a full debriefing at the end of the data collection phase? *(see debriefing guidelines[3])*	**YES**/NO
9. Will you be available to discuss the study with participants, if necessary, to monitor any negative effects or misconceptions? If "no", how do you propose to deal with any potential problems?	**YES**/NO
10. Under the Data Protection Act, participant information is confidential unless otherwise agreed in advance. Will confidentiality be guaranteed? *(see confidentiality guidelines[5])* If "yes" how will this be assured *(see[5])* All data collected will coded to protect the identity of participants and the coded information securely stored in a password protected file on a password protected computer. If "no", how will participants be warned? *(see[5])* *(NB: You are not at liberty to publish material taken from your work with individuals without the prior agreement of those individuals).*	**YES**/NO
11. Are there any ethical issues that concern you about this particular piece of research, not covered elsewhere on this form? If "yes" please specify:	YES/**NO**
12. Is this research or part of it going to be conducted in a language other than English?	YES/**NO**
If YES – Do you confirm that all documents and materials are enclosed here both in English and the other language, and that each one is an accurate translation of the other?	YES/NO

[1,2,3,4,5,6,7] **Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

(NB: If "yes" has been responded to any of questions 2, 3, 5, 11, 12 or "no" to any of questions 7-10, a full explanation of the reason should be provided – if necessary, on a separate sheet submitted with this form).

SECTION 2 (to be completed by all applicants – please tick as appropriate)

	YES	NO
13. Some or all of this research is to be conducted away from Middlesex University	X	
If "yes" tick here to confirm that a Risk Assessment form has been submitted	X	
14. I am aware that any modifications to the design or method of this proposal will require me to submit a new application for ethical approval	X	
15. I am aware that I need to keep all the materials/documents relating to this study (e.g. consent forms, filled questionnaires, etc) until completion of my degree / publication (as advised)	X	
16. I have read the British Psychological Society's *Ethical Principles for Conducting Research with Human participants*[4] and believe this proposal to conform with them.	X	

SECTION 3 (to be completed by STUDENT applicants and supervisors)

Researcher: (student signature) Alt - Kan date 15th May 2012

CHECKLIST FOR SUPERVISOR – please tick as appropriate

	YES	NO
1. Is the UG/PG module specified?	X	
2. If this a resubmission has this been specified and the original form enclosed here?		X
3. Is the name(s) of student/researcher(s) specified?	X	
4. Is the name(s) of supervisor specified?	X	
5. Is the consent form attached?	X	
6. Are debriefing procedures specified? If appropriate debriefing sheet enclosed – appropriate style?	X	
7. Is an information sheet for participants enclosed? appropriate style?	X	
8. Does the information sheet contain contact details for the researcher and supervisor?	X	
9. Is the information sheet sufficiently informative about the study?	X	
10. Has Section 2 been completed by the researcher on the ethics form?	X	

[1,2,3,4,5,6,7] **Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

PSY OFFICE: Study Reference Number _____ 5

11. Any parts of the study to be conducted outside the university? If so a Risk Assessment form must be attached – Is it?	X	
12. Any parts of the study to be conducted on another institution's premises? If so a letter of acceptance by the institution must be obtained – letters of acceptance by all external institutions are attached.		X
13. Letter(s) of acceptance from external institutions have been requested and will be submitted to the PSY office ASAP.	X	
14. Has the student signed the form? If physical or electronic signatures are not available, an email endorsing the application must be attached.	X	
15. Is the proposal sufficiently informative about the study?	X	

Signatures of approval:

PSY OFFICE received

Supervisor: _____ date: 14/5/12 date: _____

Ethics Panel: _____ date: 16/5/12 date: _____

17/5/12 (signed pending approval of Risk Assessment form) date: _____

If any of the following is required and not available when submitting this form, the Ethics Panel Reviewer will need to see them once they are received – please enclose with this form when they become available:

- letter of acceptance from other institution ✓
- any other relevant document (e.g. ethical approval from other institution): police check / CRB

PSY OFFICE received

Required documents seen by Ethics Panel: _____ (letters) date: 28/05/12 date: _____

[1,2,3,4,5,6,7] **Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

PSY OFFICE: Study Reference Number _____ 6

SECTION 4 (to be completed by the Psychology Ethics panel reviewers)

		Recommendations/comments
1. Is UG/PG module specified?	✓	
2. If it is a resubmission, has this been specified and the original form enclosed here?	NA	
3. Is the name(s) of student/researcher(s) specified? If physical or electronic signatures are not available, has an email endorsing the application been attached?	✓	
4. Is the name(s) of supervisor specified? If physical or electronic signatures are not available, has an email endorsing the application been attached?	✓	
5. Is the consent form attached?	✓	
6. Are debriefing procedures specified? If appropriate, is the debriefing sheet attached? Is this sufficiently informative?	✓	
7. Is an information sheet for participants attached?	✓	Correct typo.
8. Does the information sheet contain contact details for the researcher?	✓	
9. Is the information sheet sufficiently informative about the study? Appropriate style?	✓	
10. Has Section 2 (points 12-15) been ticked by the researcher on the ethics form?	✓	
11. Any parts of the study to be conducted outside the university? If so a fully completed Risk Assessment form must be attached, is it?	✓	
12. If any parts of the study are conducted on another institution/s premises, a letter of agreement by the institution/s must be produced. Are letter/s of acceptance by all external institution/s attached?		Requested
13. Letter/s of acceptance by external institution/s has/have been requested	✓	
14. Has the applicant signed? If physical or electronic signatures are not available, an email endorsing the application must be attached.	✓	
15. Is the proposal sufficiently informative about the study? Any clarity issues?	✓	In the telephone call to arrange the interview there should be a procedure set down to check who is being spoken to and what will be said if it is not the selected participant – they must be protected against possible harm due to participating – so an alternative explanation (eg talking about taking part in a study about women's health) should be given.
16. Is anyone likely to be disadvantaged or harmed?	No	
17. If deception, protracted testing or sensitive aspects are involved, do the benefits of the study outweigh these undesirable aspects?	✓	
18. Is this research raising any conflict of interest concerns?	No	

[1,2,3,4,5,6,7] **Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

REPUBLIC OF TRINIDAD AND TOBAGO

CERTIFICATE OF CHARACTER

POLICE HEADQUARTERS

PORT OF SPAIN

D 046140 4332

Tuesday 12th June 2012

This is to certify that according to records held in the Criminal Records Office of the Trinidad and Tobago Police Service Mr./Mrs./Miss Astra Kassiram

of ... Street Sangre Grande

holding ~~Passport~~ OP No. 637959 has **NO** previous convictions against ~~him~~/her.

14 JUN 2012 — CRIMINAL RECORDS OFFICE — TRINIDAD AND TOBAGO POLICE SERVICE

Ag. Supt.

for Commissioner of Police,
Trinidad and Tobago, W.I.

N.B.—Previous convictions if any, are listed overleaf.

DATE: 14/05/12

FROM: The Principal
Guaico Presbyterian Primary School
Eastern Main Road
Sangre Grande

RE: Permission to use Guaico Presbyterian Primary School

Dear Ms. Astra Kassiram

☑ I approve your request to use a room at Guaico Presbyterian Primary School for you to conduct interviews between the period 11th June to 31st August 2012.

☐ I do not approve your request to use a room at Guaico Presbyterian Primary School for you to conduct interviews between the period 11th June to 31st August 2012.

Sincerely,

The Principal
Guaico Presbyterian Primary School

Ministry of Education
Principal
Date 14/05/12
Guaico Presbyterian School

DATE: 11·05·12

FROM: Dr. Lynette Simmons
Academic Administrator
Corinth Teachers' College
Via St. Madeleine

RE: Permission to use Corinth Teachers' College

Dear Ms. Astra Kassiram

☑ I approve your request to use a room at Corinth Teachers' College for you to conduct interviews between the period 11th June to 31st August 2012.

☐ I do not approve your request to use a room at Corinth Teachers' College for you to conduct interviews between the period 11th June to 31st August 2012.

Sincerely,

Dr. Lynette Simmons

The Academic Administrator
Corinth Teachers' College

THE UNIVERSITY OF TRINIDAD AND TOBAGO
CORINTH CAMPUS

DATE: 11th May, 2012.

FROM: The Principal
St. Augustine Secondary School
Warren Street
St. Augustine

RE: Permission to use St. Augustine Secondary School

Dear Ms. Astra Kassiram

☑ I approve your request to use a room at St. Augustine Secondary School for you to conduct interviews between the period 11th June to 31st August 2012.

☐ I do not approve your request to use a room at St. Augustine Secondary School for you to conduct interviews between the period 11th June to 31st August 2012.

Sincerely,

N. Seemungal

The Principal (Ag)
St. Augustine Secondary School

PRINCIPAL
ST. AUGUSTINE SECONDARY SCHOOL

DATE: 14 MAY, 2012

FROM: The Chairperson
Siparia Presbyterian Church
Siparia Old Road
Siparia

RE: Permission to use Siparia Presbyterian Church

Dear Ms. Astra Kassiram

☑ I approve your request to use a room at Siparia Presbyterian Church for you to conduct interviews between the period 11th June to 31st August 2012.

☐ I do not approve your request to use a room at Siparia Presbyterian Church for you to conduct interviews between the period 11th June to 31st August 2012.

