

**EXPLORING THE EXPERIENCES  
OF ADULT FEMALE RAPE SURVIVORS IN  
THE EMERGENCY CARE ENVIRONMENT**

by

**MARIANNE GOUS**

submitted in accordance with the requirements  
for the degree of

**MAGISTER CURATIONIS (CLINICAL)**

In the

**Department of Nursing Science  
School of Health Care Sciences  
Faculty of Health Sciences  
University of Pretoria**

**Supervisor: Dr T Heyns  
Joint supervisor: Prof SP Hattingh**

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# ASSEMBLIDGE OF THIS DISSERTATION

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***This study is dedicated  
to each and every woman  
who have survived a rape incident.  
May you all find a place of peace, and win over the  
power of that evil deed.***



## **DECLARATION**

I, Marianne Gous, hereby declare that:

Exploring the experiences of adult female rape survivors in the emergency  
care environment

is my original work, that all sources that have been used or quoted have  
been indicated as well as acknowledged by means of a complete reference  
list, and that this work has not been submitted for any other degree at  
another institution.

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Marianne Gous – Researcher  
(UP Student number: 21225852)

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Date and place

## ABSTRACT

### Exploring the experiences of adult female rape survivors in the emergency care environment

**Student:** Marianne Gous  
**Student number:** 21225852  
**Degree:** Magister Curationis (Clinical), University of Pretoria  
**Supervisor:** Dr T Heyns (UP)  
**Joint Supervisor:** Prof SP Hattingh (UNISA)

**Aim and objectives.** Although many international sources in literature describe the treatment regimes for the management of adult female rape survivors, very few actually evaluate if the care that is implemented, are beneficial and supportive towards an optimal level of health. The researcher initiated this study to specifically determine what the experiences of adult female rape survivors were with regards to the management they received from health care workers in the emergency care environment. This information that was gathered was then incorporated into the writing of recommendations for health care services towards the improvement of patient-centred care.

**Method.** A qualitative phenomenological methodology guided the research process in which ten semi-structured voluntary interviews was held with adult female rape survivors. This study was conducted in a private hospital in Gauteng, South Africa, which is at the top of the international statistics list for the incidence of rape.

**Findings.** Patient management with regards to accessibility to health care services, the forensic examination and the use of medications proved to be a major concern. Participants in this study emphasized the value and importance of the physical presence of family members or significant others. A positive attitude from these support-givers improved the patient's psychological state, memory and co-operation. Prolonged waiting times in all areas of management contributed to an increased level of anxiety, where as the prompt and competent interventions by empathetic multi-disciplinary team members had improved patient satisfaction. Various patient responses after the rape incident warranted that minimal, but yet effective and professional health care workers be involved in rape survivor management. Confidentiality and honest, effective communication that is based on patient preference, should guide all interventions.

**Conclusion.** The medical management of adult female rape survivors in this hospital compared favorably to international standards, however, the need to improve the level of specific patient-centred care exists in order to ultimately facilitate a better quality of service provision.

## **Key words**

Accident and emergency unit; emergency care environment; patient-centred care and rape survivor.



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## LIST OF ABBREVIATIONS

**In alphabetical order, the abbreviation and the meaning thereof follow below.**

A & E	Accident and Emergency
AMA	American Medical Association
ARV	Anti-retroviral
CDC	Centres for Disease Control and Prevention
CINAHL	Cumulative Index to Nursing and Allied Health Literature
HIV	Human Immunodeficiency Virus
MEDLINE	Literature database
POWA	People Opposing Women Abuse
PTSD	Post traumatic stress disorder
RSA	Republic of South Africa
SAECK	Sexual assault evidence collection kit
SAFE	Sexual Assault Forensic Examiner
SANC	South African Nursing Council
SANE	Sexual Assault Nurse Examiner
SAPS	South African Police Service
STI	Sexually transmitted infections
USA	United States of America
WHO	World Health Organization



**NOTE OF CLARIFICATION:**

**For the purposes of anonymity, the hospital where this study was done will be referred to as “the hospital”, and the hospital group that they form part of will be referred to as “the hospital group”. This will apply to both the text and the referencing.**

# 1 Orientation to the study

***"The biggest worries in life are those that never happen."***

***(Unknown)***

## 1.1 Introduction

The dominant mode of most organisations is towards task orientation and a lack of responsiveness to the needs of individuals (Garbett & McCormack 2004:17). Modern trends in the development of practice are unambiguously, and without any doubt, orientated towards the improvement of patient care and services and the priority of patient-centred care. The concept of improvements in patient care should be understood to include the central importance of developing services which reflect the expressed needs of service users and the growing importance that the profession attaches to incorporating the views and opinions of patients (Binnie & Titchen 1999:167; McCormack, Garbett & Manley 2004:319). The ability to do this presupposes an environment in which nurse practitioners can make and act on decisions about care that are based on the articulated needs of patients. An environment in which this is possible is the only one in which patient-centred care can be offered (Garbett & McCormack 2004:17).

The principles of management for patients who present at an accident and emergency (A & E) unit after an incident of rape, places a primary focus on medical interventions such as the collection of forensic evidence for use in future legal proceedings. Any attempt to institute a patient-centred approach in an A & E unit must begin by paying meticulous attention to the needs and experiences of the female rape survivor and to her subjective descriptions of what she has experienced. This process of listening, recording and evaluating should be conducted with the utmost sensitivity, empathy and tact, and with a clear recognition of the trauma sustained by the survivor and the unexpected and sometimes anomalous effects that such trauma produces in the context of an individual life.

By making it clear that the patient is unconditionally valued for herself as a human being and not just as a source of symptoms and information, nurses will be able to play their role in bringing a certain degree of balance into the nurse-patient relationship. Because all patients are unique in the richness and variety of their life experiences, they are able to contribute unique insights into what it means to be a "patient" (Binnie & Titchen 1999:175). Practitioners who have committed themselves to providing more personalised care for their patients should make it part of their practice to acquire a more nuanced understanding of how the patients themselves "see their world" (O'Hagan 2004:12-13).

Because this study undertakes to explore and describe in detail how female rape survivors experience their management in an A & E unit, it will provide researchers and nurse educators with a great deal of useful and relevant information that can be used to enhance clinical practice. The richness and depth of the descriptions that emerge from this research will enable practitioners to revise their approach to the kind of patient-centred care that is appropriate for rape survivors.

## **1.2 Background to the problem**

The background to this study provides a brief overview of rape, and makes specific reference to the management of rape survivors in a patient-centred context.

### **1.2.1 The term "rape"**

"Rape" is defined by the World Health Organisation (WHO) as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person, regardless of (their) relationship to the survivor, in any setting, including but not limited to home and work" (2003:6). It is important to note that this definition of rape provided by WHO (2003:6) enables one to use the words *rape*, *sexual assault*, *sexual harassment*, *sexual violence* and *sexual abuse* interchangeably.

Various authors have observed that the perpetrators of rape are usually known to their victims (Centres for Disease Control and Prevention (CDC) 2007:3; Logan, Walker, Jordan and Leukefeld 2006:5; People Opposing Women Abuse (POWA) 2006:1 & 3; WHO 2003:7). Regardless of whether the perpetrator is known to the rape survivor or not, all of the following kinds of specifically sexual violence are recognised by the World Health Organisation: sexual slavery, sexual harassment, sexual trafficking, forced exposure to pornography, involuntary impregnation, sexual sterilisation procedures performed without the free consent of the survivor, forced abortions, compulsory marriages and virginity tests, and the practice of female genital mutilation (WHO 2003:7).

It has become a fairly common practice in recent years for perpetrators to incapacitate women as a prelude to sexual assault. "Date rape", for instance, occurs when a perpetrator administers drugs or an excessive amount of alcohol to a woman without her knowledge or against her better judgment so that she will be unable to defend herself against the perpetrator (WHO 2003:7). The use of such methods to incapacitate survivors creates a situation in which the perpetrator needs to use a minimum of physical force to subdue his "victim". This increases the likelihood that fewer physical injuries will be inflicted on the survivor. The absence of such injuries on the survivor's body will make it all the more difficult to prove any subsequent charges of rape.

While the terms *rape* and *sexual assault* refer to the same phenomenon in this research, the researcher will only use the term *rape* for the sake of simplicity. The researcher will also describe a rape victim as a rape survivor throughout this study. The researcher's rationale for using the term *survivor* is that it focuses on the strength and capacity of rape victims to cope with the trauma subsequent to such incidents (Logan et al. 2006:4).

### **1.2.2 Rape as a global concern**

It is clear that all forms of sexual violence, particularly rape, is a global problem. This is apparent from the fact that millions of people are affected each year by this type of

violence (CDC 2007:1). Statistics about sexual violence vary because of a variety of factors such as how rape is defined in a specific country, how the data is collected, where the data comes from, and the methods that are used to report this crime. Rape is one of the most underreported of all crimes (CDC 2007:1). It has been estimated that as many as two thirds of all rape incidents go unreported, even in the United States of America (USA), as reported by the American Medical Association (AMA: 1996:1). Whatever the actual figures, one may assume that the true magnitude of the problem is greatly underestimated in all countries of the world (CDC 2007:1).

Surveys have shown that in the USA itself, between 11% and 15% of people experience some form of sexual assault during their lifetimes (Roy-Byrne, Berliner, Russo, Zatzick & Pitman 2003:161). More than one third of Washington State women have, for example, been sexually assaulted during their lifetime (Berliner, Fine & Moore 2001:3). The same researchers have noted that although this data was collected from adult women in Washington State from a selected patient population, only 15% of the survivors reported the crime to the police (Berliner et al. 2001:7). An enormous discrepancy therefore exists between the official data that emerges from police statistics and other scientifically verifiable attempts to identify the true extent of this crime. Reynolds, Peipert and Collins (2000:1) have, for example, demonstrated that sexual assault is the fastest growing violent crime in the USA. This is a cause for great concern because, as Wiley, Sugar, Fine and Eckert (2003:1638) have shown, only 15% of sexual assault cases are satisfactorily resolved by the criminal justice system in a country (the USA) which can boast some of the most reliable and accessible resources available in the world.

Table 1.1 lists the number of reported rape cases and the total population for a selection of countries in 2007. These statistics from Nation Master (2008:1) indicate that the USA reported the highest number of rape incidents during the period under review. These figures should be seen in the light of the fact that the total population of the USA is nearly 300 million. It is startling to note that the Republic of South Africa (RSA), with a population that is approximately one sixth of that of the USA, reports the second highest incidence of rape in the world. It is obvious that sexual

violence against women and children is a problem of epidemic proportions in the RSA – something that has already been noted by Amnesty International (2003:1).

A study conducted in Pakistan reveals that women who report rape may in turn be accused of adultery and even be imprisoned and condemned to death (Romito 2008:55). Romito adds that approximately 80% of women who are being held in Pakistani prisons have been imprisoned on charges of “adultery”. In spite of the fact that they are rape survivors, no credence is given to their complaints or their evidence. They are then convicted on charges of “adultery” (although adultery implies consent on the part of the adulterers). There is a clear logical distinction between the causes and circumstances of rape and adultery, although the legal systems of certain countries choose to ignore these vital differences and prefer to make the assumption that all rape survivors are actually guilty of adultery (which is also a crime in their countries).

**Table 1.1: Overview of the incidence of rapes reported and total population figures for selected countries during 2007**

Country	Population size	Rapes reported
India	1 094 583 000	15 468
United States of America (USA)	296 410 400	95 136
Russia	143 133 600	6 978
Japan	127 774 000	2 357
Germany	82 469 400	8 615
France	60 873 000	8 458
United Kingdom (UK)	60 226 500	13 395
Italy	58 607 050	2 543
Republic of South Africa (RSA)	46 888 200	52 425
Canada	32 299 000	24 350
Nepal	27 132 630	158
Zimbabwe	13 009 530	5 567
New Zealand	4 098 900	1 059

Source: Adopted from Nation Master (2008:1-2)



### 1.2.3 Prevalence of rape in the RSA

The incidence of rape against women in the RSA continues to receive a great deal of attention from news media and from the population at large. Because of the excessive number of women who are raped every year, concerned individuals and organisations have taken it upon themselves to prevent or at least minimise the secondary victimisation and traumatisation that always accompanies the act of rape by providing survivors with the comprehensive management and immediate support they need from health care services.

The definition of rape has been under review in the RSA during the past few years because of the realisation that the earlier definition of rape contained in the Sexual Offences Act of 1957, failed to reflect precise and valid criteria for defining a rape incident. It also became evident that the definition of rape contained in the Sexual Offences Act of 1957 would not survive legal challenge and scrutiny in the Constitutional Court of the Republic of South Africa (Nursing Today, 2006:24).

After having been debated for over ten years, the new definition of rape as stated in Criminal Law (Sexual Offences and Related Matters) Amendment Bill (Bill 50 of 2003), passed into South African law in 2007 as Criminal Law (Sexual Offences and Related Matters) Amendment Act (32 of 2007). This new law now includes the following as rape together with the previous definition:

- Forced oral or anal sex (irrespective of any gender).
- Male rape (previously defined as indecent assault).
- Penetration by an inanimate object or animal genitalia.

The amendment bill and subsequent act also empowers survivors to obtain a court order that compels alleged offenders to undergo compulsory Human Immunodeficiency Virus (HIV) testing, the results of which will then be revealed to rape survivors (South African Medical Research Council 2008:2). Rape survivors are also entitled to receive post-exposure prophylactic medications at the expense of the state (Combrinck & Artz 2003:1; Le Roux 2007:1-2). Child rape in particular is

becoming more and more common in the RSA and the incidence of child rape is increasing from year to year (Amnesty International 2003:1).

POWA (2006:2) collated the following statistics for rape and related crimes of violence in the RSA in 2006:

- About 55 000 incidents of rape and approximately 10 000 cases of indecent assault were reported to the South African Police Service (SAPS) between April 2005 and March 2006 (Le Roux 2007:1).
- Nearly half of all rape survivors are believed to be children (Le Roux 2007:1).
- The percentage increase in reported rapes from between 2001 and 2002 stands, according to the SAPS, at about 1,5 % (SAPS 2006:1).
- One out of every two women stands a chance of being raped during her lifetime (POWA 2006:1).
- Most rapes occur in the rapist's community (POWA 2006:1).
- An average of one woman is killed every six days by her intimate partner (POWA 2006:1).
- More than 4000 women are raped in the RSA every day (Romito 2008:14).
- A Johannesburg survey revealed that 1 out of every 4 men had raped a woman (POWA 2006:1).
- Since 85% of rapes are gang rapes, women are more likely to be raped by three or more men than by a single rapist (POWA 2006:1).
- For every 400 rapes that are reported every year, only 17 become official cases for which the perpetrator appears in court. Out of this number, only one perpetrator is convicted per annum, and one case docket is either lost or sold (POWA 2006:1).
- Children are raped more frequently than adults, one every 24 minutes as opposed to one every 26 minutes (POWA (2006:2).
- 40% of young men aged 20-29 (the most common age of rapists) are infected with HIV (POWA 2006:2).
- One in every three children admitted to hospital in the RSA is infected with HIV.

In Gauteng province, rape is the most commonly reported crime (SAPS 2006:1). Provincial statistics for Gauteng account for a total of the 11923 rape cases reported during the period of 2004 / 2005. More than one third of the total number of rape incidents in the country (out of a total of 55 114) therefore occur in Gauteng province alone (SAPS 2006:1).

### **1.2.4 Management of rape in the RSA**

The management of rape in the RSA as a whole and in Gauteng in particular, leaves a lot to be desired and can only be described as tragically inadequate (Suffla 2006:1). In some health care services in the RSA, not even minimum standards are being met. This statement is supported by the research conducted by Kim, Mokwena, Ntlemo, Dwane, Noholoza, Abramsky, Marinda, Askew, Chege, Mullick, Gerntholtz, Vetten and Meerkotter (2007:1) in which they report that the unmet needs of rape survivors are receiving an increasing amount of attention. While they are of the opinion that emerging best practice guidelines suggest that existing health interventions may play a critical role in meeting some of these needs, the actual implementation and coordination of these services presents a significant challenge.

There are obstacles that discourage or prevent rape survivors from accessing appropriate after-rape care. These include the incompetent documentation of medico-legal evidence, a lack of proper resources, the insufficient and inadequate training of the health care providers who handle these cases, enormous disparities across clinics, and weak intersectoral collaboration between the state and the private sector (Suffla 2006:1). Kim et al. (2007:1) confirm that these factors influence the quality of care that is available to the survivors of rape, and they also recognise that the unmet needs of rape survivors are receiving increasing attention in the RSA. Kim et al. (2007:1) are of the opinion that the management of rape survivors by police and health care workers is (with a few notable exceptions) decidedly sub-standard.

### **1.2.5 Access to services for rape survivors**

According to Suffla, Seedat and Nascimento (2001:1), the minimisation and prevention of secondary victimisation and traumatisation is necessary for reducing the disability burden on the population as a whole, because such preventive activities will help to contain the increasing cost of health care in the country. Current research findings and the recent prioritising of issues of women's health in the RSA emphasise the extent of the difficulties that care-giving organisations and individuals experience with the management and treatment of rape in the RSA. They also confirm the critical role that health care services must play because of their capacity and expertise and because they are in a unique position to provide appropriate management and care for those who require it.

Suffla et al. (2001:1) continues by stating that the trauma associated with sexual violence is often very difficult to determine, and the quality of care that rape survivors receive from the health care service is often totally incommensurate with the harm and injuries that they have sustained. In addition to this, the health and social services that function in most low-income areas are further compromised by long-standing fragmentation and serious deficiencies in coordination. Such deficiencies often nullify the beneficial effects that such services are designed to implement.

There are also other obstacles and difficulties that stem from the ineffectiveness of the health care that women who have been sexually assaulted or abused receive. These obstacles include an absence of careful and realistic planning, the over-utilisation of health care services, the physical inaccessibility of health care services, the fact that health care services in the RSA do not make adequate provision for differences in language, culture and worldview, the persistence of prejudice among the population at large (even among health workers), deficiencies in the long-term planning of new services, the inadequate training and education of health care providers for dealing with these contingencies, and a tendency for professional staff to distance themselves from rape survivors because of a fear of possible medico-legal liabilities and complications (Jewkes & Abrahams 2000:4).

Health care professionals often view their role in collecting physical evidence for forensic purposes as illegitimate. This point of view arises out of the belief that rape examinations should be undertaken by the legally authorised and properly qualified personnel and not by ordinary health care workers or nurses. Jewkes and Abrahams (2000:13) argue that sophisticated medical forensic services should only be performed by trained and accredited health care workers such as medical practitioners or dedicated forensic nurses who have the necessary training, expertise and experience.

### **1.2.6 Patient-centred care for rape survivors**

Suffla et al. (2001:1) make a strong argument that the health care system should provide responsible, holistic and effective patient-centred care and service for rape survivors. They further argue that care of this order would undermine the extent of the harm experienced by rape survivors, and that it would also contribute to the prevention of secondary injuries and trauma and would, in consequence, improve the long-term prognosis for survivors. Although the provision of such services is inextricably dependent upon the availability of resources, one should not underestimate the potential of addressing shortcomings within health services, in order to develop resources that are not available at present.

Health care services throughout the world are consequently increasingly challenged by the need to improve the overall quality of their service delivery through the encouragement of relevant research; by continuous analysis and evaluation of all the processes involved; by the meticulous collection of data; and by reflecting on how improvements can be made in the services that are offered to patients. This study embodies many of these requirements which will be applicable to rape survivors.

Health care has for sometime been evolving away from the disease-centred model towards the patient-centred model. In the patient-centred model, patients become active participants in their own care and receive whatever services can assist them to meet their own needs and preferences. However, although the patient-centred model is becoming widely used, it is still poorly understood by many health professionals

(Stewart 2001:1). Kelly-Heidenthal (2003:257) states that patient-centred care is designed to focus on the needs of the patient rather than on the needs of the staff. Patient-centred care also recommends that the responsibility for the management of an illness or injury should be shared between the patient and health care providers (Bauman, Fardy & Harris 2003:1).

WHO's guidelines for medico-legal care for survivors of sexual violence emphasise that, regardless of the setting and location of a health care institution, "care should be ethical, compassionate, objective and above all, patient-centred" (2003:18). Hakesley-Brown and Malone (2007:8) note in addition that when it becomes normal to regard the patient as a "partner" in the nursing process, the advantages that will accrue to the nursing profession will increase the effectiveness of health care services throughout the world.

While it is clear from the above definitions that patient-centred care can be defined in various ways, there are certain elements of this concept that are common to all the definitions encountered in the literature on this subject. A careful review of the available literature enables one to divide the concept of patient-centred care into the following recurrent components:

### **1.2.6.1 Open communication**

It is vitally important for health care workers to provide patients with a welcoming, warm and non-threatening environment (Silow-Carroll, Alteras & Stepnick 2006:4) which encourages the fact that the patients' physical and personal space is allowed, because the initial impression of a patient should be perceived that he or she is being "cared for". This kind of care also requires that the caregiver provide appropriate explanations of the relevant disease and injury and to be sensitive to the patient's feelings, beliefs and expectations about his or her circumstances and condition (Bauman et al. 2003:2). Bauman et al. (2003:2) also places a strong emphasis on this kind of team work and management that proves to be successful, because it is based on clear communication. In addition to importance of teamwork, Silow-Carroll et al. (2006:4) emphasise the necessity for caregivers to act as advocates of the interests of the patient and the patient's family, and to respect referrals because they

ensure smooth transitions between the various providers of care. Silow-Carroll et al. (2006:5) draw attention to the vital role that information and education play in making caregivers effective in their ability to communicate with their patients.

### **1.2.6.2 Partnership in care**

The concept of partnership in care describes the way in which caregivers should approach decision making when the decisions concerned directly affect the patient. Bauman et al. (2003:2) notes that persons should be allowed to participate in making decisions that affect them as individuals, and that they should be encouraged to becoming involved in the consequences of the decisions that determine their welfare. In terms of this paradigm, patients should be allowed to cooperate with health care workers in a process of collaborative goal setting, and they should also be encouraged to participate in planning and interventions (Institute for Healthcare Improvement 2008a:1). Patients should therefore be encouraged to share their observations, ideas and suggestions because it is by this means that a useful partnership can be promoted between patients and their health care workers (Institute for Healthcare Improvement 2008b:30).

Because it is one of the purposes of partnerships in care to legitimate constructive dialogue and communication between caregivers and patients, patients who find themselves in this milieu are given opportunities to voice their satisfaction or dissatisfaction with the care that they are receiving. In order to establish a partnership in care, it is essential to involve the patients themselves in the formulation and approval of policies and in the planning and evaluation of programmes for the institution or organization (Institute for Healthcare Improvement 2008b:30).

### **1.2.6.3 Respect and empowerment**

Although the issue of respect will be discussed again in Chapter 2 in the Section that deals with the ethical considerations raised by this study, it also happens to be a vital component of patient-centred care. Respect for the patient requires health care

workers to be knowledgeable about the needs of their patients as well as their personal values and preferences and / or priorities about treatments and procedures (Silow-Carroll et al. 2006:4).

Patient-centred care also implies that the views of the patient about the appropriateness of family involvement should be taken into account and respected because customary behaviour in this regard is different from one family to another and among individuals. In those cases where the patient feels reassured by the presence of his or her family in the therapeutic situation, it is advisable to treat members of the family as participants in the care team (rather than as mere visitors), and to grant them 24-hour access to the patient (Institute for Healthcare Improvement 2008a:1). Kirkland (2007:59) points out that every patient has unique needs and that it is only by means of dedicated communication that one share the burden of responsibility for patients.

#### **1.2.6.4 Continued support**

Various kinds of support are essential if a patient is to survive a traumatic situation with a minimum of injury and an absence of long-term consequences. It is health care workers who provide support immediately after rape, and it is they who determine the kind of emotional and physical support that the patient most urgently needs. Family involvement can be a vital factor in maximising support and comfort (after the patient's preferences about family involvement have been reviewed), and is equally important to respect the traditions of the patient's culture and community in the aftermath of a crime as serious as rape. The support of community representatives can be deeply reassuring to patients who are afflicted by anger, guilt and grief through no fault of their own (Silow-Carroll et al. 2006:5). Community representatives such as priests and others are also usually trained in the demanding art of reassuring those who have survived traumatic experiences and violations such as rape.

There are various obstacles that need to be overcome before patient-centred care can be achieved. Silow-Carroll et al. (2006:7) mention the following challenges,



barriers and difficulties that need to be considered by any organisation that has decided to implement patient-centred care:

- Suitably qualified personnel who have been educated and trained up to a certain level need to be employed.
- It is not always easy to retain highly qualified staff because they are entitled to demand higher remuneration packages because of their qualifications and experience.
- An institution that lacks the proper equipment for implementing patient-centred care and which is unable to reward those of its personnel who demonstrate standards of outstanding performance, will find themselves in a difficult position.
- Lack of adequate finances will compromise the institution of patient-centred care.
- It is necessary for institutions which had decided to implement patient-care to invite existing staff to participate in workshops that are designed to educate them, in order to change their traditional attitudes towards patients and to adopt new methods, attitudes and ideals.
- Personnel have to be trained to educate patients so that they will also be willing to change their traditional attitudes towards care and recovery. The traditional attitude of patients is one of passivity and uninvolved in the recovery process. It is not always easy to get patients to accept more responsibility for their own health.
- Where an existing unit is understaffed, nursing staff often suffer from disabling fatigue and frustration. Because of this, they have to prioritise their task as they attempt to giving equal amount of care to all those who need it. In such circumstances they would have no extra time or energy to explore desirable options such as patient-centred care.

According to Silow-Carroll et al. (2006:25-26), it is the responsibility of the leadership of the institution or organisation to lead by example when a patient-centred approach is being implemented in an institution. Getting personnel to accept ownership of patient-centred care must first begin with the managers and leaders of the organisation. Flexibility is a critical element in the delivery of patient-centred care

because each patient is different and unique in his or her own way. Strong ties with the community are also an essential component of a patient-centred system, because (as has already been noted above), the active involvement and support of the community is an essential element in patient-centred care, as are good relationships with, for instance, members of the police force and the functionaries of faith-based organizations. A positive and supportive relationship of an institution that utilises the patient-centred approach makes referral processes much smoother for all those concerned, because those who partake in the process, are already known to one another.

While it is also vitally important to have an in-depth understanding of the various cultures and ethnic traditions of the RSA, nurses and caregivers should be cautious not to predicate their treatment of patients upon their knowledge of the patient's generic culture. It is also essential for physicians to appreciate how patient-centred care can make their practice a whole lot easier. If the medical practitioners who service the institution value the elements of patient-centred care, they will be more willing to act as valued members of the team upon which the efficacy of such care depends. If the patient, for example, desires a continuation of the counselling she is receiving (beyond that which is provided for by the priorities of the organisation), referral to a counsellor might reduce the need for the physician to continue to provide high levels of the kind of emotional support which might otherwise be necessary.

### **1.3 Problem statement**

The medical management and collection of forensic evidence are of the utmost importance in the overall management of the female rape survivors who present to the A & E unit. In the standard operating procedure of the sexual assault crisis centres in the hospital where this study was conducted (The Hospital 2006), two main management strategies are utilised (see Annexure D for further details). The A & E unit to which the adult rape survivors report, complies with the guidelines set out in the standard operating protocols of the private hospital group (of which the hospital in this study is one service provider).

These guidelines make provision for the following interventions in management of all rape survivors:

- Education of practitioners as well as members of the community.
- The medical management of injuries that have been sustained.
- Forensic evidence collection.
- The administration on specific drugs so as to prevent the likelihood of HIV transmission from the rapist.
- Laboratory tests for determining HIV status.
- The termination of pregnancy.
- The provision of counselling.
- Strict protocols for respecting the confidentiality of the survivor.
- The schedule for follow-up visits.
- The capturing of statistical data and the organisation of documentation relating to the patient.

The only two forms of non-medical intervention that are offered to rape survivors in the guidelines provided for the hospital are counselling and follow-up visits. The problem is that the guidelines devised for the management of rape survivors do not focus on the specific needs of the female rape survivor, and cannot therefore be regarded as patient-centred. This research has led the researcher to the conclusion that the provision of holistic and patient-centred care for rape survivors is imperative, because only holistic and patient-centred care can deal with the various forms of injury that such patients sustain during the course of this violent crime and its aftermath.

## **1.4 Research questions**

After careful consideration of the background and problem statement, the following research questions were formulated:

- What are the lived experiences of adult female rape survivors regarding the care they received from health care workers in the emergency care environment?
- What recommendations can be made to enhance patient-centred care in the emergency care environment, based on the needs expressed through the lived experiences of adult female rape survivors?

## **1.5 Aim and objectives of the study**

The researcher initiated this study to specifically determine what the experiences of adult female rape survivors were with regards to the management they received from health care workers in the emergency care environment. This information that was gathered was then incorporated into the writing of recommendations for health care services towards the improvement of patient-centred care. Furthermore, the researcher aimed at generating an in-depth understanding of the lived experiences of the adult female rape survivors and the care that they received, not only in an A & E unit, but in the more comprehensive emergency care environment as well.

To achieve this aim the objectives were to:

- Explore the lived experiences of adult female rape survivors regarding the care they received from health care workers in the emergency care environment, and to
- Make recommendations based on the adult female rape survivors' needs expressed through the lived experiences to enhance patient-centred care in the emergency care environment.

## 1.6 Frame of reference

The frame of reference of this study is described in the sections that follow in terms of the relevant paradigms and conceptual definitions.

### 1.6.1 Paradigm

Appleton and King (2002:642) state that it is essential to make decisions about the choice of a particular methodology and its philosophical underpinnings on the basis of its appropriateness to the circumstances of the study. Although Trigg (2001:255) is writing specifically about the social sciences, what the author says is also relevant to nursing and to the therapeutic and health sciences. Trigg writes: "The philosophy of the social sciences cannot be an optional activity, indulged in by those reluctant to get on with real empirical work. It is the indispensable starting point for all the social sciences." The need to establish the particular philosophical framework that supports research before a researcher can embark on the empirical phase of the research is clearly stated by Trigg (2001:255) in these words. Her views are also consistent with those expressed by Wilson and McCormack (2006:46).

In order to meet that challenge, this section will outline the paradigmatic perspective that underwrites this study, a perspective that was used as a frame of reference for guiding the investigatory framework that enabled the subjective ("lived") experiences of a select group of adult female rape survivors in an A & E unit, to be scientifically investigated and described. The paradigm on which this research is based is that of phenomenology, which was considered to be best suited to the aims and purposes of this study. Phenomenological investigation allowed the researcher to obtain an in-depth understanding of the lived experiences of adult female rape survivors, as they received treatment and care in a particular A & E unit, within the emergency care environment, from the time of their initial contacts to the time of their discharge.