Sincerely,

The Chairperson
Siparia Presbyterian Primary School
Siparia Old Road
Siparia

ETERNAL LIGHT
Siparia Road
PRESBYTERIAN CHURCH

INDEPENDENT FIELD/LOCATION WORK RISK ASSESSMENT FRA1

This proforma is applicable to, and must be completed in advance for, the following field/location work situations:

1. *All field/location work undertaken independently by individual students, either in the UK or overseas, including in connection with proposition module or dissertations. Supervisor to complete with student(s).*
2. *All field/location work undertaken by postgraduate students. Supervisors to complete with student(s).*
3. *Field/location work undertaken by research students. Student to complete with supervisor.*
4. *Field/location work/visits by research staff. Researcher to complete with Research Centre Head.*
5. *Essential information for students travelling abroad can be found on www.fco.gov.uk*

FIELD/LOCATION WORK DETAILS

Name ...Astra Kassiram
.....

Student No
Research Centre (staff only).....

Supervisor Dr. Miranda Horvath
.....

Degree course ...MPhil/PhD Psychology
.....

Telephone numbers and name of next of kin who may be contacted in the event of an accident	**NEXT OF KIN** **Name Mrs. Carla Kassiram – Lackhai** ..... **Phone .....1 868 642 5466** .....
Physical or psychological limitations to carrying out the proposed field/location work	.....**NONE.**.....
Any health problems (full details) Which may be relevant to proposed field/location work activity in case of emergencies.	.....**NONE**..... .....
Locality (Country and Region)	...**TRINIDAD, EIGHT ADMINISTRATVE BOUNDARIES (COUNTIES)** .....
Travel Arrangements	**PERSONAL CAR** ....
NB: Comprehensive travel and health insurance must always be obtained for independent overseas field/location work.	**PERSONAL INSURANCE IN TRINIDAD** ....
Dates of Travel and Field/location work	**JUNE TO AUGUST 2012** ....

PLEASE READ THE FOLLOWING INFORMATION VERY CAREFULLY

Hazard Identification and Risk Assessment

List the localities to be visited or specify routes to be followed **(Col. 1)**. For each locality, enter the potential hazards that may be identified beyond those accepted in everyday life. Add details giving cause for concern **(Col. 2)**.

Examples of Potential Hazards :
Adverse weather: exposure (heat, sunburn, lightening, wind, hypothermia)
Terrain: rugged, unstable, fall, slip, trip, debris, and remoteness. Traffic: pollution.
Demolition/building sites, assault, getting lost, animals, disease.
Working on/near water: drowning, swept away, disease (weils disease, hepatitis, malaria, etc), parasites', flooding, tides and range.
Lone working: difficult to summon help, alone or in isolation, lone interviews.
Dealing with the public: personal attack, causing offence/intrusion, misinterpreted, political, ethnic, cultural, socio-economic differences/problems. Known or suspected criminal offenders.
Safety Standards (other work organisations, transport, hotels, etc), working at night, areas of high crime.
Ill health: personal considerations or vulnerabilities, pre-determined medical conditions (asthma, allergies, fitting) general fitness, disabilities, persons suited to task.
Articles and equipment: inappropriate type and/or use, failure of equipment, insufficient training for use and repair, injury.
Substances (chemicals, plants, bio- hazards, waste): ill health - poisoning, infection, irritation, burns, cuts, eye-damage.
Manual handling: lifting, carrying, moving large or heavy items, physical unsuitability for task

If no hazard can be identified beyond those of everyday life, enter 'NONE'.

1. LOCALITY/ROUTE	2. POTENTIAL HAZARDS
1. ADVERSE WEATHER	1. FLOODING

The University Field/location work code of Practice booklet provides practical advice that should be followed in planning and conducting field/location work.

Risk Minimisation/Control Measures

PLEASE READ VERY CAREFULLY

For each hazard identified **(Col 2)**, list the precautions/control measures in place or that will be taken **(Col 3)** to **"reduce the risk to acceptable levels"**, and the safety equipment **(Col 5)** that will be employed.

Assuming the safety precautions/control methods that will be adopted **(Col. 3)**, categorise the field/location work risk for each location/route as negligible, low, moderate or high **(Col. 4)**.
Risk increases with both the increasing likelihood of an accident and the increasing severity of the consequences of an accident.

An acceptable level of risk is: a risk which can be safely controlled by person taking part in the activity using the precautions and control measures noted including the necessary instructions, information and training relevant to that risk. The resultant risk should not be significantly higher than that encountered in everyday life.
Examples of control measures/precautions:
Providing adequate training, information & instructions on field/location work tasks and the safe and correct use of any equipment, substances and personal protective equipment. Inspection and safety check of any equipment prior to use. Assessing individuals fitness and suitability to environment and tasks involved. Appropriate clothing, environmental information consulted and advice followed (weather conditions, tide times etc.). Seek advice on harmful plants, animals & substances that may be encountered, including information and instruction on safe procedures for handling hazardous substances. First aid provisions, inoculations, individual

medical requirements, logging of location, route and expected return times of lone workers. Establish emergency procedures (means of raising an alarm, back up arrangements). Working with colleagues (pairs). **Lone working is not permitted where the risk of physical or verbal violence is a realistic possibility.** Training in interview techniques and avoiding /defusing conflict, following advice from local organisations, wearing of clothing unlikely to cause offence or unwanted attention. Interviews in neutral locations. Checks on Health and Safety standards & welfare facilities of travel, accommodation and outside organisations. Seek information on social/cultural/political status of field/location work area.
Examples of Safety Equipment: Hardhats, goggles, gloves, harness, waders, whistles, boots, mobile phone, ear protectors, bright fluorescent clothing (for roadside work), dust mask, etc.

If a proposed locality has not been visited previously, give your authority for the risk assessment stated or indicate that your visit will be preceded by a thorough risk assessment.

3. PRECAUTIONS/CONTROL MEASURES	4. RISK ASSESSMENT (low, moderate, high)	5. SAFETY/EQUIPMENT
1. USUALLY LOCALIZED FLOODING THAT WOULD QUICKLY SUBSIDE AFTER THE RAIN STOPS; THIS IS A USUAL OCCURANCE FOR CITIZENS OF TRINIDAD.	1. LOW	1. PROPER SHOES 2. UMBRELLA

PLEASE READ THE FOLLOWING INFORMATION AND SIGN AS APPROPRIATE

DECLARATION: The undersigned have assessed the activity and the associated risks and declare that there is no significant risk or that the risk will be controlled by the method(s) listed above/over. Those participating in the work have read the assessment and will put in place precautions/control measures identified.

NB: Risk should be constantly reassessed during the field/location work period and additional precautions taken or field/location work discontinued if the risk is seen to be unacceptable.

Signature of Field/location worker (Student/Staff) A.A - Ka ..... **Date** 14th May 2012

Signature of Student Supervisor ..... **Date** 14/5/12.

APPROVAL: (ONE ONLY)

Signature of Director of Programmes (undergraduate students only) ..... **Date** .....

Signature of Research Degree Co-ordinator or Director of Programmes (Postgraduate) ..... **Date** 17/05/12

pp Ethics Chair

Signature of Research Centre Head (for staff field/location workers) ..... **Date** .....

FIELD/LOCATION WORK CHECK LIST

1. Ensure that **all members** of the field party possess the following attributes (where relevant) at a level appropriate to the proposed activity and likely field conditions:

X Safety knowledge and training?

X Awareness of cultural, social and political differences?

X Physical and psychological fitness and disease immunity, protection and awareness?

X Personal clothing and safety equipment?

X Suitability of field/location workers to proposed tasks?

2. Have all the necessary arrangements been made and information/instruction gained, and have the relevant authorities been consulted or informed with regard to:

n/a Visa, permits?

n/a Legal access to sites and/or persons?

n/a Political or military sensitivity of the proposed topic, its method or location?

X Weather conditions, tide times and ranges?

X Vaccinations and other health precautions?

n/a Civil unrest and terrorism?

X Arrival times after journeys?

X Safety equipment and protective clothing?

X Financial and insurance implications?

X Crime risk?

X Health insurance arrangements?

X Emergency procedures?

X Transport use?

X Travel and accommodation arrangements?

Important information for retaining evidence of completed risk assessments:

Once the risk assessment is completed and approval gained the **supervisor** should retain this form and issue a copy of it to the field/location worker participating on the field course/work. In addition the **approver** must keep a copy of this risk assessment in an appropriate Health and Safety file.

Appendix Sa: Questionnaire for Religious Leaders

SECTION A
This section is designed to gather some general information about you. This information will not be used to identify you but instead look for trends.

Please tick the appropriate answer or write you answer where indicated.

Participant Number: _____

Q.3: Please indicate your religious orientation.

CHRISTIAN	
HINDU	
MUSLIM	
OTHER	

Please Specify_____

Q.4: Please indicate which setting you use to practice as a religious leader.

PRIVATE GROUP PRACTICE (You operate your religious establishment in collaboration with other leaders)	
PRIVATE SOLO PRACTICE (You own and operate your religious establishment independently)	
FORMAL INSTITUTION (Your religious institution is operated by a governing body)	
OTHER	

Please specify _____

Q.5: Please indicate the highest level of education you have:

NO FORMAL TRAINING	
CERTIFICATE	
DIPLOMA	
ASSOCIATES DEGREE	
BACHELOR DEGREE	
MASTERS DEGREE	
OTHER	

Please Specify_____

Q.6: If you have a religious qualification please could you state which year you obtained the qualification?