The subjective (lived) experiences of all aspects of everyday life are what a researcher focuses on during the process of phenomenological inquiry. What follows

is a brief description of how the phenomenological research method developed and the distinguished philosophers who contributed towards its development.

### **1.6.1.1 Historical overview and definitions of phenomenology**

Cohen (1987:31) points out that phenomenology first appeared in Western philosophy as a result of the work of Immanuel Kant in 1764 on the nature of how phenomena or things appear to individual human beings. Heidegger (1962) states that phenomenology is derived from the Greek word *phenomenon* which means "to show itself". A phenomenon is therefore something that shows itself or brings itself into the light in the sense of manifesting itself, so that it becomes visible to itself (Heidegger, cited in Ray 1994:118). Different philosophers and philosophical traditions have contributed to the methods of phenomenological research. The roots of phenomenology can therefore be traced through the contributions of Merleau-Ponty (1962), Martin Heidegger (1962) and Edmund Husserl (1969).

Husserl, whom Ray (1994:118) describes as the father of phenomenology, introduced the concept of the "life-world" or "lived experience" of an individual. Husserl was of the opinion that the "life-world" or "lived experience" of an individual is usually taken for granted or veiled (obscured) by embedded prejudices, assumptions and preconceptions. He therefore advocated focusing human perceptions on "things themselves" and emphasised the importance of "bracketing", a technique that is used to suspend preconceived ideas, prejudices and assumptions about whatever is being perceived. Koch (1995:828) states that it is central to Husserl's philosophy that the subjective ("lived") experience is "the ultimate ground and meaning of knowledge".

Merleau-Ponty suggests that phenomenology is a rigorous philosophical technique that enables us to search for what he calls "essences". Merleau-Ponty's understanding is that people habitually exist in a world of primary and unadorned experiences ("lived experiences") that precede human reflection on those experiences. Heidegger, a student of Husserl, emphasises the importance of discovering how people come to experience phenomena in the way that they do. This approach takes into account the value and importance of past experiences as well future concerns, hopes and plans. The methods of Heidegger and Merleau-Ponty

differ from those of Husserl because they came to the conclusion that “bracketing” is impossible for human beings to achieve (Koch 1995:828).

Schutz (1970:320) regards the world of everyday life as the “total sphere of experiences of an individual which is circumscribed by the objects, persons and events encountered in the pursuit of the pragmatic objectives of living”. Streubert-Speziale and Carpenter (2007:77) state that “lived experiences” are those that are true for an individual in the context of the individual's life, because they give meaning to each person's perception of particular phenomena and are influenced by everything that is internal and external to the individual.

Spiegelberg (1975:3) defined phenomenology as “the name for a philosophical movement whose primary objective is the direct investigation and description of phenomena, as consciously experienced, without theories about their causal explanation and as free as possible from unclaimed preconceptions and presuppositions”. In addition, Spiegelberg (1982:381-382) states that phenomenology represents a movement rather than a uniform method or set of doctrines, and he emphasizes the fact that any fixed list of steps would not reflect the philosophical depth of phenomenological practice.

Phenomenological research illuminates some fundamental ways in which human beings make sense of everyday life, so that they will be in a position to “see what is normally hidden and forgotten” (Spiegelberg 1982:382). Spiegelberg suggests that the methods that human beings use to bring to mind (recollect) and to recognise the value of what is hidden, concealed and forgotten, is fundamental to the pursuit of phenomenology of the kind that he is describing. Another component meaning of the term “phenomenology” in its most literal sense is a method of taking the hidden out of its hiding, and of detecting it as unhidden, i.e. as truth.

Wagner (1983:8) states that phenomenology is “a system of interpretation that helps us perceive and conceive ourselves, our contacts and interchanges with others, and everything else in the realm of our experiences in a variety of ways, including to describe a method as well as a philosophy or way of thinking.”

Streubert-Speziale and Carpenter (2007:76) describe phenomenology as “a science whose purpose is to describe particular phenomena or the appearance of things, as lived experience”. Driessnack, Sousa and Mendes (2007:684) state that the purpose of phenomenological research is to describe specific phenomena as they emerge from the lived experiences of individuals. These authors also add that the focus of phenomenological studies is on understanding what the experiences means to individual people within the context of those people’s lives.

### **1.6.1.2 Phenomenology as a philosophy and a method of research**

Spiegelberg (1975) and Merleau-Ponty (1962), as cited by Streubert-Speziale and Carpenter (2007: 77), describe phenomenology as both a philosophy and a method. Husserl (1970), as cited in Ray (1994:118), states that phenomenology is a philosophy, a method of research and an approach to perception and understanding.

Phenomenology is rooted in the belief that everyday experiences can be examined without prior prejudices, preconceptions and assumptions. It is not helpful to rely on preconceived ideas and theories when trying to understand the actual experiences of human beings because such preconceptions restrict human experience by confining it in conceptual boxes, and by reducing the richness of human experience into unrelated component parts. The main purpose of the phenomenological approach is to discover and identify the meaning of the human experience, through analysis of the participants’ descriptions of his / her lived experience and perceptions.

Streubert-Speziale and Carpenter (2007:81) point out that while the philosophical underpinnings of phenomenology are complex, its methodological applications remain dynamic and evolving. These authors encourage the reading of original texts in order to gain an in-depth understanding of the philosophical foundations of phenomenology and to discover the most suitable phenomenological method for a particular enterprise because there is no single, simplistic step-by-step approach that characterises phenomenological inquiry.

There is also no authoritative school of phenomenology whose views and methods are universally acknowledged and applied. Instead of this, we find that phenomenology



has been described as a “movement” because it comprises a number of different approaches that have been adapted and refined over time. It is the aim of the phenomenological research method to “borrow” the experiences of “others” (among the participants themselves) in order to provide coherent descriptions and / or interpretations of the experiences that emerge. Phenomenology is concerned with how the individual views the world and lives his or her life from the “inside” (Newell & Burnard 2006:89). Phenomenology takes great pains to identify what it must be like to actually **be** the person who is being studied and who continues with his or her ordinary life throughout the course of the investigation.

Participants in phenomenological interviews are given opportunities to describe the subjective meanings that they attach to their lived experiences (the inner and outer phenomena of their lives). It is from these accounts that a researcher is able to compile rich and layered descriptions of what the participants subjectively experience. Such descriptions in turn provide a basis for ascribing coherent meanings to what might otherwise be scattered and unrelated anecdotes and observations (Van Manen 1990:36).

### **1.6.1.3 The phenomenological researcher**

The phenomenological researcher is constantly alert to the “lived experiences” of individual human beings – the way each person views, experiences and expresses his or her inner or private world (Newell & Burnard 2006:90). An experience includes both its occurrence and the meaning that an individual attaches to such an occurrence (Polkinghorne 1988:23). It is essential for phenomenological researchers to exercise the greatest tact, sensitivity and ethical sense as they penetrate beneath the surface of the inner lives of participants because much of the information that people impart is private and can be harmful if revealed to unsympathetic outsiders. It is, after all, the private inner world that “keeps people together” (Newell & Burnard 2006:90). It is therefore absolutely necessary for phenomenological researchers to act ethically and not be unduly intrusive because phenomenology is not a form of counselling or psychotherapy.

#### 1.6.1.4 Steps in the phenomenological enquiry process

Brink, Van der Walt and Van Rensburg (2006:113) note that the phenomenological approach consists of a set of steps or stages that guide researchers in the study of particular phenomena. This is also suggested by Giorgi (1970), Spiegelberg (1976) and Van Manen (1990). According to Streubert-Speziale and Carpenter (2007:81), phenomenological research is the rigorous, critical and systematic investigation of phenomena. It is necessary in phenomenological research to identify the “essence” of a phenomenon and then to accurately describe it in terms of everyday lived experiences.

Spiegelberg (1975) points out a number of steps or elements that are encountered in phenomenological investigations. These include descriptive phenomenology, the phenomenology of essences, the phenomenology of appearances, constitutive phenomenology, and reductive phenomenology. Descriptive phenomenology, which involves the “direct exploration, analysis and description of particular phenomena (as free as possible from presuppositions); is aiming at maximum intuitive presentation” (Spiegelberg 1975, cited in Streubert-Speziale & Carpenter 2007:82). This approach emphasises an assumption-free perception of the experiences of a person while emphasizing the richness, uniqueness and depth of those experiences.

These phenomenological steps or elements will now be briefly discussed.

- **Descriptive phenomenology**

Descriptive phenomenology consists of a three-step process which comprises the intuiting, analysing and describing of a phenomenon.

**Intuiting** requires the researcher to avoid (or “bracket”) any criticism, preconception, evaluation or assumption and only to concentrate on the phenomenon under investigation. It is the aim of the researcher to become totally immersed in the phenomenon under investigation. This is the first step in the process and it is the one in which the researcher begins to experience the phenomenon as described by the

participant. In the course of this step, the researcher becomes an “instrument” or “tool” for collecting data in the interviewing process collecting data, while she listens to individual descriptions. After this initial process of “bare” listening, the researcher repeatedly scrutinises the data that has been transcribed in order to try to grasp the essence of what the participants have transmitted in their communications.

The second step is phenomenological **analysing**. This means identifying the “essences” of the phenomenon under investigation from the data that has been obtained, and the manner in which the data has been represented. As the researcher analyses the data that has been collected from participants, she also remains alert to possible relationships and connections with adjacent phenomena. As the researcher becomes totally immersed in the data and as she listens attentively to the data, common themes or “essences” will begin to emerge. These are pure and accurate descriptions of the data.

**Describing** in this context means to communicate and render the written and verbal descriptions in meaningful forms. Description is based on various ways of classifying or grouping of the phenomenon. Intuiting, analysing and description often occur simultaneously.

- **Phenomenology of essences**

This step requires the researcher to scrutinise and examine the data in order to identify common themes or essences, and to establish recurrent patterns by means of which particular phenomena can be classified. The researcher extracts concrete examples from the collected data in order to exemplify the relationships that exist among phenomena.

- **Phenomenology of appearances**

In this step, the researcher pays particular attention to the ways in which the phenomena appear. This step focuses the attention of the researcher on phenomena as they reveal themselves through the researchers’ immersion in the data.

- **Constitutive phenomenology**

In this step, the phenomena that are being studied become established or “constituted” in the researcher’s consciousness. According to Streubert-Speziale and Carpenter (2007:87), constitutive phenomenology means “the process in which the phenomena take shape in our consciousness as we advance from first impressions to the full picture of their structure”.

- **Reductive phenomenology**

This step is coextensive as a whole of the phenomenological investigation. The researcher is at pains to continually address his or her personal biases, assumptions and presuppositions, and to set aside these in order to obtain the purest description of the phenomenon under investigation. The researcher takes all that he or she knows about the phenomenon and “brackets” it or sets it aside in an effort to keep what is already known, separate from the lived experiences that have been described by the participants. Phenomenological reduction is critical if the researcher is to achieve pure description. The reductive process can also be advanced as a good reason for postponing any review of the literature until the researcher has completely analysed the data.

## **1.6.2 Conceptual definitions**

For the sake of simplicity and consistency throughout this dissertation, the following key concepts have been defined as follows.

### **1.6.2.1 Accident and Emergency (A & E) nurse practitioner**

In order to qualify as a registered nurse in the RSA, a nurse practitioner should have completed the compulsory training and registration procedures required by the South African Nursing Council (SANC). These enable her to practise in all South African hospitals. It is necessary for a registered nurse to have received her education from an accredited nursing school, to have been registered as a student while completing

her studies for the qualification, and to have completed the prescribed education programme successfully (SANC 2007:2). After an individual has been accepted as a registered nurse by the SANC, she may proceed to obtain an additional qualification in the field of critical care nursing, with speciality in trauma and emergency nursing (South African Nursing Council (SANC) Regulation 212 of 1993, as amended by Regulation 74 of 1997), by following a prescribed course of studies and practical assignments. Since this qualification is not a precondition for becoming a registered nurse, both registered nurses as well as qualified trauma and emergency nurses will be designated as **A & E nurse practitioners** for the purposes of this study.

It has already been mentioned above that the term **A & E nurse practitioner** refers to registered nurses as well as to those registered nurses who possess the additional qualification in trauma and emergency nursing science, who were working in the A & E unit in which this research was conducted, and who are involved in the management of adult female rape survivors as part of their professional responsibilities.

#### **1.6.2.2 Accident and Emergency (A & E) unit**

An emergency department or unit is described in the literature survey as a "section of a hospital or other health care facility that is designed, staffed, and equipped to treat injured people and also those afflicted with sudden, severe illness" (Stedman's Medical Dictionary 2005:466). Because an emergency department is often referred to as an **A & E unit** in the South African context, this term will be used consistently throughout the course of this study.

The A & E unit, in which this research was undertaken, is a specialised unit in a particular private hospital in Gauteng that is capable of providing care for injured, ill and traumatised patients who are in need of emergency interventions (including adult female rape survivors). The A & E unit will sometimes be mentioned as a separate entity when the context that is being described only forms part of the actions that occur within the unit itself. The A & E unit does however form part of the more comprehensive emergency care environment, and will be included when the researcher mentions the environment as a whole.

### 1.6.2.3 Adult female rape survivor

While this definition will be used repeatedly throughout this study, it is important to clarify each of the words that comprise this definition before interpreting what this term means in the context of the study itself.

According to Stedman's Medical Dictionary for the Health Professions and Nursing (2005:35), an **adult** is someone that is fully grown and physically mature. The legal definition of an adult in the RSA is any person of 18 years or older. This definition was stipulated in the Criminal Law (Sexual Offences and Related Matters) Amendment Bill (50 of 2003).

**Female** is defined by Stedman's Medical Dictionary for the Health Professions and Nursing (2005:535) as "denoting the gender that produces oocytes and thus bears the young".

**Rape** in the RSA used to be legally defined as "intentional unlawful sexual intercourse with a woman without her consent" (POWA 2006:1). According to POWA (2006:1), there were several problems with this definition. Neither forced anal or oral penetration, nor penetration with a foreign object, was addressed in the above definition. Sexual crimes between people of the same sex were also not recognised as rape. This definition was therefore replaced by the Criminal Law (Sexual Offences and Related Matters) Amendment Act (32 of 2007), which became law in 2007 when the Amendment Bill passed. The amended definition, that was drafted in the preceding Bill as well, makes provision for including forced anal or oral sex as rape (irrespective of the gender of either the survivor or perpetrator). It also "recognises male rape" as a crime of equal gravity to female rape, and "widens rape to include sexual penetration with an inanimate object or animal genitalia" (Le Roux 2007:1).

A **survivor**, as defined by Dictionary.com (2008:1), is a person that survives, or a person who continues to function or prosper in spite of opposition, hardship or setbacks.

For the purposes of this study, an **adult female rape survivor** is described as an adult of 18 years and older, a female by gender, who, after an incident of rape, confirms that she has been sexually penetrated by any of the bodily parts of a male human or by a non-human object of any kind. The researcher's use of the term "survivor" is consistent with the operational definition suggested by Suffla et al. (2001:1), which "separates the experience of being violated (the victimisation of rape) from what women do about it". The use of term "survivor" in no way expresses the slightest intention on the part of the researcher to minimise or undermine the intensity and seriousness of the sense of victimisation that many women who have been raped, experienced in their interactions with people in the larger society as well as in their interactions with the criminal justice system.

#### 1.6.2.4 Emergency care environment

A few other terms which recur in this study will be briefly defined below.

The Reader's Digest Oxford Dictionary (1994:479) defines an **emergency** as a "sudden state of danger, requiring immediate action" and a "medical condition requiring immediate medical treatment".

**Care** (as a verb) is defined as "to look after" (Reader's Digest Oxford Dictionary, 1994:213).

**Environment** is defined by Stedman's Medical Dictionary for the Health Professions and Nursing (2005:484) as the milieu, the aggregate of all of the external conditions and influences that affect the life and development of an organism.

For the purposes of this study, **emergency care** refers to all medical and non-medical management and to the collection of forensic evidence from a female rape survivor. It includes all aspects of care rendered and interventions performed within the emergency unit subsequent to an incident of rape. The **emergency care environment** refers to all the places and service providers that are involved in the management of a rape survivor. Since this environment is a comprehensive and all-inclusive management entity, it therefore includes paramedics (if applicable), the hospital and all the members of the multi-disciplinary team who work there, as well

as members of the South African Police Service. The A & E unit will form part of this emergency care environment.

### 1.6.2.5 Health care workers

Since this term is made up of three separate concepts, each concept will be defined in turn before the way in which the whole concept is applied in this study.

**Health** has been described as the “state of an organism” when it functions optimally and when it shows no sign of being diseased or abnormal. It can also be defined as a state characterised by anatomical, physiological and psychological integrity, as an ability to embody valued family, work, and community roles, as an ability to deal with physical, biological, psychological and social stress, as a feeling of well-being, and as freedom from the occurrence of disease and untimely death. Lastly, it can also be defined as complete physical, mental and social well-being, and not just as the absence of disease (Stedman’s Medical Dictionary for the Health Professions and Nursing 2005:641).

The concept **care** can be described as a general term for the application of knowledge and experience in order to benefit a person, family, or community. In a more restricted medical sense, it means to provide medical or health care-related services to a patient (Stedman’s Medical Dictionary for the Health Professions and Nursing, 2005:239).

**Workers** can be defined as persons who are gainfully employed, including owners, managers, other paid employees, the self-employed and unpaid family workers (National Safety Council, 2008:2).

For the purposes of this study **health care workers** include any person who played a part in the medical management of adult female rape survivors in the A & E unit of the private hospital in Gauteng that was selected for the purposes of this research. It therefore included receptionists, the A & E nurse practitioners, doctors, the laboratory staff, the pharmacy staff and the counsellors. As the police deal more with the legalities in a rape incident, they will be referred to separately during the course of this dissertation and will not be included as health care workers specifically.



### 1.6.2.6 Lived experiences

**Lived experiences**, according to Polit and Beck (2008:227), refer to the perceptions that individuals have of all the events of their conscious world, whether inner or outer. According to Streubert-Speziale and Carpenter (2007:77), lived experiences describe an individual human being's awareness of the world of everyday life and are therefore the "total sphere of experiences of an individual which is circumscribed by the objectives, persons, and events encountered in the pursuit of the pragmatic objectives of living".

In this study, the ***lived experiences*** of the adult female rape survivor are regarded as having the status of surviving a rape being true or real for her, in the context of her life and experience. Lived experiences are also the source of the meanings that she attributes to her management in the A & E unit after the experience of rape incident, between the time of her admission to the unit and her discharge from the unit.

### 1.6.2.7 Patient-centred care

**Patient-centred care** can be described as individualised care that recognises the uniqueness of each patient's preferences, needs and condition. Urden, Stacy and Lough (2006:6-7) state that physiological illness are usually much better understood and more predictable than the effect of psychosocial influences on the healing process of the body and mind. The aim of patient-centred care should be to identify and apply those interventions "that will positively impact" on both these aspects of the human entity so that the patient can progress as quickly as possible towards the desired outcome. The concept of care has already been described in Section 1.6.2.5, and nothing needs to be added here to that definition.

For the context of this study, ***patient-centred care*** can be described as being able to identify and determine the unique needs that arise from the lived experiences of each adult female rape survivor and matching the care that she is offered to such experiences as part of the management in the A & E unit.

## 1.7 Research methodology

Methodology refers to the framework of theories and principles on which the design and method of research are based (Holloway & Wheeler 2002:287). Qualitative research was adopted as an appropriate methodology for this study, and the research itself made use of a systematic, subjective approach. This qualitative approach was considered to offer an appropriate method for identifying and recording the personal perceptions of adult female rape survivors, and their perceptions of how they were being managed in the emergency care environment (the A & E unit). The steps involved in the application of a qualitative methodology therefore comprised the gathering of data, the analysis and classification of the data thus gathered, the identification of emergent trends and patterns in the data, the drawing of conclusions from recurrent patterns, trends and observations, and finally drawing up recommendations for the enhancement of the effectiveness of a patient-centred care approach to adult female rape survivors.

A more detailed and in-depth description will be provided of this process in Chapter 2.

### 1.7.1 Research design

The research design is a blueprint that guides the conduct of the study. Adhering to the research design maximises control over factors that could interfere with the validity of the findings (Burns & Grove 2005:211). The researcher therefore used the research design to plan and implement the study, to achieve the set aims and objectives of the research (Burns & Grove 2007:553), and to certify the study's integrity (Polit & Beck 2008:764). An overall plan of action (the research design) ensures that a researcher remains in control of the research process. This puts the researcher in a better position to cope with whatever difficulties or anomalies that may arise in the process.

The design of this research was therefore explorative, descriptive and contextual in nature (see Section 2.3.2 for more details).

## 1.7.2 Research method

Research is a process that begins with a problem and ends when the problem has either been resolved or addressed in a satisfactory way (Brink et al. 2006:50). The research method includes indications of the techniques that should be used to structure the study and methods that should be used to gather and analyse the information that has been collected in a systematic and coherent fashion (Polit & Beck 2008:765). All this is undertaken with the ultimate aim of answering the research question or addressing the problem in a satisfactory way.

Table 1.2 (below) sets out details of the way in which the research method was utilised to fulfil the stated aim of the research.



**Table 1.2: Research method**

Sampling plan	Data collection	Data analysis	Trustworthiness
<p><b>Population:</b> Adult rape survivors</p>	<p><b>Individual interviews:</b> -Audio taped -Field notes</p>	<p><b>The analysis of content (data) was based on Giorgi's principles (Giorgi 1985, cited in Streubert-Speziale 2007:82):</b> -Reading of the entire description -Re-reading of the description -Identifying transitional units -Clarifying and elaborating on meanings -Reflecting on constituents -Transforming concrete language -Integrating and synthesising -Literature control</p>	<p><b>Using Guba and Lincoln's model to determine trustworthiness (1989:329) by using the following four strategies:</b> -Credibility -Transferability -Dependability -Conformability</p>
<p><b>Sample:</b> Adult female rape survivors presenting at an A &amp; E unit of a selected private hospital in Gauteng, SA</p>			
<p><b>Timeframe:</b> Data collected between 01 June 2007 and 30 September 2008</p>			
<p><b>Sampling:</b> -Non-probability sampling -Purposive sampling</p>			
<p><b>Sample size:</b> 10 participants</p>			

## **1.8 Trustworthiness**

Guba and Lincoln (1989:329) were the authors of the original study from which much of the current debate about rigour emerged. The strategies for trustworthiness that are recommended by Guba and Lincoln include credibility, transferability, dependability and conformability.

The application of these strategies is discussed in depth in Chapter 2 (in Sections 2.5.1 to 2.5.4).

## **1.9 Ethical considerations**

The ethical considerations in this study focussed primarily on the rights of the participants who were interviewed for the purpose of gathering data. The Research Ethics Committee of the Faculty of Health Science at the University of Pretoria reviewed the researcher's proposal for protecting the ethical rights of the participants and confirmed that the proposal fulfilled all their requirements for certifying ethical research (see Annexure A).

The researcher also sought and obtained the informed consent of all the ten participants who took part in this study (see Annexure E). Since participation was strictly voluntary (which means that participants can choose whether they wish to participate in the study or not), the participants retained the right to withdraw themselves from the study at any time. This right is referred to as "the right to self-determination" (Burns & Grove 2005:751).

The researcher was careful to inform all the individuals who participated in this research about the aims and objectives of the study, as well the methods and occasions that the researcher would use to gather the necessary information. None of the information that was collected was collected without their consent and knowledge. The participants were told that that the information collected from them would be utilised for making recommendations to the management of the hospital for improvements in the patient-centred care approach of future rape survivors. The

participants were also told that a report on the study would be presented in a journal article once the study had been completed. Such an article would not compromise their right to privacy because the identity of each participant was carefully protected (Burns & Grove 2005:747). All questions that the participants raised about the study were answered, and high professional standards were maintained at all times for the purpose of ensuring confidentiality and the anonymity of the participants.

The application of how further ethical measures were included in this study will be discussed in more detail in Chapter 2.

## **1.10 Significance and contribution of this research**

This research might produce considerable benefits for both the patients and the registered nurses who work in the A & E unit. Burns and Grove (2005:3) stated that the nursing profession is accountable to society for providing quality and cost-effective care and for seeking ways whereby such care might be improved in the future.

While the current guidelines for the management of rape survivors focus on managing the initial visible evidence of the trauma, on gathering forensic evidence and on taking steps to protect the survivor from becoming infected with HIV, they do not take the female rape survivor's personal experience of the traumatic experience and her subsequent needs, into account. The researcher's aim in taking the personal experiences of the rape survivors into consideration was to suggest ways in which current practice could be improved and patient-centred care could be made more effective (McCormack et al. 2004:316).

## **1.11 Scope and limitations of this study**

Limitations in research are the restrictions and weaknesses that are inherent in research itself (Polit & Beck 2008:74). One of the limitations of all qualitative research studies is that one cannot generalise the findings of the research to other similar situations and conditions (Holloway & Wheeler 2002:35).

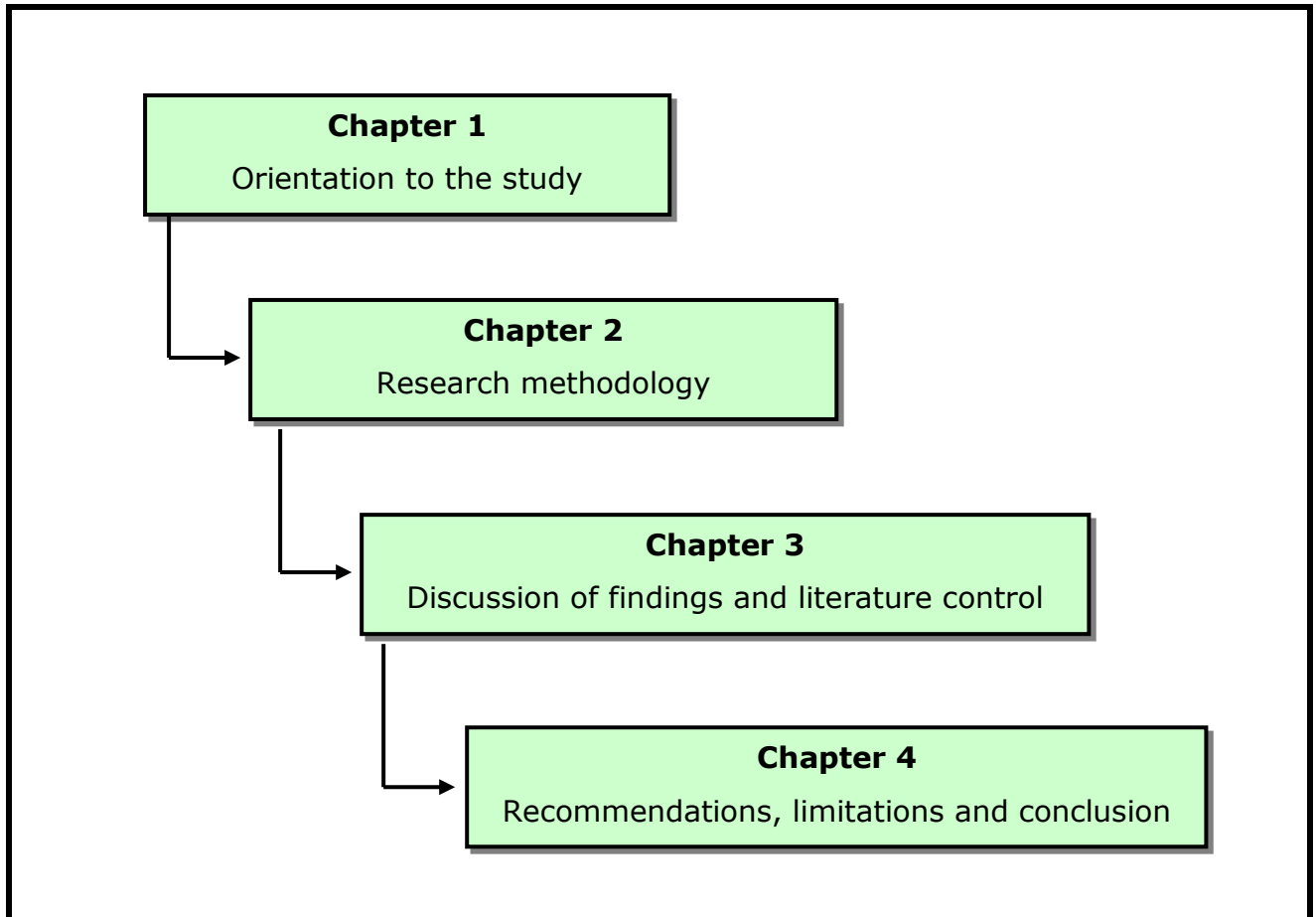
The qualitative data that was collected for this study was limited to participants in a private hospital in Gauteng, RSA. The findings of the study are therefore only applicable to the representative sample from which they were taken. Although these findings cannot be generalised, it would, of course, be possible to adapt the methods used in the study so that they could be applied to participants in other A & E units which operate according to similar guidelines. The particularity of this qualitative research is therefore one of its limitations.

One of the features of the study is that only adult female participants were included in the participating sample. The study therefore excluded both male and paediatric patients. It is also worth noting that this study was undertaken in an affluent socio-economic region of the city in which a variety of the best resources and facilities were available to patients. The findings would probably have been very different had the study been undertaken in a different environment where such facilities were not available. The social and economic homogeneity of the sample is therefore one of the limitations of this study.

For practical reasons, rape survivors who were not fluent in either Afrikaans or English were excluded from this study. The results would in all likelihood have been somewhat different if the sample had included participants whose first language was neither English nor Afrikaans. The absence of participants who are not fluent in either English or Afrikaans is one of the limitations of the study.

## **1.12 Layout of this study**

The findings of this study have been reported in four chapters. The layout and organisation of the chapters is set out in Figure 1.1 (below).



**Figure 1.1: Schematic representation of the layout of the research study**

### **1.13 Conclusion**

In this chapter the researcher provided an orientation to the study. The background to the problem was described, and the research questions, aim and objectives were derived from the problem statement. The frame of reference that was used in this study has been identified, and the research methodology has been briefly described and summarised in Table 1.2. This was followed by a summary of the ethical considerations, significance and intended contribution of the study as well the discussion of the scope and limitations of the research. The layout of the study set out in Figure 1.1 offers a visual overview of the organisation of the chapters that follow.

Chapter 2 contains a detailed discussion on the research methodology that was used in this research.