_____

Q.7: If you have a religious qualification did you obtain it from an institution:

IN TRINIDAD	
OUTSIDE TRINIDAD	

Q.8: On average how many total hours per week do you spend attending to people within the religious setting?

_____

Q.9: Which ethnicity do you identify as?

INDO-TRINIDADIAN	
AFRO-TRINIDADIAN	
MIXED ETHNICITY	
OTHER	

Please specify_____

Q.10: What is your gender?

MALE	
FEMALE	

Q.11: Please state your age:

_____

Section B
This section is designed to gather information with regards to resources and the assistance you provide to women who have been identified as experiencing some physical concerns.

Please tick/circle the appropriate answer or write your answer where indicated.

Q.12: Have you heard the term Somatization Disorder?

YES	
NO	

Q.13: If yes, briefly state what you understand the term somatization disorder means and then proceed to the definition provided below and then continue to question 14:

_____

_____

If no, please read the below definition and then proceed to question 14

Somatization is a mental disorder that presents with multiple (somatic) body symptoms and is seen mostly in women by age 30. The multiple (somatic) bodily complaints cannot be otherwise explained by a general medical condition or substance use. It is characterized by a combination of pain (e.g. head, joints, chest, abdomen), gastrointestinal (e.g. nausea, bloating, vomiting), sexual (e.g. irregular menses, excessive menstrual bleeding) and pseudo neurological (e.g. weakness, lump in throat, paralysis, lack of coordination or balance that are not real) symptoms. The symptoms must cause clinically significant distress or impairment in social, occupational, or other areas of functioning (DSM-IV-TR, 2000 p.485 & 486).

Q.14: Now that you have read the definition of what is somatization disorder; as a religious leader have you ever met any women with those symptoms?

YES ☐

NO ☐

If yes, please proceed to question 15

If no, please proceed to question 21

Q.15: How often do you ask:

a. WOMEN YOU SEE FOR THE FIRST TIME ABOUT SYMPTOMS ASSOCIATED WITH SOMATIZATION DISORDER

Always (5) Often (4) Sometimes (3) Rarely (2) Never (1)

b. RETURNING WOMEN ABOUT THEIR SYMPTOMS ASSOCIATED WITH SOMATIZATION DISORDER

Always (5) Often (4) Sometimes (3) Rarely (2) Never (1)

Q.16: As a religious leader, in the past six months with roughly how many women have you DISCUSSED somatization disorder with?

_____

If you have not discussed somatization disorder with any of the women you meet please proceed to question 21

If you have discussed somatization disorder with any of the women please proceed to question 17

Q.17: As a religious leader, based on the women you have met which ethnicity is most likely to have somatization disorder?

INDO-TRINIDADIAN	
AFRO-TRINIDADIAN	
MIXED ETHNICITY	
NO DIFFERENCE	
OTHER	

Please specify_____

Q.18: When any of the symptoms presented in the definition for somatization disorder is first identified in a woman, how often do you do each of the following:

Question	Always (5)	Often (4)	Sometimes (3)	Rarely (2)	Never (1)
a. DOCUMENT THE SYMPTOMS					
b. GIVE VALIDATING MESSAGES AND SHOW CONCERN					
c. PROVIDE INFORMATION VERBALLY TO INCREASE THE WOMAN'S KNOWLEDGE ABOUT SOMATIZATION DISORDER					
d. PROVIDE WRITTEN MATERIALS ON SOMATIZATION DISORDER					
e. ARRANGE FOR FOLLOW-UP VISITS OR CALLS					
f. I LOOK TO GOD AND PRAY FOR A SOLUTION					
g. I SUGGESTS THE WOMAN TURNS TO GOD AND PRAYS FOR SUPPORT/SOLUTION					
h. REFER THE WOMAN TO ANOTHER RESOURCE					

Q.19: If you have referred women to another source for help please indicate where (please tick all that apply):

MEDICAL DOCTOR	
PSYCHOLOGIST	
PSYCHIATRIST	
ANOTHER RELIGIOUS LEADER	
OTHER	

If other, please specify

_____

Q.20: When the woman is willing to discuss her symptoms of somatization disorder, roughly how much time in a single visit for you spend discussing them with her (number of minutes)?

_____

Q.21: Please indicate the extent to which you feel the following task is part of your role as a religious leader.

INTERVENING IF SYMTOMS OF SOMATIZATION DISORDER ARE IDENTIFIED

VERY IMPORTANT (5) IMPORTANT (4) NEUTRAL (3) SOMEWHAT MY ROLE (2) NOT MY ROLE(1)

Q.22: FOR QUESTIONS A TO G TO WHAT EXTENT YOU AGREE OR DISAGREE WITH THE STATEMENT PRESENTED USING THE SCALE BELOW.

Question	Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
A: I have adequate resources to refer the women to additional services for somatization disorder.				
B: I know how to assess women for somatization disorder.				
C: I know how to intervene with women to address somatization disorder.				
D: My efforts to facilitate change are likely to be successful.				
E: I would rather refer the women for counseling for their symptoms of somatization disorder than provide counseling myself.				
F: If I could bill for my time spent counseling/educating the women, I would spend more time addressing their symptoms of somatization disorder.				
G: Please indicate the extent to which you feel your work with other parishioners has affected the time you spend in prevention work with women who have somatization disorder.				

Q.23: Does your institution/office have a system to remind you to assess for the somatization disorder?

Yes No Don't Know

Q.24: Does you institution/office have a system to record information for women with somatization disorder?

Yes No Don’t Know

Q. 25: If yes, please indicate what system is currently in place:

Put it as an 'additional information' note on her record	
I record it in a specific section of her records	
Other	

Please specify _____

Q.26: Do you have access to self-help materials (e.g., brochures) for women who come to you with somatization disorder?

Yes No Don't Know

SECTION C

This section is designed to gather information with regards to your knowledge, resources and assistance you provide to women who have experienced domestic violence.

Please tick/circle the appropriate answer or write your answer where indicated.

Q.27: Have you heard the term Domestic Violence:

YES	
NO	

Q.28: If yes, briefly state what you understand the term domestic violence means and then proceed to the definition provided below and then continue to question 29

_____

_____

If no, please read the below definition of what is domestic violence and then proceed to question 29:
Domestic violence is the "physical, sexual, emotional or psychological or financial abuse committed by a person against a spouse, child, any other person who is a member of the household or dependent" (The Domestic Violence Act 27 of 1999 p.292).

Q.29: Now that you have read the definition of what is domestic violence; as a religious leader have you ever met with any women with domestic violence experiences?

YES ☐

NO ☐

If yes, please proceed to question 30

If no, please proceed to question 36

Q.30: How often do you ask:

a. WOMEN YOU SEE FOR THE FIRST TIME ABOUT THEIR EXPERIENCES OF DOMESTIC VIOLENCE

Always (5) Often (4) Sometimes (3) Rarely (2) Never (1)

b. RETURNING WOMEN ABOUT THEIR EXPERIENCES OF DOMESTIC VIOLENCE

Always (5) Often (4) Sometimes (3) Rarely (2) Never (1)

Q.31: As a religious leader, in the past six months with roughly how many women have you discussed domestic violence?

_____

If you have not discussed domestic violence with any of the women in the past six months please proceed to question 36

If you have discussed domestic violence with any of the women in the past six months please proceed to question 32

Q.32: As a religious leader, based on the women you have met which ethnicity is most likely to have experienced domestic violence?

INDO-TRINIDADIAN	
AFRO-TRINIDADIAN	
MIXED	
NO DIFFERENCE	
OTHER	

Please specify_____

Q.33: When you first realize a women has experienced domestic violence how often do you do each of the following?

Question	Always (5)	Often (4)	Sometimes (3)	Rarely (2)	Never (1)
a. DOCUMENT THE DOMESTIC VIOLENCE					
b. GIVE VALIDATING MESSAGES AND SHOW CONCERN					
c. PROVIDE VERBAL INFORMATION ABOUT SHELTERS AND OTHER SERVICES					
d. PROVIDE WRITTEN MATERIALS ON DOMESTIC VIOLENCE					
e. ARRANGE FOR FOLLOW-UP VISITS OR CALLS					
f. I LOOK TO GOD AND PRAY FOR A SOLUTION					
g. I SUGGESTS THE WOMAN TURNS TO GOD AND PRAYS FOR SUPPORT/SOLUTION					
h. REFER THE WOMAN TO ANOTHER RESOURCE					

Q.34: If you have referred women to another source for help please indicate where (please tick all that apply):

POLICE	
MEDICAL DOCTOR	
PSYCHOLOGIST	
A SHELTER	
INSTITUTION THAT SPECIFICALLY DEALS WITH DOMESTIC VIOLENCE	
ANOTHER RELIGIOUS LEADER	
OTHER	

If other, please specify _____

Q.35: When a woman is willing to discuss her domestic violence experiences, on average much time in a single visit for you spend discussing this with her (number of minutes)?