## 2 Research methodology

***"A journey of a thousand miles begins with a single step."  
(Unknown)***

### 2.1 Introduction

What follows in this chapter is a discussion on the research methodology that was used in this study. This will provide readers with a comprehensive summary of the research design and method. In order to answer the research question of this study, the researcher used a qualitative, exploratory, descriptive and contextual design that she derived from the paradigm of phenomenology.

### 2.2 Research methodology

Henning, Van Rensburg and Smit (2005:36) state that methodology refers to "the coherent group of methods that complement one another and have the goodness of fit to deliver data and findings that will reflect the research question and suit the research purpose". Her understanding of Henning's statement allows the researcher to characterise methodology as the complete process of research, rather than one specific element or phase thereof. The research methodology therefore includes the research design and method.

### 2.3 Choice of qualitative research design

The terms that describe the research design of this study are *qualitative*, *exploratory*, *descriptive* and *contextual*.



### 2.3.1 Qualitative research

According to Burns and Grove (2005:52), qualitative research provides a means of “exploring the depth, richness, and complexity of inherent phenomena”. Qualitative studies are further described by Brink et al. (2006:113) as a method which is used “to explore the meaning or describe and promote (an) understanding of human experiences” such as pain and grief (to mention but two examples of human experience) as well as a variety of views and opinions about a specific phenomenon.

The researcher’s purpose in carrying out this research was not to manipulate events or to influence and describe any variables, or even to predict causal relationships as might have been the case if it had been quantitative rather than qualitative research (Burns & Grove 2005:23). Other authors such as Henning et al. (2005:3), for example, state that “it is exactly this freedom and natural development of action and representation that one wish to capture” when a researcher undertakes qualitative research.

The qualitative nature of this research will become evident from the descriptions of the lived experiences and needs of the participant adult female rape survivors and their opinions about the way that they were being managed in the A & E unit. Qualitative research is guided by a specific paradigmatic philosophical stance. Because this philosophical paradigm determines the shape and methods that are used in the research methodology, it also influences the way in which the data is collected and interpreted (Burns & Grove 2005:54-55). The research method that is derived from phenomenology usually results in a broad and global explanation of the phenomena that it undertakes to describe (Burns & Grove 2005:745).

The researcher deliberately selected a phenomenological research method as the most appropriate for the purposes of this study because she

believed that the affected people (the adult female rape survivors), their surrounding environment and the experiences that they underwent in that environment, all functioned in interdependence upon one another (as one extended entity) with inseparable connections between the constituent components. It has already been noted that phenomenology can be described as both a philosophy as well as a research paradigm (Burns & Grove 2005:55). These authors emphasise that the purpose of phenomenological research is to describe and make coherent sense of the experiences or phenomena of the research participants, as they are subjectively perceived and understood by the participants in the sample.

Henning et al. (2005:5) add that phenomenological research encourages participants to offer a more "open ended way of giving their views", and that this particular technique contributes to the richness, texture and variety of the descriptions that are obtained from the participants. Phenomenological research is particularly successful in obtaining the nuances, colouration and tones of the experience of human trauma that might well pass unnoticed and unobserved with the use of other research methods. Donalek (2004:516) confirms this when she notes that the techniques of phenomenological research are particularly helpful in the exploration of sensitive or disturbing content. The researcher therefore deliberately selected a phenomenological paradigm as the methodology to gain insights into the disturbing experiences endured by adult female rape survivors (Burns & Grove 2005:52), with specifically their opinions about the management that they were receiving in the trauma unit.

The phenomenological approach was exemplified in this research by the fact that each of the participants offered her own recollections and interpretations from the point of view of her own unique assumptions, expectations and beliefs. In so doing, each of these women was able to offer different (yet equally important) evaluations of the way in which the management in the unit affected them. Even though each of the participants had survived the violent crime of rape, and even though each of them was treated in terms of the same protocols that governed the

functioning of the A & E unit, the way in which each of the participants experienced these phenomena was unique. In spite of the fact that many different varieties of phenomenological research exist, and in spite of the fact that these variably differ in method and results, the researcher chose (as one of the foundation views of her methodology) the assumption that our subjective human experiences of the world are constantly being shaped by the changing fluctuations of our ideas and experiences of the self. This assertion was constantly borne in mind by the researcher as she constructed each individual participant's subjective interpretation of the outrages to which she had been subjected (the phenomenon of violent rape as subsequent management in the A & E unit). Brink et al. (2006:113) state quite clearly: "Phenomenological studies examine human experiences through the descriptions that are provided by the people involved."

Donalek (2004:516) states that phenomenological research should incorporate the researcher's beliefs about data analysis. This research will therefore reflect both the participants' descriptions as well as the researcher's experience and assumptions in the final construction of the data.

### **2.3.2 Nature of the research**

Since the nature of this research was explorative, descriptive and contextual, it was the purpose of the research to understand the phenomenon of rape management by means of careful reconstructions of the raw data obtained from the participants. These reconstructions reflected in the research have deepened understanding of how the participants' experienced their management after being admitted to the A & E unit (their "lived experiences"). By critically examining and evaluating the quality of care offered to these female rape survivors in an A & E unit in the context of a private hospital, the researcher ended up by being able



to offer a range of recommendations about how the quality of patient-centred care could be improved for all such survivors in similar contexts.

### **2.3.2.1 Explorative nature of the research**

The process of exploration in research is defined by Burns and Grove (2005:736) as the process of “examining data descriptively to become as familiar as possible with the nature of the data, and searching for hidden structures or models”. Polit and Beck (2004:20) explain that although exploratory research begins with the “phenomenon of interest” rather than mere descriptions, exploratory research in its totality is committed to investigating every possible detail and nuance of the phenomenon, of the way in which these are manifested in “lived experiences” and in the other factors on which this kind of research focuses.

By using an exploratory design in this study, the researcher anticipated that she would increase her understanding of the various phenomena that revealed themselves in the subjective perceptions of female rape survivors, and that she would therefore be able to use this understanding to make helpful recommendations for enhancing the quality of the patient-centred approach that was the modus operandi of the A & E unit.

This approach and design were implemented throughout the whole research process and thus verifying or contradicting the findings of research reported in the previous literature, by comparing those findings to the data that the researcher collected and interpreted during the empirical phase of the study (Burns & Grove 2005:577). This naturally implies that the researcher had opened herself to the possibility of the emergence of new ideas and possibilities and that she did not permit either of her own assumptions or the findings of other researchers in this field to direct or influence the ultimate conclusions that arose out of the research.



### 2.3.2.2 Descriptive nature of the research

Polit and Beck (2004:263) assert that the descriptive element in descriptive research manifests itself in the comprehensive summaries of various phenomena and events in everyday language. Brink et al. (2006:111) state that a descriptive design approach also allows the researcher to obtain information about the actual and perceived needs of research subjects, which, in this study, includes the needs, hopes, fears and attitudes, as well as the specific experiences, of the female rape survivors in the sample. Brink et al. (2006:102, 111) also note that descriptive designs are used when more information is needed to supply a richer and more nuanced understanding of the particular field or phenomenon, or when too little is known about the phenomenon in spite of any previous research that may have been undertaken (Burns & Grove 2005:26).

The researcher therefore adopted a descriptive design for this research as she explored and scrutinised the testimonies of the survivors and obtained more information about the needs of the participants. This will enable the researcher to be in a position towards the conclusion of the study to incorporate this information within the framework of a coherent and categorical explanation of the phenomenon under scrutiny. It should be noted that a descriptive design is also utilised in quantitative research methods (Burns & Grove 2005:44, 232-233), and that most studies contain descriptive elements even though such studies may not have been conceptualized in terms of the necessity to adopt a specifically descriptive approach to design. It is also important to note that no variables were used or manipulated in this research, that no theory was developed, and that no problem identification or justification of any current practice was sought or envisaged. The descriptive aspect should be evident in the "clarity and the factual accuracy of the researcher's account of the study" (Burns & Grove 2005:628).



### **2.3.2.3 Contextual nature of the research**

The contextual nature of a study refers to “the body, the world and the concerns unique to each individual”, and the particularity and limitations of each person who was involved in the research, whether as researcher or participant contributor (Burns & Grove 2005:732). “Contextual nature” in this particular study implies that the researcher scrutinised and examined the lived experiences of the participants in a natural setting (the A & E unit, in this instance) and within the concrete circumstances and boundaries within which they had occurred.

The contextual aspect of this study is therefore evident in the sample selection because the sample consisted only of adult female rape survivors who were being managed in the A & E unit of a specific private hospital in Gauteng, RSA. The researcher had no plans or intentions to generalise her findings, or to include any participants outside the original context which she had defined in the research design. Babbie and Mouton (2001:272) argue that it is only when “one understands events against the background of a whole context, and how much a context confers meaning to these events, that one truly understand the events.”

The researcher therefore adopted the attitude that the events themselves (just as they occurred) and the background to those events, as well as the influence that the background exerted on the participants’ individual experiences of those events, all needed to be fully taken into account before it would be possible to construct a deeply layered, rich and textured description of the stated research phenomenon.

## **2.4 Research process**

In what follows, the research process is described in terms of the research context, the population, the sampling methods, the criteria for selecting participants, the methods that the researcher used to gain access to the

participants, the settings of the interviews, the methods of data collection and analysis, and some of the essential ways in which the researcher prepared herself to undertake the empirical work.

### **2.4.1 The context**

The context that the researcher chose for this research was the A & E unit of a particular private hospital situated in Gauteng, RSA. The unit as selected was involved in the day-to-day care and the management and treatment of adult female rape survivors. The A & E unit concerned is part of an accredited Level III hospital that is a member of a consolidated group of hospitals that operates throughout the country.

This hospital was therefore able to provide specialist care for rape survivors, whether they were males, females or children of either gender. The rape survivors are managed in terms of standard protocols to which each of the constituent hospitals in the group subscribes.

Some of the relevant statistics about the rape survivors in the sample who were managed in the A & E unit over a three year timeframe are summarised in Table 2.1 (below). As indicated in the table, the total number of rape survivors that are being managed in the A & E unit is increasing from year to year, even though Amnesty International (2008:1) states that the incidence of rape among adults has begun to stabilise. Because the majority of the patients who are admitted to the A & E unit are adult female rape survivors, the researcher decided to focus on this population for the purposes of this study. Since the ages of the participants covered a wide range, it may be concluded that rape is not an age-related phenomenon, but rather that people of all ages are being subjected to this form of sexual and psychological violence. Table 2.1 also shows that the mean age of the patients in the unit decreased to from 32 years of age in 2006 to 30 years of age in 2008.





**Table 2.1: Rape statistics in the A & E unit**

<b>Year</b>	<b>Total number of rape survivors admitted to the unit (including females, males and children)</b>	<b>Total number of female rape survivors admitted (adults and children)</b>	<b>Total number of adult female rape survivors only, selected as part of the study population</b>	<b>The range of adult female rape survivors' ages, with averages of each subgroup</b>
<b>2006</b>	28	27	19	19-63 years (mean age 32 years)
<b>2007</b>	34	34	27	18-75 years (mean age 32 years)
<b>2008</b>	29	22	18	19-57 years (mean age 30 years)

Source: Statistics A & E unit (2006; 2007; 2008)

The A & E unit provides a free service to rape survivors, regardless of whether they are able to pay for the service or contribute to the total medical aid costs. The A & E unit is equipped with the same standard "evidence collection kits" for the collection of forensic evidence that are used by the South African Police Services in the RSA. There is a program of continuous professional development for all health care professionals who work in the A & E unit of a hospital. In addition to this, a professional counselling service is provided for all the survivors of rape who are admitted to the unit.



## 2.4.2 Population

The study population and the method that the researcher used for selecting the participants for this study are described below.

The term “population” refers to an “entire set of individuals having some common characteristics” (Polit & Beck 2004:727). Brink et al. (2006:123) describe a population in a similar way. These researchers all describe a population as the entire group of people who are of interest to the researcher for the purpose of the research or who meet the criteria that will allow them to contribute to the purpose of the research.

The population from which the participants were selected for this study comprised all the adult female (18 years and older) rape survivors who visited, or who were admitted to, the A & E unit of the private hospital in Gauteng between 1 June 2007 and 30 September 2008.

## 2.4.3 Sampling

Although qualitative studies use small samples because of the sheer quantity of data that can be collected from in-depth interviews, they also yield a rich amount of data from these relatively small samples (Green & Thorogood 2004:80). A qualitative research study’s theoretical richness is not dependent on the number of participants included in a study, but rather on the quality and depth of the descriptions of the experiences that the participants describe. It is the density and relevance of these lived experiences that enable the researcher to distil richness, texture and coherence from the data (Holloway 2005:74).

Sampling is the process of selecting a research sample from a given population. A sample refers to a “subset of a population selected to participate in a study” (Polit & Beck 2004:731). In this study, each member of the sample is referred to as a participant.

Purposive sampling is the most commonly used method in phenomenological inquiry. Purposive sampling is used by a researcher who is looking for those individuals who have the potential of presenting a narrative that is so rich in meaning, that the researcher will be able to learn a great deal about those issues that are central to the study. Purposive sampling (which is also referred to as *selective* or *judgemental* sampling) was used as the method to select the required sample from the population. Brink et al. (2006:133) state that the efficacy of this technique is dependent on the judgement and perceptions of the researcher about the available subjects or objects that are typical, or representative of the study phenomenon, or who are particularly knowledgeable about the circumstances and conditions that originally led to the formulation of the research question.

This type of sampling regarded all the adult female rape survivors who were being managed in the A & E unit as potentially suitable for selection because each of them would be able to impart details that would contribute to an information-rich, in-depth study. This method of selection would allow the central components of the phenomenon (the personal experience of how the adult female rape survivors experienced their management in the A & E unit subsequent to their survival of the rape), to be described with the required amount of depth and detail. When the narratives of the participants are sufficiently detailed and rich with information, the researcher is given an opportunity to uncover whatever deeper meanings may be concealed in the phenomenon that is implied in the research question. According to Burns and Grove (2005:747), the “conscious selection” of participants for research concentrates the attention of the researcher on the phenomenon that is being studied.

According to Driessnack, Sousa and Mendes (2007:686), phenomenological researchers purposefully select individuals or groups that have experienced the phenomenon that is the subject of investigation. The inclusion and exclusion criteria that the researcher uses are firstly derived from an intuitive understanding of what she hopes to

achieve, and also reflects the methods that she intends to adopt to elicit the necessary information. According to Morse (2000:4), the number of participants chosen will depend on the amount and quality of information that each participant makes available, the scope of the study, the nature of the topic and the number of interviews conducted with each participant.

For the purposes of this research, the researcher compiled a selection of criteria that included a “list of characteristics essential for membership or eligibility in the target population” (Burns & Grove 2005:342). The sampling criteria that would make a participant eligible for inclusion in the sample included the following qualifying factors:

- Each participant needed to be a female rape survivor of 18 years or older.
- Each participant was required to have been admitted to the A & E unit of the specified hospital at some time between 01 June 2007 and 30 September 2008.
- Each participant had to be able to speak fluent English or Afrikaans so that she could be meaningfully interviewed by the researcher without the assistance and intervention of a translator.
- Each participant needed to be mentally sound and stable at the time of the incident and during the subsequent interviews.
- Each participant would have to be willing to give her informed consent to participate in the study.

#### **2.4.4 Gaining access**

As this study dealt with an intimate and deeply distressing event that engendered a number of possible ethical consequences, the researcher pursued a rigorous process to gain access to the participants. It is one of the reasons why the process of obtaining a suitable sample has been explained in such detail.

Firstly, the researcher obtained the necessary consent and approval from (1) the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria in combination with the Medical Research Council of South Africa, (2) the central management of the selected hospital group, and (3) the hospital itself (see Annexures A, B and C for further details).

Secondly, the participants were selected by the counsellors before they were referred to the researcher. Every patient who is managed after a rape incident in the A & E unit of the hospital, in which this study was conducted, is referred to a counsellor before being discharged from the A & E unit after their initial visit. In order to select the best possible sample for this study, the researcher called upon the counsellors mentioned above to help her to recruit and enrol the most suitable participants. Each of these counsellors would have had the opportunity of interviewing survivors soon after their initial admission, or in follow-up sessions, about the nature and purpose of the study. It was on these occasions that the survivor was informed about the interview that would take place should she be willing to participate in the research.

Only once the survivor had understood the conditions of the research and had indicated that she was willing to participate in the study, did the counsellor concerned ask her permission to divulge her name and contact details to the researcher. A convenient date and time for the first contact from the researcher was negotiated between the counsellor and the rape survivor, which now became a participant. If the participant wished to remain anonymous, the participant and counsellor together agreed upon a pseudonym that was later divulged by the counsellor to the researcher. Only at this stage did the researcher have access to the participant, and the interview was arranged at a suitable time for both parties.

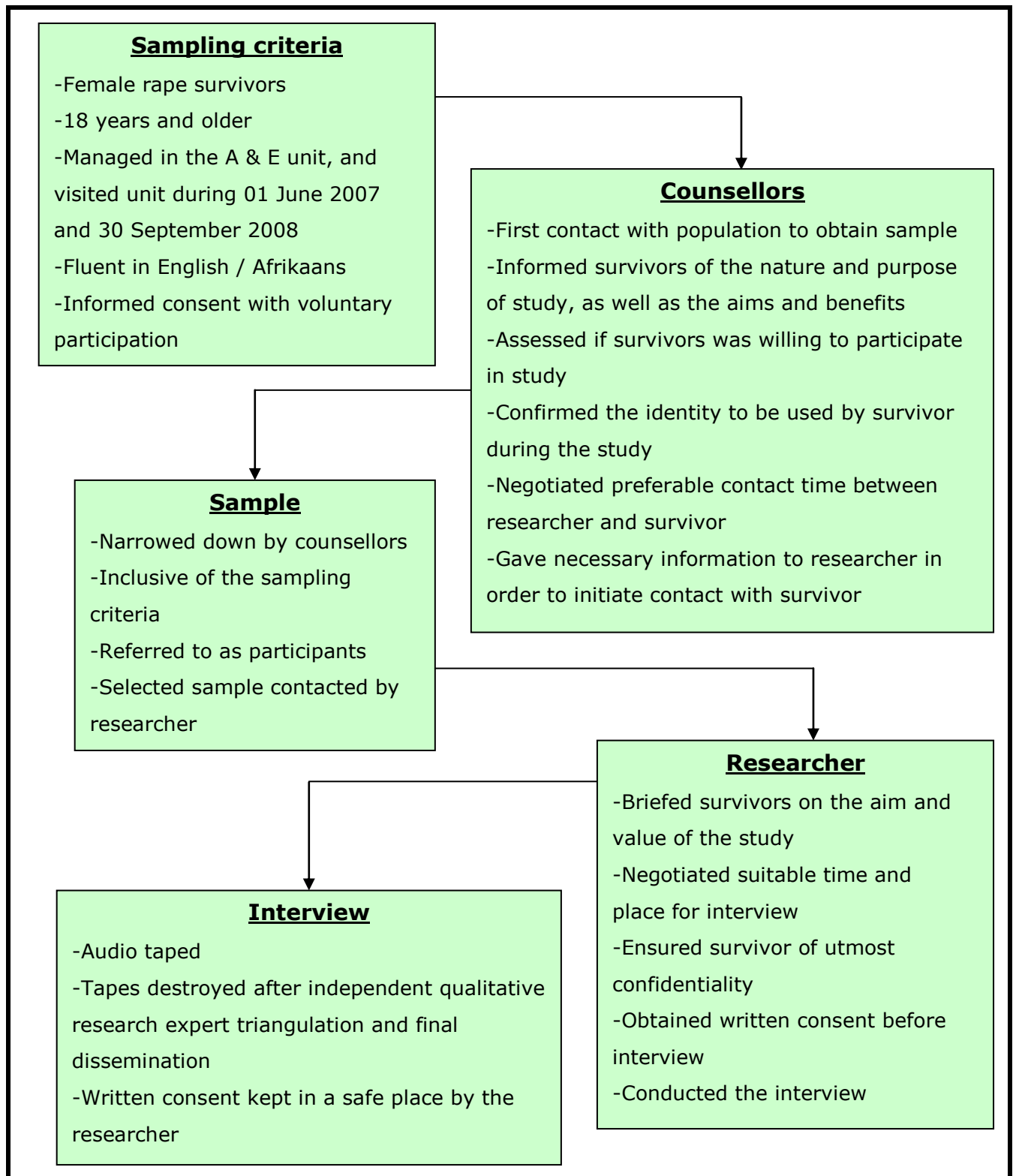
If the rape survivor indicated that she did not wish to participate, she was thanked for considering the option before the counsellor invited the next



person during another counselling session. A detailed diagram of how this process operated is provided in Figure 2.1.

The size of the sample in this study was restricted by information saturation, which Holloway and Wheeler (2002:288) described as that “state where no new data of importance to the study emerge”. Driessnack et al. (2007:684) point out that a focused study with a clearly defined topic and a limited scope requires a relatively small sample size (i.e. ten or fewer participants). But Holloway and Wheeler (2002: 302) note that if each participant is interviewed only once, and if the limited amount of information is too little or trivial, then it would be necessary to select a much larger number of participants for the study (up to 60 participants is the figure that they mention). “Saturation” is the state where no more new data of importance to the study emerges and the various elements of all the themes, concepts and theories have been accounted for.

Data saturation in this study was reached after the seventh participant had been interviewed. In spite of this, three additional participants were interviewed to confirm that data saturation had, in fact, occurred.



**Figure 2.1: Schematic representation of the process utilised to gain access and conduct the interview**



### **2.4.5 The researcher as instrument**

The phenomenological researcher looks for the “lived experiences” of individual human beings. These good experiences exemplify the way in which each person views, experiences and expresses his or her inner or private world (Newell & Burnard 2006:90). An experience is comprised of both the event as it occurred and its meaning (Polkinghorne 1988:23). It is nevertheless important for phenomenological researchers not to penetrate too far beneath the surface of people’s inner lives, because some of the most deeply buried ideals, emotions and memories are so explosive that they might damage the integrity of the subject’s personality if they are too suddenly exposed to the consciousness. This unfortunate possibility indicates how deeply sensitive a researcher needs to be to the integrity and balance of the participant during the interviewing process. Since it is the integrity of the private inner world of human beings that “keeps people together” (Newell & Burnard 2006:90), it is vitally important for phenomenological researchers not be unduly intrusive and to remember that phenomenology is not a form of counselling or psychotherapy.

For the purposes of this research, the rape incidents were neither explored nor discussed, and the researcher confined herself to inquiries based upon the two questions that guided the progress of the interviews.

### **2.4.6 Data collection**

Interviews were used as the method of choice for collecting the data. The interviewing of participants is regarded as “by far the most common method of qualitative data collection” (Donalek 2005:124). Interviewing is used in qualitative research because, as Henning et al. (2005:79) state, “In essence interviews are communicative events aimed at finding what participants think, know and feel.” While interviews are useful to elicit the thoughts, perceptions and opinions of the participants, the process needs



to be carefully controlled if the research goal is to be accomplished (Holloway & Wheeler 2002:82). Walker (2007:39) also points out that the strategy for generating knowledge in phenomenological research “typically involves conversational techniques”, and he identifies interviews as a valuable instrument for collecting data on sensitive topics.

Interviews are frequently used in exploratory and descriptive research because they offer the most direct way of obtaining facts from participants (Brink et al. 2006:151). The researcher selected interviews for gathering information because she regarded this method as being most suited to the nature of this study. It was the purpose of this study to explore and describe the lived experiences of the adult female rape survivors. These one-on-one interviews also offered opportunities for the researcher to clarify details and to reassure and support these survivors in a way that would not have been possible in a group setting.

Burns and Grove (2005:397) state that because interviewing is flexible, it allows a researcher to arrive at a depth of understanding that other data collection techniques do not offer. The researcher was thus able also to observe and record the significance of the non-verbal behaviour, body language and mannerisms displayed by the participants during the interviews (Brink et al. 2006:147). Statements and questions that were unclear to either the researcher or the participants could also be clarified during interviews. This would not have been possible if a questionnaire (for example) had been used in place of the interviews.

What are called “semi-structured interviews” were then used to explore the phenomenon under investigation. Semi-structured interviews combine various elements of structured and unstructured interviews. This allows the researcher to obtain the maximum amount of relevant information by using various questioning techniques from both these kinds of interviews. Brink et al. (2006:151) define structured interviews as formalised events that are structured in such a way that “all respondents hear the same questions in the same order and in the same manner”. Brink et al. are of



the opinion that structured interviews are appropriate at times “when factual information is desired”. They add that unstructured interviews are, by contrast, free-flowing and that they depend for their success on the improvisation and creative probing of the researcher.

Semi-structured interviews therefore exhibit certain features of both structured and unstructured interviews because although a certain number of specific questions are asked, the researcher is free to ask additional questions and pursue fruitful lines of inquiry (Brink et al. 2006:152). It is therefore a feature of semi-structured interviews that they contain both closed and open-ended questions. Donalek (2005:124) states that semi-structured interviews may suit the purpose of qualitative research in which the aim is to understand a specific human lived experience, and that this type of interview is “used to elicit participant experiences” such as those in this study.

Because the researcher used the semi-structured interview format, she allowed the participants to guide the interviews to a certain extent. The researcher did this because she was of the opinion that this kind of approach would be more successful in eliciting a certain quantity of deeper information about the lived experiences of the participants. This statement is consistent with the views of Brink et al. (2006:152), who add that this feature contributes to the trustworthiness of the findings.

#### **2.4.6.1 The setting in which the interview took place**

Once the participants had agreed to participate in the study, a setting in which the interviews could take place was negotiated between the participant and the researcher. Brink et al. (2006:147) state that interviews are capable of revealing the personal lived experiences and in-depth responses of interviewees. The researcher therefore suggested that the interviews take place in a quiet, private and comfortable environment such as the participant’s home where the participant would have the



freedom and confidence to share her experiences without intimidation or hindrance.

The researcher carefully planned the ways in which she would deal with the variety of practical difficulties and challenges that could arise during the course of the interviews. With these possibilities in mind, the researcher checked the recording equipment in advance so as to ensure that it was in good working order; she also printed out a number of participant consent forms, and checked the addresses of the participants. These are but three examples of the careful preparations that had to be made before the commencement of each interview. These actions are consistent with the advice given by Donalek (2005:124-125). The researcher also prepared an individual letter of appreciation for each of the participants.

#### **2.4.6.2 Preparation for the interview**

The preparations for the interviews included making the appointment with the participant, confirming this appointment on the day before the interview, and the careful checking of all equipment for possible malfunctions. The researcher also occasionally revised the stated aim and the purpose of the interviews in relation to some of the research questions in order to maintain focussed on the topic during the interviews.

#### **2.4.6.3 Conducting the interview**

The researcher approached each interview by taking pains to create an environment that would facilitate peace of mind and comfortable conversation. The researcher initially engaged each of the interviewees in general topics of discussion in order to attempt as far as possible to put the participant at her ease (Burns & Grove 2005:540-541). She also ensured that sufficient time was spent in establishing rapport between herself and the interviewee, and in creating a comfortable environment

before, she briefed the participant once again about the aim and value of the study. Once she was certain that the participant had understood the contribution that she could make to the study, the researcher once again reassured the survivor that her confidentiality would be protected. She then produced the form for obtaining informed written consent and explained its purpose. Once the participant had really given her written consent to participation, the researcher asked for her consent to audiotape the entire interview because Walker (2007:39) suggests that audiotape offers a reliable medium for the accurate collection and verification of data. Once all these preliminaries had been accomplished, the actual interview took place.

During the course of the semi-structured interview, the researcher asked the participant a number of specific questions. These same questions were asked to all the participants. The researcher made use of probing throughout the interviews whenever she felt that she could obtain more detailed explanations of what the participant had experienced directly after the incident. Probing was also used to obtain further details of the events and stages of her management, between the participant's initial admission to the emergency care environment of the A & E unit, until the time of her discharge from the A & E unit's rape management programme (which expired one year after an initial assessment had been made).

The researcher followed the advice of Price (2002), cited in Donalek 2005:124), in choosing questions that were suited to the method and type of the interview and the kind of information that she wished to obtain. The researcher actively sought the guidance and advice of her supervisors before she formulated a list of questions because both her supervisors had amassed a considerable amount of experience in the conduct of qualitative research. The supervisors helped the researcher to formulate a list of pertinent and direct questions that they thought would help the researcher to complete the study successfully.

The following questions were therefore addressed to all the participants in the context of the one-on-one interviews that had been organised by the researcher:

- Tell me about your experiences of the management you received by the health care workers after the rape incident in the emergency care environment;
- What recommendations would you suggest should be implemented to improve the experiences for future rape survivors in the emergency care environment?

The researcher at all times maintained a natural and easy manner in order to make it easier for the participant to impart the necessary information, and she made it clear that she was there to learn about the participant's lived experience. The researcher was careful not to register any sign of positive acknowledgement or reinforcement when participants mentioned aspects of care that she herself knew to be deficient in the A & E unit, because of the personal knowledge that she had gained during the course of her own management of rape survivors. This was necessary in order to respect the opinions of participants and to avoid cueing (Burns & Grove 2005:541-542).

The researcher used communication skills such as paraphrasing and active listening during the interview. She was also active in clarifying uncertainties, encouraging the participants' lines of thought and using reflection to obtain more in-depth information – something suggested by De Vos, Strydom, Fouche and Delport (2002:294-295). The researcher also used prompting and probing during the interviews to reduce anxiety levels for both herself and for the participants, and encouraged participants "to search for elaboration, meaning and reasons" (Holloway & Wheeler 2002:84).

Once the interview had been completed, the researcher summarised the key points of the session and reflected her perceptions back to the

participant. By doing this, she gave each participant an opportunity to confirm what had been recorded by affirming that the summary was indeed an accurate reflection of what the participant intended to convey. These summaries gave a structure to the interviews and even stimulated further elaborations on the part of the participants (De Vos et al. 2002:295).

After the above summary of the interview has been reflected back to the participant and the audiotape had been stopped, the researcher reverted to a certain amount of light social conversation so that she would not leave the participant with a feeling of having been used. Donalek (2005:125) also recommends that the researcher remains present “through this seemingly less important phase of the interview”, which is considered to be the last conversational phase after the data has been collected. It is the opinion of the researcher that this final period of general social conversation contributed to the overall value of the interview. The researcher took care to thank the participants upon the completion of the interview and emphasised and acknowledged the value of their inputs. Donalek (2005:125) confirms how important this action is, because many participants do in fact entertain the belief that their participation will benefit others and that some good will therefore be derived from the reliving of their painful experiences.