_____

Q. 36: Please indicate the extent to which you feel the following task is part of your role as a religious leader.

INTERVENING IF DOMESTIC VIOLENCE IS IDENTIFIED

VERY IMPORTANT (5) IMPORTANT (4) NEUTRAL (3) SOMEWHAT MY ROLE (2) NOT MY ROLE(1)

Q.37: FOR QUESTIONS A TO G TO WHAT EXTENT YOU AGREE OR DISAGREE WITH THE STATEMENT PRESENTED USING THE SCALE BELOW.

Question	Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
A: I have adequate resources to refer the women to additional services for this domestic violence.				
B: I know how to assess women for domestic violence.				
C: I know how to intervene with women to address the risk of domestic violence.				
D: My efforts to facilitate change in each of these areas of risk are likely to be successful.				
E: I would rather refer the women for counseling for this risk than provide counseling myself.				
F: If I could bill for my time spent counseling/educating the women, I would spend more time addressing this risk.				
G: Please indicate the extent to which your work with other parishioners has affected the time you spend on prevention work for domestic violence.				

Q.38: Does your institution/office have a system to remind you to assess for domestic violence?

Yes No Don't Know

Q.39: Do you have access to self-help materials (e.g., brochures) for domestic violence?

Yes No Don't Know

Q.40: Does you institution/office have a system to record information for women who had domestic violence experiences?

Yes No Don't Know

Q. 41: If yes, please indicate what system is currently in place:

Put it as an 'additional information' note on her record	
I record it in a specific section of her records	
Other	

Please specify _____

Q.42: In your experience roughly what proportion of women who have experienced domestic violence also have somatization disorder?

Less than 10%	
10% - 20%	
21% - 30%	
31% - 40%	
41% - 50%	
51% - 60 %	
61% - 70%	
71% - 80%	
81% - 90%	
91% - 100%	
UNABLE TO JUDGE	

THANK YOU FOR YOUR CO-OPERATION AND PARTICIAPTION

Appendix Sb: Questionnaire for Medical Doctors

SECTION A
This section is designed to gather some general information about you. This information will not be used to identify you but instead look for trends.

Please tick the appropriate answer or write you answer where indicated.

Participant Number: _____

Q.3: Please indicate your primary specialty.

FAMILY PRACTICE	☐
INTERNAL MEDICINE	☐
GENERAL INTERNAL MEDICINE	☐
OTHER	☐

Please Specify_____

Q.4: Would you say you are practicing as a generalist or a specialist?

GENERALIST	☐
SPECIALIST	☐

Q.5: Please indicate the setting of your primary practice site.

PRIVATE GROUP PRACTICE	☐
PRIVATE SOLO PRACTICE	☐
UNIVERSITY/TEACHING HOSPITAL	☐
PUBLIC COMMUNITY HEALTH CENTER/CLINIC	☐
PRIVATE NON-TEACHING HOSPITAL	☐
GOVERNMENT-OWNED HOSPITAL	☐
OTHER PRIVATE	☐

Q.6: What year did you graduate medical school?

_____

Q.7: Where did you graduate from medical school?

IN TRINIDAD ☐

OUTSIDE TRINIDAD ☐

Q.8: On average how many hours per week are you in primary care practice? (all sites combined)?

_____

Q.9: Which ethnicity do you identify as?

INDO-TRINIDADIAN ☐

AFRO-TRINIDADIAN ☐

MIXED ETHNICITY ☐

OTHER ☐

Please specify_____

Q.10: What is your gender?

MALE ☐

FEMALE ☐

Q.11: Please indicate your religious orientation.

CHRISTIAN ☐

HINDU ☐

MUSLIM ☐

OTHER ☐

Please Specify_____

Q.12: Please state your age:

_____

Section B
This section is designed to gather information with regards to resources, patients and the assistance you provide to women who have been identified as having somatization disorder.

Please tick/circle the appropriate answer or write your answer where indicated.

Q.13: Have you heard the term Somatization Disorder?

YES ☐

NO ☐

Q.14: If yes, briefly state what you understand the term somatization disorder means and then proceed to the definition provided below and then continue to question 15:

_____

_____

_____

_____

If no, please read the definition provided below and then proceed to question 3:

Somatization is a mental disorder that presents with multiple (somatic) body symptoms and is seen mostly in women by age 30. The multiple (somatic) bodily complaints cannot be otherwise explained by a general medical condition or substance use. It is characterized by a combination of pain (e.g. head, joints, chest, abdomen), gastrointestinal (e.g. nausea, bloating, vomiting), sexual (e.g. irregular menses, excessive menstrual bleeding) and pseudo neurological (e.g. weakness, lump in throat, paralysis, lack of coordination or balance that are not real) symptoms. The symptoms must cause clinically significant distress or impairment in social, occupational, or other areas of functioning (DSM-IV-TR, 2000 p.485 & 486).

Q.15: Now that you have read the definition of what is somatization disorder, have you ever DIAGNOSED any women with somatization disorder?

YES ☐

NO ☐

If yes, please proceed to question 17

If no, please proceed to question 16

Q. 16: Now that you have read the definition of what is somatization disorder, do any of your female patients present with symptoms associated with somatization disorder but you did not actually diagnose it?

YES ☐

NO ☐

If yes, please proceed to question 17

If no, please proceed to question 24

Q.17: How often do you ask:

a. NEW PATIENTS (WOMEN) ABOUT SYMPTOMS ASSOCIATED WITH SOMATIZATION DISORDER

Always (5) Often (4) Sometimes (3) Rarely (2) Never (1)

b. REGULAR PATIENTS (WOMEN) ABOUT SYMPTOMS ASSOCIATED WITH SOMATIZATION DISORDER

Always (5) Often (4) Sometimes (3) Rarely (2) Never (1)

Q.18: In the past six months, with roughly how many women have you DISCUSSED symptoms of somatization disorder?

_____

If you have not discussed somatization disorder with any of your female patients in the past six months please proceed to question 24

If you have discussed somatization disorder with any of your female patients in the past six months please proceed to question 19

Q. 19: In the past six months how many women have you DIAGNOSED as having somatization disorder.

_____

If you have diagnosed women with somatization disorder in the past six months please proceed to question 20

If you have not diagnosed any women with somatization disorder in the past six months please proceed to question 24

Q.20: Based on your patients, women from which ethnicity are most likely to have somatization disorder?

INDO-TRINIDADIAN	
AFRO-TRINIDADIAN	
MIXED ETHNICITY	
NO DIFFERENCE	
OTHER	

Please specify_____

Q.21: When symptoms of somatization disorder are first identified in a woman, how often do you do each of the following:

Question	Always (5)	Often (4)	Sometimes (3)	Rarely (2)	Never (1)
a. DOCUMENT THE SYMPTOMS					
b. GIVE VALIDATING MESSAGES AND SHOW CONCERN					
c. PROVIDE INFORMATION VERBALLY TO INCREASE PATIENT KNOWLEDGE ABOUT SOMATIZATION DISORDER					
d. PROVIDE WRITTEN MATERIALS ON SOMATIZATION DISORDER					
e. ARRANGE FOR FOLLOW-UP VISITS OR CALLS					
f. I LOOK TO GOD AND PRAY FOR A SOLUTION					
g. I SUGGEST THE WOMAN TURNS TO GOD AND PRAYS FOR SUPPORT/SOLUTION					
h. REFER TO ANOTHER RESOURCE					

Q.22: If you have referred women to another source for help please indicate where (please tick all that apply):

ANOTHER MEDICAL DOCTOR	
PSYCHOLOGIST	
PSYCHIATRIST	
RELIGIOUS LEADER	
OTHER	

If other, please specify _____

Q23: When the woman is willing to discuss her symptoms of somatization disorder, about how much time in a single visit for you spend discussing them with her (number of minutes)?

_____

Q.24: Please indicate the extent to which you feel the following task is part of your role as a physician.

INTERVENING IF SOMATIZATION DISORDER IS IDENTIFIED

VERY IMPORTANT (5) IMPORTANT (4) NEUTRAL (3) SOMEWHAT MY ROLE (2) NOT MY ROLE (1)

Q.25: FOR QUESTIONS A TO G TO WHAT EXTENT YOU AGREE OR DISAGREE WITH THE STATEMENT PRESENTED USING THE SCALE BELOW.

Questions	**Strongly Agree (4)**	**Agree (3)**	**Disagree (2)**	**Strongly Disagree (1)**
A: I have adequate resources to refer patients (women) to additional services for somatization disorder.				
B: I know how to assess patients (women) for somatization disorder.				
C: I know how to intervene with patients (women) to address somatization disorder.				
D: My efforts to facilitate change are likely to be successful.				
E: I would rather refer my patients (women) for counseling for their symptoms of somatization disorder than provide counseling myself.				
F: If I could bill for my time spent counseling/educating my patients (women), I would spend more time addressing their symptoms of somatization disorder.				
G: Please indicate the extent to which you feel your work with other patients has affected the time you spend in prevention work with women who have somatization disorder.				

Q.26: Does your institution/office have a system to remind you to assess for somatization disorder?

Yes No Don't Know

Q. 27: Does you institution/office have a system to record information for patients with somatization disorder?

Yes No Don't Know

Q. 28: If yes, please indicate what system is currently in place:

I put it as an 'additional information' note on her record ☐

I record it in a specific section of her records ☐

Other ☐

Please specify _____

Q.29: Do you have access to self-help materials (e.g., brochures) for somatization disorder?