While the length of the interview depended on the participant, the average duration of the interviews was between 40 and 60 minutes. The termination of the interview occurred when the participant came to a point of closure and had nothing further to share with the researcher. This is consistent with the experience of Walker (2007:39), who states that interviews in qualitative research usually last for about one hour.

#### **2.4.6.4 Transcribing the audio taped data**

The audiotapes were transcribed verbatim by the researcher and an independent person, both of whom were also obliged to give their written



consent to preserving the confidentiality of the content and the anonymity of the participants (see Annexure I). Wherever the transcriptions were not performed by the researcher herself, the researcher checked the transcriptions by comparing the audiotaped and the transcribed information. She did this in order to guarantee the accuracy of the transcribed interview data.

Once all the interviews had been completed, the audiotapes were transcribed word for word. These transcriptions were then printed out and copied, while the originals were deposited for safekeeping with the researcher – a procedure suggested by Burns and Grove (2005:547). The researcher presented both her supervisors with copies so that they might assist in the coding process. One set of copies was also given to an independent qualitative research expert who had acquired a great deal of experience in coding processes. (More information about what happened at this point will be given in Section 2.4.7.2.)

The researcher then studied the transcribed interviews in conjunction with the field notes that she had taken during the interviews. During the process of examining the two sets of documents, the researcher wrote a series of reflective remarks on the transcribed documents (Burns & Grove 2005:547-549). These reflective remarks were later taken into account by the researcher during the later coding process.

### **2.4.7 Data analysis**

The researcher used content analysis for the purpose of systematically organising and evaluating the data. She performed an analysis of the data that emerged from the content of the interviews. Burns and Grove (2005:731) define “content analysis” as a qualitative technique that is used “to classify words in a text into a few categories chosen because of their theoretical importance”. Stemler (2001:1) defines content analysis as “a systemic, replicable technique for compressing many words of text



into fewer content categories based on explicit rules of coding". He continues that content analysis is useful for identifying emergent trends and patterns in documents such as transcribed interviews. The researcher therefore created a list of words or phrases to describe various themes, ideas and observations that kept on recurring during the interviews held. She then compiled lists of these words or phrases and compared them so that she would be able to classify them more broadly under more inclusive generic headings.

This process is also described as "coding the data". Burns and Grove (2005:548) point out that coding is a means of categorising and classifying words or phrases that recur in the data. Taylor-Powell and Renner (2003:2) state that the qualitative categorising process consists of, firstly, the identification of themes or patterns, and, secondly, the organisation of these themes or patterns into coherent categories by reading and re-reading the matrix in which they are embedded. These authors also refer to the coding or categorising of information as "indexing of the data", which they call the "crux of qualitative analysis" (Taylor-Powell & Renner 2003:2). The researcher also noticed the frequency with which certain themes, trends and patterns emerged in the transcribed texts, and applied the concept of frequency to identify those themes, trends and patterns that were of the greatest concern to the participants (Stemler 2001:2). These themes, trends and patterns were finally organised into main themes, categories and sub-categories as the reader will notice in Chapter 3.

Some qualitative researchers refuse to recognise content analysis as a qualitative analysis technique because it makes use of the numeric method of counting (Burns & Grove 2005:554). In stating his opposition to this opinion, Stemler (2001:3) states that it is exactly this reliance on coding and categorising that makes this technique "particularly rich and meaningful". Holloway and Wheeler (2002:235) advise researchers to organise and group recurrent themes and patterns into units with similar





characteristics, as a way of confirming the existence of patterns and relationships during the process of data analysis.

#### **2.4.7.1 Coding the data**

The process of data analysis was regarded as a means for bringing order, structure and meaning into the mass of disparate data that was collected during the interviews (De Vos et al. 2002:339). Although there are software programmes that can be used for performing the coding and analysis of data, the researcher preferred to undertake the process manually so that she would be in a position to enrich the categories by applying the handwritten notes that she had made when reviewing the transcribed text. The researcher therefore made the decision to code the text by hand by writing in the margins of the transcribed pages and highlighting the relevant words and phrases (see Annexure G). This data was analysed and reviewed by the researcher herself as well as by a skilled, independent qualitative research expert.

The researcher followed Giorgi's method of data interpretation during the coding of the data. The steps and applications of this method, as they were applied by the researcher, are summarised in Table 2.2 (below).



**Table 2.2: Giorgi’s process of data interpretation as applied to this study**

<b>Giorgi’s process of data interpretation</b>	<b>Application by the researcher in this study</b>
<p><b>Step 1:</b> Read the entire description of the experience to get a sense of the whole text.</p> <p><b>Comment:</b> <i>This was an important initial phase in becoming acquainted with the data. Verbatim transcripts were essential for the arrangement of all data as the researcher could not rely on her memory or notes to capture all that had occurred during the interview.</i></p>	<ul style="list-style-type: none"> <li>-An independent person was used together with the researcher herself to transcribe the verbatim interviews.</li> <li>-The researcher then listened to the audio tapes as recorded during the individual interviews, and while listening, compared the audio version and the written transcribed version of the interviews of each participant in order to familiarise her with the data. Each interview was read individually to gain a sense of the whole text.</li> <li>-This was repeated at least three times to ensure that every single word, phrase, hesitation and verbal and non-verbal clue was transcribed (for example shuffling, laughter, pauses, sighing, crying). The nuances of language used and the emotions were captured. The initial understandings, thoughts, feelings and general impressions in relation to the interviews were recorded against the interview transcripts.</li> <li>-The notes taken during and directly after the interviews were also compared simultaneously.</li> <li>-While listening to the tapes and comparing it to the transcribed versions, the researcher made additional notes of each participants version as to get a sense of the whole. It also enabled the researcher to make sense of the data acquired.</li> <li>-The tapes, as well as the transcribed material, were then given to an independent qualitative research expert who verified the accuracy of the data.</li> </ul>



(Table 2.2 continued)

<b>Giorgi's process of data interpretation</b>	<b>Application by the researcher in this study</b>
<p><b>Step 2:</b> Re-read the description.</p> <p><b>Comment:</b> <i>By re-reading the transcribed interviews, the researcher gains in-depth understanding and insight of the lived experiences as expressed by the participants.</i></p>	<p>-After the researcher had listened to the taped version, was certain that all data was accurately transcribed, and the independent qualitative research expert had verified its accuracy, the researcher locked the tapes as well as the back-up tapes away so that it could not be accessed by any other person except for the researcher, if necessary the supervisors and / or the independent qualitative research expert if so required.</p> <p>-The researcher then reread the entire transcribed versions of each participant while making additional notes. The re-reading was replicated three times.</p>
<p><b>Step 3:</b> Identify the transition units of the experience.</p> <p><b>Comment:</b> <i>Hycner (1985:282) states units of general meaning is "those words, phrases, non-verbal or paralinguistic communications which expressed a unique and coherent meaning, clearly differentiated from that which preceded and followed".</i></p>	<p>-This step involves returning to each transcribed interview and extracting phases or sentences that directly pertains to the phenomenon, capturing the essence of participant's lived experience as units of a general meaning.</p> <p>-The units of general meaning were then recorded alongside the transcriptions (see Annexure G).</p> <p>-All general meanings were included even though some seemed redundant and vague.</p>
<p><b>Step 4:</b> Clarify and elaborate the meaning by relating constituents to each other and to the whole.</p>	<p>-During Step 4, the researcher started classifying and grouping the phenomena. This enabled the researcher to move from "first impressions" to the "full picture".</p> <p>-During this stage, the researcher identified patterns of meaningful connection.</p>



(Table 2.2 continued)

<b>Giorgi's process of data interpretation</b>	<b>Application by the researcher in this study</b>
<p><b>Comment:</b> <i>Spiegelberg (1975:70) states that constitutive phenomenology can develop the sense of dynamic adventure in our relationship with the world".</i></p>	
<p><b>Step 5:</b> Reflect on the constituents in the concrete language of the participant.</p>	<p>-Units of general meaning from the text were changed as little as possible in order to retain the participants real meaning.</p>
<p><b>Step 6:</b> Transform concrete language into the language or concepts of science.</p>	<p>-On completion, there were 16 categories that had been identified and from these 6 main themes emerged from the descriptions of the lived experiences of women who had been raped. Each category was listed and interrogated to determine if there were central themes that expressed the essence of the categories.</p> <p>-Categories and central themes were discussed with the independent qualitative research expert and supervisors and discrepancies discussed and the final categorisation was agreed upon.</p>
<p><b>Step 7:</b> Integrate and synthesise the insight into a descriptive structure of the meaning of the experience.</p>	<p>-During this stage the researcher reflected on the initial reading along with the interpretive reading to ensure a comprehensive understanding of the findings.</p> <p>-Once these were clear, the researcher undertook a literature review in relation to the themes in order to link the findings to published literature. This assisted the researcher in providing a wider perspective and enabled a richer dialogue around the themes to merge.</p>

Adapted from: Bowling (2002:387) and Steubert-Speziale and Carpenter (2007:83, 94)



### **2.4.7.2 Role of the independent qualitative research expert**

The researcher presented all the data that she had collected during the interviews to an independent qualitative research expert (whom Bowling 2002:387 refers to as a “co-controller”). This independent qualitative research expert was requested to serve as an independent co-coder of the data. The purpose of utilising her services was to enhance the trustworthiness of the data.

### **2.4.7.3 Dissemination of the findings**

The results of the content analysis as well as the views of the participants that had been reported in the study were verified by reference to the existing literature. They were then incorporated into evidence-based recommendations that were made in the hope of making a positive contribution to the current guidelines that are used in A & E units, such as the one that was used in this study. The ultimate goal of this study was to create the possibility of improving the patient-centred approach that is used in the management of adult female rape survivors within this and similar units.

A thorough and comprehensive literature control was done after the data analysis. The researcher used information that she had gained from the literature control specifically to validate the findings that were generated by the present research project. She also did this in order to identify “similarities and differences” (Burns & Grove 2005:95).

## **2.5 Issues of trustworthiness**

Trustworthiness refers to the degree of methodological accuracy inherent in any kind of qualitative research and includes “the means by which we show integrity and competence” (Aroni et al. (1999), cited in Holloway & Wheeler 2002:251; 256). Krefling (1991:215) also regards



trustworthiness as a primary means of ensuring rigour in qualitative research without any concomitant sacrifice of relevance.

The aim of trustworthiness in qualitative research is to support the argument that the researcher's findings are "worth paying attention to" (Lincoln & Guba 1985:290). Streubert-Speziale and Carpenter (1999:333) define trustworthiness as the establishment of the extent of the validity and reliability of any given qualitative research. Qualitative research may be characterised as trustworthy when it accurately represents the lived experiences of the study participants.

The researcher used mainly Guba's model of trustworthiness (cited in Krefting 1991:215-217) as her point of reference for the purposes of this study. The application of each of the aspects of Guba's model and their definitions is described in Section 2.5.1 to Section 2.5.4. For the sake of clarity, Table 2.3 (below) offers a comprehensive summary and overview of the application of these strategies that were utilised in this study to enhance trustworthiness.

**Table 2.3: Overview of Guba’s strategies to ensure trustworthiness in this study**

Strategy	Criteria	Application
<p><b>Credibility</b></p> <p><i>Credibility is truth-value. It is usually obtained from the discovery of human experiences as they are lived and perceived by informants (Krefting 1991:215). Lately credibility and validity can be used in the same context.</i></p>	<p>Prolonged and varied field experience</p>	<ul style="list-style-type: none"> <li>-The researcher has been involved in the A &amp; E unit as an A &amp; E nurse practitioners for a period of seven years, thus understands the guidelines utilized in the A &amp; E unit for the management of rape survivors as well as the use and importance of the rape kit</li> <li>-The independent expert is an experienced qualitative researcher</li> <li>-Both supervisors are experienced qualitative researchers, having used the phenomenology paradigm</li> </ul>
	<p>Time and data Sampling</p>	<ul style="list-style-type: none"> <li>-Time and data sampling were effectively monitored</li> <li>-Individual in-depth phenomenological interviews were conducted with participants</li> <li>-Ten interviews of 40 to 60 minute minutes each were conducted</li> <li>-Field notes were taken directly after each interview</li> <li>-All the interviews were audio taped</li> <li>-A literature control with regard to the themes were conducted</li> <li>-Data analysis according to Giorgi’s phenomenological analysis was conducted</li> </ul>
	<p>Reflexivity</p>	<ul style="list-style-type: none"> <li>-Transcription checked with supervisors and independent qualitative research expert</li> <li>-Data analysis confirmed with independent qualitative research expert and supervisors</li> </ul>
	<p>Peer examination</p>	<ul style="list-style-type: none"> <li>-Description and comparison of results with supervisors and independent qualitative research expert</li> <li>-Research methodology described in detail according to international recognised and reliable sources</li> </ul>

(Table 2.3 continued)

Strategy	Criteria	Application
	Field notes	-Field notes were taken directly after the interviews
	Authority of researcher	-The focus is placed on lived experiences of women who has been raped with regard to their treatment in an A & E unit in a private hospital in Gauteng -Ethical permission were obtained to conduct the study
<p><b>Transferability</b></p> <p><i>Transferability refers to the fittingness of data, and can it be transferable to another context (Brink et al. 2006:118). This generalization extends the implications of findings from the studied sample to a larger population, or from the situation studied to a larger situation (Burns &amp; Grove 2005:737). Thus transferability / generalisability refers to whether this findings can be applied in another context.</i></p>	Purposive sampling	-A purposive sampling method was used
	Time sampling	-Women within a specific time frame who was admitted to the A&E unit, between the period of 01 June 2007 and 30 September 2008,were approached to serve as participants
	Dense description	<ul style="list-style-type: none"> <li>-Every action in the research process are clearly described and justified</li> <li>-Findings only applicable for adult female rape survivors in this specific research setting</li> <li>-Purposive sampling was used, but the research process can be repeated in another settings to generalise findings</li> <li>-The inclusion of relevant participant quotes was used to enhance the thick description of the research findings</li> </ul>



(Table 2.3 continued)

Strategy	Criteria	Application
<b>Dependability</b> <i>Dependability implies variability that can be tracked, or ascribed to identified sources (Guba (1981) in Krefting, 1991:216)</i>	Dependability audit	-Independent qualitative research expert verification, literature control and discussions with supervisors were conducted
	Dense description	-Research methods are clearly described -Steps of data collection are repeated with more than one participant
	Stepwise replication	-Data collection by means of interviews and field notes -Data analysis by means of content analysis and Giorgi's phenomenological analysis -Literature search and control
	Peer examination	-Discussion and control of results with independent qualitative research expert -Repeated discussions with experienced supervisors and independent qualitative research expert
	Code-recode Procedure	-Following the steps as prescribed by Giorgi, coding and re-coding was conducted
<b>Conformability</b> <i>Conformability guarantees that the findings, conclusions and recommendations are supported by the data and that there is internal agreement between the investigator's interpretation and the actual evidence (Brink et al. 2006:119).</i>	Bracketing	-The researcher used bracketing to eliminate biasedness and to avoid misinterpreting the participants' reflection on their experiences
	Intuiting	-Intuition was used by the researcher to continuously be aware of the lived experiences of the participants, and to guide data collection
	Immersion in the data	-The researcher immersed herself in the data through prolonged engagement with this study, and by doing a literature control to validate all findings



### **2.5.1 Credibility (Truth value)**

Credibility is equivalent to truth-value. It is usually “obtained from the discovery of human experiences as they are lived and perceived by informants” (Krefting 1991:215). According to Tobin and Begley (2004:391), credibility can be demonstrated by means of a number of strategies such as member checks, peer debriefing, prolonged engagement, persistent observation and audit trials.