Yes No Don't Know

SECTION C

This section is designed to gather information with regards to your knowledge, resources and assistance you provide to women who have had experiences of domestic violence.

Please tick/circle the appropriate answer or write your answer where indicated.

Q.30: Have you heard the term Domestic Violence:

YES ☐

NO ☐

Q.31: If yes, briefly state what you understand the term domestic violence means and proceed to the definition provided below and then continue to question 32:

_____

_____

If no, please read the below definition of what is domestic violence and then proceed to question 32:

Domestic violence is the "physical, sexual, emotional or psychological or financial abuse committed by a person against a spouse, child, any other person who is a member of the household or dependent"(The Domestic Violence Act 27 of 1999 p.292).

Q.32: Now that you have read the definition of what is domestic violence, have you ever identified any women with experiences of domestic violence?

YES ☐

NO ☐

If yes, please proceed to question 34

If no, please proceed to question 33

Q.33: Now that you have read the definition of what is domestic violence, do you think any of your female patients have experienced domestic violence?

YES ☐

NO ☐

If yes, please proceed to question 34

If no, please proceed to question 40

Q.34: How often do you ask:

a. NEW PATIENTS (WOMEN) ABOUT THEIR EXPERIENCES OF DOMESTIC VIOLENCE

Always (5) Often (4) Sometimes (3) Rarely (2) Never (1)

b. REGULAR PATIENTS (WOMEN) ABOUT THEIR EXPERIENCES OF DOMESTICVIOLENCE

Always (5) Often (4) Sometimes (3) Rarely (2) Never (1)

Q.35: In the past six months, with roughly how many women have you DISCUSSED domestic violence?

_____

If you have not discussed domestic violence with any of your female patients in the past six months please proceed to question 40
If you have discussed domestic violence with any of your female patients in the past six months please proceed to question 36

Q36: Based on your patients, women from which ethnicity are most likely to have experienced domestic violence?

INDO-TRINIDADIAN	
AFRO-TRINIDADIAN	
MIXED	
NO DIFFERENCE	
OTHER	

Please specify_____

Q.37: When you first realize a women has experienced domestic violence how often do you do each of the following?

Question	**Always (5)**	**Often (4)**	**Sometimes (3)**	**Rarely (2)**	**Never (1)**
a. DOCUMENT THE DOMESTIC VIOLENCE					
b. GIVE VALIDATING MESSAGES AND SHOW CONCERN					
c. PROVIDE VERBAL INFORMATION ABOUT SHELTERS AND OTHER SERVICES					
d. PROVIDE WRITTEN MATERIALS ON DOMESTIC VIOLENCE					

Q.37 con't: When you first realize a women has experienced domestic violence how often do you do each of the following?

Question	Always (5)	Often (4)	Sometimes (3)	Rarely (2)	Never (1)
e. ARRANGE FOR FOLLOW-UP VISITS OR CALLS					
f. I LOOK TO GOD AND PRAY FOR A SOLUTION					
g. I SUGGESTS THE WOMAN TURNS TO GOD AND PRAYS FOR SUPPORT/SOLUTION					
h. REFER TO ANOTHER RESOURCE					

Q.38: If you have referred women to another source for help please indicate where (please tick all that apply):

POLICE	
ANOTHER MEDICAL DOCTOR	
PSYCHOLOGIST	
A SHELTER	
INSTITUTION THAT SPECIFICALLY DEALS WITH DOMESTIC VIOLENCE	
RELIGIOUS LEADER	
OTHER	

If other, please specify _____

Q.39: When the woman is willing to discuss her experiences of domestic violence, on average how much time in a single visit for you spend discussing this with her (number of minutes)?

_____

Q.40: Please indicate the extent to which you feel the following task is part of your role as a physician.

INTERVENING IF DOMESTIC VIOLENCE IS IDENTIFIED

VERY IMPORTANT (5) IMPORTANT (4) NEUTRAL (3) SOMEWHAT MY ROLE (2) NOT MY ROLE(1)

Q.41: For questions A to G to what extent you agree or disagree with the statement presented using the scale below.

Question	Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
A: I have adequate resources to refer patients to additional services for domestic violence.				
B: I know how to assess patients (women) for domestic violence.				
C: I know how to intervene with patients (women) to address the risk of domestic violence.				
D: My efforts to facilitate change in the risk of domestic violence are likely to be successful.				
E: I would rather refer my patients (women) for counseling for this risk than provide counseling myself.				
F: If I could bill for my time spent counseling/educating my patients (women), I would spend more time addressing domestic violence.				
G: Please indicate the extent to which you feel your work with other patients has affected the time you spend on prevention work for domestic violence.				

Q.42: Does your institution/office have a system to remind you to assess for domestic violence?

Yes No Don't Know

Q.43: Do you have access to self-help materials (e.g., brochures) for domestic violence?

Yes No Don't Know

Q. 44: Does you institution/office have a system to record information for patients with experiences of domestic violence?

Yes No Don't Know

Q. 45: If yes, please indicate what system is currently in place:

I put it as an 'additional information' note on her record ☐

I record it in a specific section of her records ☐

Other ☐

Please specify _____

Q.46: In your experience roughly what proportion of women who have experienced domestic violence also have somatization disorder?

Less than 10%	
10% - 20%	
21% - 30%	
31% - 40%	
41% - 50%	
51% - 60 %	
61% - 70%	
71% - 80%	
81% - 90%	
91% - 100%	
UNABLE TO JUDGE	

THANK YOU FOR YOUR CO-OPERATION AND PARTICIPATION!

Appendix T: Administrative Boundaries (Counties) and Gatekeepers

Administrative Boundary (Counties)	Gate Keeper
1. St. David	Corporal Sheldon Kassiram
2. St. Andrew	Mrs. Margaret Gopaul-Mohammed (Teacher)/Mrs. Shirley Kassiram (Retired Accountant)
3. Nariva	Mrs. Florence Nunu (Teacher)
4. Mayaro	Corporal Sheldon Kassiram
5. St. George	Mrs. Margaret Chatoor(Counselor)/ Mrs. Tracey Kassiram-Lackhai (Secondary School Teacher)
6. Caroni	Mrs. Fatima Thomas (Secondary School Teacher)
7. Victoria	Mr. Nero Doonath (Retired Teacher)
8. St. Patrick	Mrs. Sita Singh (Retired Teacher)

Appendix U: Online Invitation to Participate

Email Invitation for Online Participation

Dear Participant

My name is Astra Kassiram and I am a PhD student studying in the United Kingdom. You are being invited to participate in a research study entitled *"Help agencies understanding and intervention for women with somatization disorder and domestic violence".* Please take a few moments to carefully read the below information and attached information sheet that provides details about the study. If after reading this information you still need further clarification or have questions please do not hesitate to contact the primary investigator by email (a.kassiram@mdx.ac.uk). Participation is voluntary, so take your time in deciding whether or not you would like to become involved in this research.

What is the purpose of the study?

This study focuses on the medical practitioner and religious leaders' resources, willingness to explore and intervention strategies they employ when consulting with women who may have domestic violence experiences and somatization disorder. The Trinidad and Tobago Government is funding this study; therefore it is hoped the results of this will inform them about the help offered by medical practitioners and religious leaders to women who have somatization disorder and experience domestic violence.

What will the study involve?

You will be required to complete a questionnaire which has three sections. The sections ask questions about your practice and the help you may have offered to women with domestic violence experiences and somatic symptoms. It should take you no longer than 25 minutes to complete; there is no right or wrong answers; I simply want your opinion. When you have finished the questionnaire there will be an opportunity for you to further discuss the study with me, in order to fully address any questions or concerns you may have.

Your participation in this study is entirely voluntary. You may for any reason choose to withdraw from the study AT ANY TIME. Only consent to participate if you have read and understood the above information. Thank you for taking time out to consider taking part in this study.

If you would like to complete the questionnaire, please go to:

If you have any questions about participating in this study please do not hesitate to contact Ms. Astra Kassiram at 780 1336; a.kassiram@mdx.ac.uk or my supervisor Dr. Miranda Horvath (m.horvath@mdx.ac.uk).

THANK YOU FOR YOUR CO-OPERATION AND PARTICIPATION!

Appendix V: Information Sheet

Middlesex University School of Health and Social Sciences
Psychology Department

Information Sheet

Somatization and Domestic Violence

Your participation is appreciated.

Participant Number: _____

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

Who am I?

My name is Astra Kassiram and I am conducting this research as part of my doctoral studies with Middlesex University, London.

What is the title of research?

Help agencies understanding and intervention for women with somatization disorder and domestic violence

What is the purpose of this study?

This study is designed to gather information from various help agencies (medical doctors and religious leaders) about the help resources they have available, willingness to explore and intervention strategies they employ when meeting with women who may have domestic violence experiences and somatization disorder. A study like this one has never been done in Trinidad before, therefore the different Ministries in Trinidad will be informed and hopefully makes changes to Health Care, Education and Social Services to provide better services.

What will the study involve?

You will be required to complete a questionnaire which has three sections. The sections ask questions about your practice, the help you may have offered to women with domestic violence experiences and somatic symptoms.

It should take you no longer than 25 minutes to complete; there is no right or wrong answers; I simply want your opinion. When you have finished the questionnaire there will be an opportunity for you to further discuss the study with me, in order to fully address any questions or concerns you may have.

Why should I take part?

Not only will you be helping me personally with my PhD, but you will also be contributing to the collection of human knowledge about this topic, and so benefiting society as a whole. A study of this kind has so far never been done in Trinidad and therefore you will be helping in the growth of the nation. Additionally, you may also find the experience of participating in an academic study to be personally interesting.

Why shouldn't I take part?

Participating in the study will use up some of your time, for which you will not receive any financial compensation. Additionally, whilst the questionnaires will not specifically ask about topics of a sensitive nature, there is some possibility that you may find recounting certain events to be emotionally troubling.

What if I decide not to take part?

Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decide to take part you may withdraw at any time without giving a reason.

What if I change my mind part way through the survey?

You are totally free to withdraw your participation at this point without prejudice.

What if I change my mind after the survey?

You can withdraw any data that has not yet been published at any point following completing the questionnaire, via the contact details below. You just need to make sure you remember your participation number and you information will be completely destroyed.

Will this study be properly conducted?

I am doing my PhD at Middlesex University in England and all proposals for research using human participants are reviewed by an Ethics Committee at this university before they can proceed. The Middlesex Psychology Department's Ethics Committee has reviewed this proposal. The risks in participating in this study are minimal as no identifying information about you will be released to the public. All data collected will coded to protect the identity of participants and the coded information securely stored in a password protected file on a password protected computer

Informed Consent prior to participation?

Before you participate you will be asked to sign a consent form (like the one on the next page) which will show that you understand what you are taking in part in and what the information you provide will be used for.

What if I have further questions or concerns?

If you have any questions about participating in this study please do not hesitate to contact Ms. Astra Kassiram at 07931718288 (UK) or 1868 780 1336 (T&T); a.kassiram@mdx.ac.uk or my supervisor Dr. Miranda Horvath (m.horvath@mdx.ac.uk).

Thanking you for your time.

Yours sincerely,

Ms. Astra Kassiram
Doctoral Student
Department of Psychology
Middlesex University
United Kingdom

Appendix W: Informed Consent

Middlesex University School of Health and Social Sciences
Psychology Department

Written Informed Consent

Participant Number: _____

Title of study: **Help agencies understanding and intervention for women with somatization disorder and domestic violence**

I have understood the details of the research as explained to me by the researcher and in the information sheet, confirm that I have consented to act as a participant.

I have been given contact details for the researcher in the information sheet.

I understand that my participation is entirely voluntary, the data collected during the research will not be identifiable, and I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.

I further understand that the data I provide may be used for analysis and subsequent publication, and provide my consent that this might occur.

_____ _____

Print name Sign Name

Online participants please tick here ☐

Date: _____

To the participants: Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Social Sciences Ethics committee of Middlesex University, if required by institutional audits about the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you do not wish your data to be included in audits: _____

If you have any questions about participating in this study please do not hesitate to contact Ms. Astra Kassiram at 07931718288 (UK) or 1868 780 1336 (T&T); a.kassiram@mdx.ac.uk or my supervisor Dr. Miranda Horvath (m.horvath@mdx.ac.uk).

Appendix X: Debriefing Sheet

Debriefing Information

Help agencies understanding and intervention for women with somatization disorder and domestic violence

Participant Number: _____

Thank you very much for taking part in my study, I hope you found it an interesting experience.

What if I want to know more about the study?

If you have any further questions or concerns about this study then I would be happy to discuss them now.

Alternatively, if you would like to discuss any aspect of the study at some point in the future then please contact either myself or my supervisor as detailed below.

What if I change my mind later?

You can partially or completely withdraw your data from this study at any point in the future, provided it has not yet been published. To do so please contact either myself or my supervisor as detailed below.

What if I found the study troubling?

In the event that you find any of the issues raised by this study to be troubling then you may wish to contact one of the following individuals listed below for assistance or contact either The Trinidad and Tobago Coalition Against Domestic Violence at 624 - 0402 or Families in Action at 628 - 2333 for free counselling. Additionally, you can contact the Ministry of Community Development and Gender Affairs at 623 - 6621 or 800-SAVE for information on any of the free counselling drop-in centres in your area.

Research Contacts:

Ms. Astra Kassiram (PhD Researcher)
a.kassiram@mdx.ac.uk
Telephone Numbers: 07931718288
18687801336

Dr. Susan Hansen (Director of Studies)
s.hansen@mdx.ac.uk

Dr. Miranda Horvath (Supervisor)
m.horvath@mdx.ac.uk

Dr. Paul deMornay Davies (Supervisor)
p.deMornayDavies@mdx.ac.uk

All of whom are located in the School of Health and Social Science, Psychology Department, Middlesex University, Hendon, London, NW4 4BT

Appendix Y: Coded Questions for SPSS

Religious Leaders	Medical Doctors	Coded Responses
*---------	Q 3: Please indicate your primary specialty	**Family Practice/Other
*---------	Q 5: Please indicate the setting of your primary practice site	**Public Community Health Center/Clinic and Government Owned Hospital, Private Sole and Public Community Health Centre/Clinic, Private Solo and University Teaching Hospital, University Teaching and Government Owned Hospital
Q 6: If you have a religious qualification please state which year you obtained the qualification	Q 6: What year did you graduate from medical school	1950s, 1960s, 1970s, 1980s, 2000s and above 2011
Q 7: On average how many hours per week do you spend attending to people within the religious setting?	Q 8: On average how many hours per week are you in primary care practice? (all sites combined)	None, less than 1 hour, 30 – 60 minutes, 61 – 90minutes, 91 – 120minutes, more than 120 minutes
Q 11: Please state your age	Q 12: Please state you age	18- 25, 26-30, 31-40, 41-50,51-60, 61-70, 70+
Q 16: As a religious leader, in the past six months with roughly how many women have you discussed symptoms of somatization disorder with?	Q 18: In the past six months, with roughly how many women have you DISCUSSED symptoms of somatization disorder?	None, 1-5, 6-10, 11-15, 16-20, more than 20

***** These questions were not asked of the religious leaders
** These categories were added to the original options

Appendix Y con't: Coded Questions for SPSS

Religious Leaders	Medical Doctors	Coded Response
*---------	Q 19: In the past six months how many women have you DIAGNOSED as having somatization disorder	None, 1-5, 6-10, 11-15, 16-20, more than 20
Q 20: When a women is willing to discuss her symptoms of somatization disorder, roughly how much time in a single visit do you spend discussing them with her (time in minutes)	Q 23: When a woman is willing to discuss her symptoms of somatization disorder, about how much time in a single visit do you spend discussing them with her (number in minutes)	None, less than 30 minutes, 30 -60 minutes, 61-90 minutes, 91 – 120 minutes, more than 120 minutes
Q 31: As a religious leader, in the past six months with roughly how many women have you discussed domestic violence?	Q 35: As a medical doctor, in the past six month, with roughly how many women have you discussed domestic violence?	None, 1-5, 6-10, 11-15, 16-20, more than 20
Q 35: When a woman is willing to discuss her experiences of domestic violence, about how much time in a single visit do you spend discussing them with her (number in minutes)	Q 39: When a woman is willing to discuss her experiences of domestic violence, about how much time in a single visit do you spend discussing them with her (number in minutes)	None, less than 30 minutes, 30 -60 minutes, 61-90 minutes, 91 – 120 minutes, more than 120 minutes

***** These questions were not asked of the religious leaders
** These categories were added to the original options

Appendix Z: Ethics Approval Forms for Study Three

Joanne Nicolaou

From: Fabia Franco
Sent: 21 December 2012 11:37
To: Joanne Nicolaou
Cc: Paul De Mornay Davies
Subject: Astra's RA

I have read the proposal and understand that this is a continuation of Astra's PhD work. I have read the RA about the presently submitted study and I am happy to sign approval.

Best wishes,

Fabia

Dr Fabia Franco
Department of Psychology
Middlesex University
Town Hall
The Burroughs, Hendon
London NW4 4BT
Tel 020 8411 5471 (direct)
E-mail: f.franco@mdx.ac.uk

From: Joanne Nicolaou
Sent: 21 December 2012 11:18
To: Fabia Franco
Subject: FW: Attached Image

Hi Fabia,

As discussed attached please find Proposal and RA - I wait to hear from you.

Regards
Joanne

-----Original Message-----
From: "Joanne Nicolaou" [mailto:j.nicolaou@mdx.ac.uk]
Sent: 21 December 2012 11:05
To: Joanne Nicolaou
Subject: Attached Image

PSY.OFFICE:Study Reference Number 189/JG 1

Middlesex University, Department of Psychology

REQUEST FOR ETHICAL APPROVAL (STUDENT)

Applicant (specify): *UG* ***PG*** *(Module:* ***MPhil/PhD*** *Date submitted:...12th DECEMBER 2012.....*

Research area (please circle)				
Clinical	Cognition + Emotion	Developmental	**Forensic**	Health
Occupational	Psychophysiological	Social	Sport + Exercise	
Other _____			**Sensitive Topic☒**	
Methodology:				
Empirical/Experimental	**Questionnaire-based**	Qualitative	Other _____	

No study may proceed until this form has been signed by an authorised person indicating that ethical approval has been granted. For collaborative research with another institution, ethical approval must be obtained from all institutions involved.

This form should be accompanied by any other relevant materials (e.g. questionnaire to be employed, letters to participants/institutions, advertisements or recruiting materials, information and debriefing sheet for participants[1], consent form[2], including approval by collaborating institutions).

- Is this the first submission of the proposed study? **Yes**/No
- Is this an amended proposal (resubmission)? Yes/**No**
  Psychology Office: If YES, please send this back to the original referee
- Is this an urgent application? (To be answered by Staff/Supervisor only)[1] **Yes**/No

Supervisor to initial here ____S.H._____

Name(s) of investigator: Ms. Astra Kassiram

Name of Supervisor (s) :
Dr. Miranda Horvath; Dr. Susan Hansen; Dr. Paul de Mornay Davies

Title of Study:
Help agencies understanding and intervention for women with somatization disorder and domestic violence

Results of Application:

REVIEWER – please tick and provide comments in section 5:

[1]See Guidelines on MyUnihub

[1,2,3,4,5,6,7]**Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

PSY OFFICE:Study Reference Number _____ 2

APPROVED	APPROVED SUBJECT TO AMENDMENTS	APPROVED SUBJECT TO RECEIPT OF LETTERS	NOT APPROVED

SECTION 1

1. Please attach a brief description of the nature and purpose of the study, including details of the procedure to be employed. Identify the ethical issues involved, particularly in relation to the treatment/experiences of participants, session length, procedures, stimuli, responses, data collection, and the storage and reporting of data.

SEE ATTACHED PROJECT PROPOSAL

2. Could any of these procedures result in any adverse reactions? YES/NO

If "yes", what precautionary steps are to be taken?

respondent will be given an information sheet describing the nature of the study, risks involved in participating and they are free to withdraw from the study at any point without prejudice.They will then be presented with an informed consent to sign; online participants will be required to tick a box on the informed consent page. On completion of the questionnaire each participant will be given a debriefing sheet which includes free help agencies in Trinidad if they feel distress about anything that may have presented during the study. The information sheet, informed consent and debriefing sheet are all attached to this proposal.

3. Will any form of deception be involved that raises ethical issues? YES/**NO**

(Most studies in psychology involve mild deception insofar as participants are unaware of the experimental hypotheses being tested. Deception becomes unethical if participants are likely to feel angry, humiliated or otherwise distressed when the deception is revealed to them).

Note: if this work uses existing records/archives and does not require participation per se, tick here ..... and go to question 10. (Ensure that your data handling complies with the Data Protection Act).

4. If participants other than Middlesex University students are to be involved, where do you intend to recruit them? *(A full risk assessment must be conducted for any work undertaken off university premises)*[6,7]

Participants will be medical doctors and religious leaders from the eight administrative counties in Trinidad. For a detailed explanation about recruitment please see the attached proposal.

5a. Does the study involve:

Clinical populations	YES/**NO**
Children (under 16 years)	YES/**NO**
Vulnerable adults such as individuals with mental or physical health problems, prisoners, vulnerable elderly, young offenders?	YES/**NO**
Political, ethnic or religious groups/minorities?	YES/**NO**
Sexually explicit material / issues relating to sexuality	YES/**NO**

[1,2,3,4,5,6,7]**Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

5b. If the study involves any of the above, the researcher may need CRB (police check) YES/NO Staff and PG students are expected to have CRB – please tick UG students are advised that institutions may require them to have CRB please confirm that you are aware of this by ticking here _____ Since this study is being conducted in Trinidad W.I. a CRB is not required but I have obtained the equivalent from Trinidad; a Certificate of Character
6. How, and from whom (e.g. from parents, from participants via signature) will informed consent be obtained? (*See consent guidelines[2]; note special considerations for some questionnaire research)* Participants completing a written questionnaire will be asked to sign an informed consent form (attached)after when they are satisfied they have obtained enough information about the study. Participants completing an online questionnaire will be required to tick a box indicating they are satisfied and understand the information provided.
7. Will you inform participants of their right to withdraw from the research at any time, without penalty? (*see consent guidelines[2]*) **YES**/NO

8. Will you provide a full debriefing at the end of the data collection phase? (*see debriefing guidelines[3]*) **YES**/NO
9. Will you be available to discuss the study with participants, if necessary, to monitor any negative effects or misconceptions? **YES**/NO If "no", how do you propose to deal with any potential problems?
10. Under the Data Protection Act, participant information is confidential unless otherwiseagreed in advance. Will confidentiality be guaranteed? **YES**/NO (*see confidentiality guidelines[5]*) If "yes" how will this be assured *(see[5])* All data collected will coded to protect the identity of participants and the coded information securely stored in a password protected file on a password protected computer. If "no", how will participants be warned? *(see[5])* (*NB: You are not at liberty to publish material taken from your work with individuals without the prior agreement of those individuals*).
11. Are there any ethical issues that concern you about this particular piece of research, not covered elsewhere on this form? YES/**NO** If "yes" please specify:
12. Is this research or part of it going to be conducted in a language other than English? YES/**NO**

[1,2,3,4,5,6,7]**Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

If YES – Do you confirm that all documents and materials are enclosed here both in English and the other language, and that each one is an accurate translation of the other?	N/A

(NB: If "yes" has been responded to any of questions 2, 3, 5, 11, 12 or "no" to any of questions 7-10, a full explanation of the reason should be provided – if necessary, on a separate sheet submitted with this form).

SECTION 2 (to be completed by all applicants – please tick as appropriate)

	YES	NO
13. Some or all of this research is to be conducted away from Middlesex University	X	
If "yes" tick here to confirm that a Risk Assessment form has been submitted	X	
14. I am aware that any modifications to the design or method of this proposal will require me to submit a new application for ethical approval	X	
15. I am aware that I need to keep all the materials/documents relating to this study (e.g. consent forms, filled questionnaires, etc) until completion of my degree / publication (as advised)	X	
16. I have read the British Psychological Society's *Ethical Principles for Conducting Research with Human participants*[1] and believe this proposal to conform with them.	X	

SECTION 3(to be completed by <u>STUDENT</u> applicants and supervisors)

Researcher: (student signature) Ast – Kur – date 17th Dec 2012

CHECKLIST FOR <u>SUPERVISOR</u> – please tick as appropriate

	YES	NO
1. Is the UG/PG module specified?	X	
2. If it is a resubmission, has this been specified and the original form enclosed here?	N/A	
3. Is the name(s) of student/researcher(s) specified?	X	
4. Is the name(s) of supervisor specified?	X	
5. Is the consent form attached?	X	
6. Are debriefing procedures specified? If appropriate, debriefing sheet enclosed – appropriate style?	X	
7. Is an information sheet for participants enclosed? appropriate style?	X	
8. Does the information sheet contain contact details for the researcher and supervisor?	X	
9. Is the information sheet sufficiently informative about the study?	X	

[1,2,3,4,5,6,7]**Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

PSY OFFICE:Study Reference Number _____ 5

10. Has Section 2 been completed by the researcher on the ethics form?	X	
11. Any parts of the study to be conducted outside the university? If so a Risk Assessment form must be attached – Is it?	X	
12. Any parts of the study to be conducted on another institution's premises? If so a letter of acceptance by the institution must be obtained – Letters of acceptance by all external institutions are attached	N/A*	
13. Letter(s) of acceptance from external institutions have been requested and will be submitted to the PSY office ASAP.	N/A*	
14. Has the student signed the form? If physical or electronic signatures are not available, an email endorsing the application must be attached	X	
15. Is the proposal sufficiently informative about the study?	X	

*Some participants may complete the questionnaire in their place of work while the researcher is present; however their signature on the informed consent form is sufficient. List of premises to be visited will be added to Risk Assessment form (cleared by Chair of Ethics Team).

Signatures of approval:

PSY OFFICE received

Supervisor: Smith date: 14/12/12 date:

Ethics Panel: [signature] date: 18/12/12 date:

(signed pending approval of Risk Assessment form) date:

If any of the following is required and not available when submitting this form, the Ethics Panel Reviewer will need to see them once they are received – please enclose with this form when they become available:

- letter of acceptance from other institution
- any other relevant document (e.g. ethical approval from other institution):_____

PSY OFFICE received

Required documents seen by Ethics Panel: _____ date: _____ date:

[1,2,3,4,5,6,7]**Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

PSY OFFICE:Study Reference Number _____ 6

SECTION 4 (to be completed by the Psychology Ethics panel reviewers)

		Recommendations/comments
1. Is UG/PG module specified?	✓	
2. If it is a resubmission, has this been specified and the original form enclosed here?	NA	
3. Is the name(s) of student/researcher(s) specified? If physical or electronic signatures are not available has an email endorsing the application been attached?	✓	
4. Is the name(s) of supervisor specified? If physical or electronic signatures are not available, has an email endorsing the application been attached?	✓	
5. Is the consent form attached?	✓	
6. Are debriefing procedures specified? If appropriate, is the debriefing sheet attached? Is this sufficiently informative?	✓	
7. Is an information sheet for participants attached?	✓	
8. Does the information sheet contain contact details for the researcher?	✓	
9. Is the information sheet sufficiently informative about the study? Appropriate style?		Please add that participants' responses are confidential and anonymous.
10. Has Section 2 (points 12-15) been ticked by the researcher on the ethics form?	✓	
11. Any parts of the study to be conducted outside the university? If so a fully completed Risk Assessment form must be attached - is it?	✓	
12. If any parts of the study are conducted on another institution/s premises, a letter of agreement by the institution/s must be produced. Are letter/s of acceptance by all external institution/s attached?	NA	
13. Letter/s of acceptance by external institution/s has/have been requested.	NA	
14. Has the applicant signed? If physical or electronic signatures are not available, an email endorsing the application must be attached.	✓	
15. Is the proposal sufficiently informative about the study? Any clarity issues?	✓	
16. Is anyone likely to be disadvantaged or harmed?	No	
17. If deception, protracted testing or sensitive aspects are involved, do the benefits of the study outweigh these undesirable aspects?	N/A	
18. Is this research raising any conflict of interest concerns?	No.	

[1,2,3,4,5,6,7]**Guidelines are available from the Ethics folder on MyUniHub, General Psychology Area**

INDEPENDENT FIELD/LOCATION WORK RISK ASSESSMENT FRA1

This proforma is applicable to, and must be completed in advance for, the following field/location work situations:

1. *All field/location work undertaken independently by individual students, either in the UK or overseas, including in connection with proposition module or dissertations. Supervisor to complete with student(s).*
2. *All field/location work undertaken by postgraduate students. Supervisors to complete with student(s).*
3. *Field/location work undertaken by research students. Student to complete with supervisor.*
4. *Field/location work/visits by research staff. Researcher to complete with Research Centre Head.*
5. *Essential information for students travelling abroad can be found on www.fco.gov.uk*

FIELD/LOCATION WORK DETAILS

Name ...Astra Kassiram

Student No

Research Centre (staff only).....

Supervisor Dr. Miranda Horvath

Degree course ...MPhil/PhD Psychology

Telephone numbers and name of next of kin who may be contacted in the event of an accident

NEXT OF KIN

Name Mrs. Carla Kassiram – Lackhai

Phone 1 868 642 5466

Physical or psychological limitations to carrying out the proposed field/location work

.....NONE.....

Any health problems (full details) Which may be relevant to proposed field/location work activity in case of emergencies.

.....NONE.....

Locality (Country and Region)

...TRINIDAD, W.I.EIGHT ADMINISTRATVE BOUNDARIES (COUNTIES), which includes the following regions: Sangre Grande; Arima; St. Augustine, Port or Spain; San Fernando; Sipiara; Chaguanas; Mt. Hope; Couva; Penal; Diego Martin; Tunapuna; Curepe; Tacarigua; Valencia; Mayaro

Travel Arrangements

PERSONAL CAR

NB: Comprehensive travel and health insurance must always be obtained for independent overseas field/location work.

PERSONAL INSURANCE IN TRINIDAD

Dates of Travel and Field/location work FEBRUARY TO MAY 2013

.....

.....

PLEASE READ THE FOLLOWING INFORMATION VERY CAREFULLY

Hazard Identification and Risk Assessment

List the localities to be visited or specify routes to be followed **(Col. 1).** For each locality, enter the potential hazards that may be identified beyond those accepted in everyday life. Add details giving cause for concern **(Col. 2).**

Examples of Potential Hazards :
Adverse weather: exposure (heat, sunburn, lightening, wind, hypothermia)
Terrain: rugged, unstable, fall, slip, trip, debris, and remoteness. Traffic: pollution.
Demolition/building sites, assault, getting lost, animals, disease.
Working on/near water: drowning, swept away, disease (weils disease, hepatitis, malaria, etc), parasites', flooding, tides and range.
Lone working: difficult to summon help, alone or in isolation, lone interviews.
Dealing with the public: personal attack, causing offence/intrusion, misinterpreted, political, ethnic, cultural, socio-economic differences/problems. Known or suspected criminal offenders.
Safety Standards (other work organisations, transport, hotels, etc), working at night, areas of high crime.
Ill health: personal considerations or vulnerabilities, pre-determined medical conditions (asthma, allergies, fitting) general fitness, disabilities, persons suited to task.
Articles and equipment: inappropriate type and/or use, failure of equipment, insufficient training for use and repair, injury.
Substances (chemicals, plants, bio- hazards, waste): ill health - poisoning, infection, irritation, burns, cuts, eye-damage.
Manual handling: lifting, carrying, moving large or heavy items, physical unsuitability for task

If no hazard can be identified beyond those of everyday life, enter 'NONE'.

1. LOCALITY/ROUTE	2. POTENTIAL HAZARDS
1. ADVERSE WEATHER	1. FLOODING

The University Field/location work code of Practice booklet provides practical advice that should be followed in planning and conducting field/location work.

Risk Minimisation/Control Measures

PLEASE READ VERY CAREFULLY

For each hazard identified **(Col 2),** list the precautions/control measures in place or that will be taken (Col 3) to **"reduce the risk to acceptable levels"**, and the safety equipment **(Col 5)** that will be employed.

Assuming the safety precautions/control methods that will be adopted **(Col. 3),** categorise the field/location work risk for each location/route as negligible, low, moderate or high **(Col. 4).**
Risk increases with both the increasing likelihood of an accident and the increasing severity of the consequences of an accident.

An acceptable level of risk is: a risk which can be safely controlled by person taking part in the activity using the precautions and control measures noted including the necessary instructions, information and training relevant to that risk. The resultant risk should not be significantly higher than that encountered in everyday life.
Examples of control measures/precautions:

Providing adequate training, information & instructions on field/location work tasks and the safe and correct use of any equipment, substances and personal protective equipment. Inspection and safety check of any equipment prior to use. Assessing individuals fitness and suitability to environment and tasks involved. Appropriate clothing, environmental information consulted and advice followed (weather conditions, tide times etc.). Seek advice on harmful plants, animals & substances that may be encountered, including information and instruction on safe procedures for handling hazardous substances. First aid provisions, inoculations, individual medical requirements, logging of location, route and expected return times of lone workers. Establish emergency procedures (means of raising an alarm, back up arrangements). Working with colleagues (pairs). **Lone working is not permitted where the risk of physical or verbal violence is a realistic possibility.** Training in interview techniques and avoiding /defusing conflict, following advice from local organisations, wearing of clothing unlikely to cause offence or unwanted attention. Interviews in neutral locations. Checks on Health and Safety standards & welfare facilities of travel, accommodation and outside organisations. Seek information on social/cultural/political status of field/location work area.
Examples of Safety Equipment: Hardhats, goggles, gloves, harness, waders, whistles, boots, mobile phone, ear protectors, bright fluorescent clothing (for roadside work), dust mask, etc.

If a proposed locality has not been visited previously, give your authority for the risk assessment stated or indicate that your visit will be preceded by a thorough risk assessment.

3. PRECAUTIONS/CONTROL MEASURES	4. RISK ASSESSMENT (low, moderate, high)	5. SAFETY/EQUIPMENT
1. USUALLY LOCALIZED FLOODING THAT WOULD QUICKLY SUBSIDE AFTER THE RAIN STOPS; THIS IS A USUAL OCCURANCE FOR CITIZENS OF TRINIDAD.	1. LOW	1. PROPER SHOES 2. UMBRELLA

PLEASE READ THE FOLLOWING INFORMATION AND SIGN AS APPROPRIATE

DECLARATION: The undersigned have assessed the activity and the associated risks and declare that there is no significant risk or that the risk will be controlled by the method(s) listed above/over. Those participating in the work have read the assessment and will put in place precautions/control measures identified.

NB: Risk should be constantly reassessed during the field/location work period and additional precautions taken or field/location work discontinued if the risk is seen to be unacceptable.

Signature of Field/location worker (Student/Staff) Ari-Kai ..... **Date** 17th Dec 2012

Signature of Student Supervisor Smith ..... **Date** 14/12/12 .....

APPROVAL: (ONE ONLY)

Signature of Director of Programmes (undergraduate students only) ..... **Date** .....

Signature of Research Degree Co-ordinator or ..... **Date** .....

Director of Programmes (Postgraduate)

Signature of Research Centre Head (for staff field/location workers) ..... **Date** .....

FIELD/LOCATION WORK CHECK LIST

1. Ensure that **all members** of the field party possess the following attributes (where relevant) at a level appropriate to the proposed activity and likely field conditions:

X Safety knowledge and training?

X Awareness of cultural, social and political differences?

X Physical and psychological fitness and disease immunity, protection and awareness?

X Personal clothing and safety equipment?

X Suitability of field/location workers to proposed tasks?

2. Have all the necessary arrangements been made and information/instruction gained, and have the relevant authorities been consulted or informed with regard to:

n/a Visa, permits?

n/a Legal access to sites and/or persons?

n/a Political or military sensitivity of the proposed topic, its method or location?

X Weather conditions, tide times and ranges?

X Vaccinations and other health precautions?

n/a Civil unrest and terrorism?

X Arrival times after journeys?

X Safety equipment and protective clothing?

X Financial and insurance implications?

X Crime risk?

X Health insurance arrangements?

X Emergency procedures?

X Transport use?

X Travel and accommodation arrangements?

Important information for retaining evidence of completed risk assessments:

Once the risk assessment is completed and approval gained the **supervisor** should retain this form and issue a copy of it to the field/location worker participating on the field course/work. In addition the **approver** must keep a copy of this risk assessment in an appropriate Health and Safety file.