Another method of ensuring credibility (which was also applied in this study), is by performing triangulation on the data. The triangulation of data refers to one of the multiple methods, albeit one of the most common, that are used to collect and interpret data (Babbie & Mouton 2001: 275). The researcher performed the triangulation of the data by comparing the audiotaped transcribed interviews, the notes that she had made during the interviews, and the notes which were compiled by an independent expert in qualitative research about themes that emerged as notably important (Burns & Grove 2005:225). Burns and Grove (2005:539) note that the credibility of qualitative data analysis “has been seriously questioned” by some members of the scientific community. They counter this scepticism by suggesting that, in order to maximise credibility, the researcher should define the rules that were used to generate all the coded category identification during the data analysis process. Burns and Grove (2005:539) also suggest that all raw data should also be locked away in secure conditions by the researcher in case another researcher or an independent expert wishes to use the same set of data to see whether it will generate the same set of findings.

In the case of this study, the data was given to an independent expert in the qualitative research who acted as the verifier of the findings and conclusions. In addition to this, the whole collection of information-rich and comprehensive interviews and field notes that the researcher had

made, both before and during the interviewing process, was kept in secure conditions in order to contribute to credibility.

Other factors such as the practice of precision in the planning, recording and analysing phases also ensure credibility. Burns and Grove (2005:540) state that the truth value of research is enhanced when participants are allowed to speak freely, without leading questions or coercion from the researcher. These were procedures that the researcher followed meticulously. Burns and Grove (2005:540) also mention the disconfirmation of data during the dissemination of the findings. Throughout the research process, it was the researchers aim to offer evidence that would prove the findings by means of proper descriptions.

### **2.5.2 Transferability (Applicability)**

Transferability refers to the “fittingness” of the data and whether it could be transferred to another context (Brink et al. 2006:119) and generalised to fit similar circumstances. Donmoyer (1990:175) argues that it is necessary to reject commonly held notions about generalisability in order to accept that naturalistic inquiries are, in themselves, replete with individual subjective meanings.

One may observe that these findings were applicable only to adult female rape survivors and not to male or paediatric patients. The researcher used purposive sampling so that it would be possible to repeat this study with another population in order to validate the findings (Babbie & Mouton 2001:277). It was never the researcher’s aim to produce findings that could be neatly transferable; her goal was to explore the lived experiences of adult female rape survivors in a very specific research setting (the qualitative phenomenological setting in which the research took place).



### **2.5.3 Dependability (Consistency)**

Dependability implies “variability that can be ascribed to identified sources” (Guba 1981, cited in Krefting 1991:216). It also refers to the stability of data over time and in different conditions. If the data proves to be unstable under certain conditions, the researcher needs to be able to account for this instability (Polit & Beck 2004:716). Tobin and Begley (2004:392) add that dependability is achieved through a process of auditing, and that researchers are responsible for producing research that is clearly documented and that is also logical and traceable. Schwandt (2001:126) agrees with this point of view, and notes that dependability can be demonstrated by means of an audit trial in which properly qualified, but independent experts, are invited to examine the researcher’s documentation of data, methods, decisions and the final product.

Since the purpose of the study was clearly communicated to all the participants before their consent was obtained, the study maximised cooperation. The researcher also clearly explained to the participants what they might expect from the study.

### **2.5.4 Conformability (Neutrality)**

“Conformability guarantees that the findings, conclusions and recommendations are supported by the data and that there is internal agreement between the investigator’s interpretation and the actual evidence” (Brink et al. 2006:119).

The researcher used (1) (phenomenological) bracketing, which may be defined as a “technique of suspending or laying aside what is known about an experience being studied” (Burns & Grove 2005:729), and (2) intuiting (intuition) to minimise the occurrence of bias during the course of the research. The researcher used bracketing in this study so that she might

be able to “avoid misinterpreting a phenomenon as it is experienced by the individual” (Burns & Grove 2005:539).

Since intuition also plays a vital role in determining which data to collect (Burns & Grove 2005:561), the researcher relied on her own intuition to guide the interview process. Intuition can be described as an instinctive awareness and understanding of the lived experience (Brink et al. 2006:114). This allowed the researcher to focus all her energy and awareness on the phenomenological subject, as Burns and Grove (2005:556) recommend, and to totally immerse herself in the phenomenon under investigation (Brink et al. 2006:114). Methods of limiting undue participant fatigue wherever possible are also described in these sources. This factor was, however, not really applicable during the interview process because only one interview was held with each participant, and each interview lasted for less than an hour in each case.

Other environmental factors that might have influenced the interview process were also carefully managed. Thus, for example, the ambient noise level was reduced to a minimum so that the recordings made during the interviews would be of the best quality (Burns & Grove 2005:540-542).

## **2.6 Ethical considerations**

All researchers subscribe to various ethical standards and measures in order to ensure that their research conforms to the highest required ethical standards. In pursuance of this aim, the researcher submitted her research proposal to the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, the Hospital Group Ethics Committee, and the Hospital itself (see Annexures A, B and C). Walker (2007:37) is of the opinion that research that needlessly duplicates the work of others or which is so inferior that it is unable to contribute



something useful to the body of existing knowledge in a particular field, is in itself unethical.

The maintenance of ethical standards, especially in phenomenological research, is dependent on friendly and cooperative relations between the researcher and the participants, and on the availability of an open-ended dialogue format that allows the researcher fully to appreciate the participant's perceptions of the research topic. Walker (2007:37) adds that the most critical ethical obligation of a researcher is to describe the experiences of others in the most faithful possible manner (Munhall 1998, cited in Walker 2007:42). In order to fulfil this responsibility in qualitative research, the researcher needs to adopt the strategy of phenomenological bracketing – to suspend or to set aside her own personal beliefs about the phenomenon that is being studied. She does this in order to avoid influencing both the collection and the interpretation of the data. In this study, the researcher remained continuously aware of her own preconceptions and consciously set them aside as she collected and interpreted the data.

The following ethical considerations that were applied to this study were adapted from the principles suggested by Brink et al. (2006:30-40) and by Walker (2007:36-44).

### **2.6.1 Principle of respect for human dignity**

Steps that were taken to protect the participants during the course of the research included self-determination. Self-determination in this context means the perpetual right of a participant to withdraw from the research process at any time, and to nullify the validity of her informed consent without the application of any pressure or adverse consequences.



**Self-determination** meant giving the participants the choice of whether they wished to be included in the research or not since all involvement was voluntary. The participants suffered no penalties or prejudice after they had made their decisions. In those cases where no response was forthcoming from the rape survivors who had been asked to participate in this study, their non-responsiveness was interpreted as an unwillingness to participate and no further contact was therefore made with these survivors.

Those survivors who had agreed to participate were made aware of their **right to withdraw** at any stage of the research, with the assurance that no questions would be asked. Each participant was directly asked to confirm whether she would be willing to participate.

A clear and comprehensive information document that explained and requested **informed consent** was given to each of the participants before the interviews commenced. This document contained detailed information about:

- The nature and purpose of the study.
- The structure of the interview and the questions that would be asked.
- An assurance of absolute confidentiality and anonymity.
- The right of the participants to discontinue with an interview or to postpone an interview at any given time.
- The full contact details and availability of the researcher in case it should be needed.

An example of the information and informed consent document is included as Annexure D to this research. All the participants who contributed towards this research project therefore did so on the basis of free and voluntary consent. "Informed consent" implies that the participants have been given "adequate information regarding the research, that they are



capable of comprehending the information, and have the power of free choice” (Walker 2007:41).

Before each interview took place, any questions that the participant had were answered truthfully and frankly by the researcher. Informed consent in this case implied that participation was voluntary and that because each participant had clearly understood the purpose of the research, she was competent to give consent. Written consent was obtained from each of the participants, and they were assured that their confidentiality would be protected. The completion of the interview by a participant also implies full consent (Brink et al. 2006:30-40; Somekh & Lewin, 2005:56). This statement is supported by Walker (2007:41) who states that qualitative consent is often ongoing in nature because it is implied by a transactional process (Brink et al. 2006:30-40; Walker 2007:36-44).

### **2.6.2 Principle of beneficence**

All of the participants were willing and informed adults (18 years and older); no children were allowed to participate in this study. No participant with diminishment of her mental or physical functions was approached to participate. Consent was in no case promoted by any means of remuneration or any promise of advantage or reward (other than the satisfaction that participants would have of knowing that their contributions would ultimately contribute to the improvement of patient-centred care for others in the same situations as a result of the study). No participants were in any way exploited. The primary meaning of beneficence is, above all, to do no harm.

**Benefits** that flowed from this study included an increase in the researcher’s knowledge about the needs of these survivors, improved patient-centred care to the public, an improved assessment of the health needs of participants, and the psychological benefit that participants



might, if they so desired, be in a position to help other survivors in the future.

Some of the **risks** that the study generated might have included the time which participants lost in cooperating with a researcher, some degree of temporary emotional discomfort or pain during the interview, and the feeling (delusion) that the researcher was penetrating their most personal thoughts and violating the participants' innermost personal space. But since the interviews were not be used to obtain any information about the rape incident itself, the possibility of generating feelings of paranoia or insecurity in the participants was absolutely minimal. The aim of the researcher was purely to talk about the participant's needs and to solicit her views on the quality of the management she received after she had been admitted to the A & E unit.

The possible benefits as well as the possible discomforts and risks of participation were clearly explained to all the participants. While the researcher accepted that it was necessary for each participant to give her consent and that it would be desirable for each of them to complete the interview, she firmly believed that the **benefits of participation would outweigh the risks.**

It has now become evident, as was originally expected, that no intentional permanent psychological or physical damage has been inflicted on any of the participants. Walker (2007:40) is of the opinion that participants should be assessed for signs of distress during research into sensitive topics, and that a strategy for minimising distress that could be applied in case of need should be identified prior to the commencement of the interviews. Any signs of psychological discomfort or emotional upset were therefore immediately addressed by the researcher whenever they became visible. The researcher was of the opinion that wherever the interview might be the cause of emotional distress to the participant, participant welfare should in every case take priority over the needs of the research study. What would have happened in this study, for example,

was that the interviewer would have remained with the participant if she showed signs of becoming emotionally too distraught to continue with the interview. The researcher would then have summoned the counsellor (who had originally referred the participant to the researcher) to debrief the distressed participant. All the necessary arrangements to cope with emotional stress on the part of any of the participants were obviously concluded before the interviews actually began. The researcher also followed up the interview by making telephonic contact with each of the participants on the day after the interviews in order to demonstrate her continuing support and understanding unless the participant had made it clear that she declined any further contact. These protocols were followed by the researcher independently of whatever arrangements the counsellor might have concluded with the participant.

The intensity of emotional **discomfort was minimised** by encouraging participants to inform their family or their significant other about the approaching interview. Wherever there were any signs of distress during the interview, the researcher immediately terminated the interview. The participant was then given an opportunity to ask whatever questions she wished to ask, and also to debrief and “restore her composure” in the presence of the researcher (Burns & Grove 2005:541). The counsellor that had originally referred the participant to the researcher was always on standby while the interview was taking place, and was therefore available for conduct a debriefing session if the participant needed it. The counsellors also committed themselves to be available for personal and independent consultations should the survivors whom they had individually referred to the researcher, need any further assistance at a later stage of the process. It is ethically questionable for a researcher to attempt to address sensitive issues without being properly equipped to deal with the possibility of resultant distress on the part of the participants (Coyle & Wright 1996, cited in Walker 2007:40). The researcher was in fact more than adequately prepared by her experience, understanding and training to cope with any signs of distress during interviews (Brink et al. 2006:30-40; Walker 2007:36-44).



### 2.6.3 Principle of justice

Justice implies dealing **justly and fairly** with people. The need for implementing the principles of justice was addressed in the following way during this research.

In order to **protect the privacy** of the participants, the researcher determined that no visual recording of the interview would be made. The proceedings of the interview were only audiotaped for construction purposes after the informed consent of the participant had been obtained. Only information that had been voluntarily disclosed was used for purposes of analysis. The participants were also informed that the audiotape would be set in motion before the commencement of the interview in order to facilitate the complexities of analysis over the subsequent few weeks. No names were used in this research study.

No personal information of any shape or form was included in any of the recorded or transcribed data. Apart from the researcher, only the counsellors had access to the true identity of the participants during the process of identifying the sample, and the counsellors in turn had no knowledge of the interview data that had been collected by the researcher. If the participant had preferred to remain **anonymous** during the interview, the researcher would have only have interacted with her by using a pseudonym that had been allocated before the interviewing process began. This procedure was agreed upon by both the participants and the counsellors. No formal list of names and allocated pseudonyms was kept because only one interview per participant was conducted.

All the data upon which this study is based was secured in a locked safe in the researcher's home. No part of the data that has been used and reported upon could be traced to any specific source.

All the raw data was divulged only to the researcher and to an independent qualitative expert in the field of research. This was done in an effort to minimise incidence of subjectivity and bias. The identities of all the participants were anonymous, and all the proceedings between the researcher and the participants were strictly confidential, as mentioned before, because no names were disclosed during the course of this research. The researcher had determined beforehand that all relevant parts of the audiotapes and the written notes would be kept in a secure place and that they would be destroyed in the event of consent was revoked. No copies of the recordings were made, and once this study is complete, all the recordings and notes will be destroyed. It should be stressed once more that only the counsellor, whom the participant had previously met and spoken to, was allowed to know the true identity of the survivor should the survivor have preferred to present herself in that way (Somekh & Lewin 2005:57; Brink et al. 2006:30-40; Walker 2007:36-44).

## **2.7 Conclusion**

This chapter presented an in-depth description of the applied research methodology. It included an in-depth discussion of the data collection technique that the researcher used, an analysis of the data as well as the various actions that were taken to implement the trustworthiness of the data. This was followed by a discussion about the specific ethical issues and the way in which they were taken into consideration in the study.

The following chapter will present and discuss the findings, and will describe the literature control that was used to validate the findings.

## 3 Discussion of findings and literature control

***"Concern should drive us to action and not into depression."  
(Karen Horney)***

### 3.1 Introduction

This chapter sets out the findings of the study and the details of the literature control. The content of the findings has been coded and organized (see Table 3.1). The literature control demonstrates how the researcher has identified the most recent and authoritative information that is available on the subject (Mouton 2001:87).

The researcher was aware that each of the participants would be able to give specific information and make recommendations that would affect the findings of this study, because each of them experienced the way in which she was managed within the emergency care environment of the A & E unit, in a unique and different way. Since researcher had guaranteed that participation in this study would be totally confidential because of the disturbing and intimate nature of the topic, the researcher has only offered a limited amount of the incident and circumstantial information that she collected from the participants. This circumstantial information is designed to familiarise the reader with the particular stage of management in which the specific participant found herself at the time of the interview. The researcher believes that this information is necessary for the sake of comprehensiveness as some of the participants produced no comments about the follow-up visits, because they had either not attended any of them at the time of the interview, or else they had exercised their right not to attend any of these follow-up sessions.

Ten female participants volunteered to participate in this study. Their ages ranged from between 18 years and 63 years, with a mean age of approximately 33 years. Table 3.1 (below) summarises the most important information about the participants. The literature control will demonstrate just how important it is to take aspects of this information into account.

**Table 3.1: Participant information**

Number	Age	Management programme completed
1	21	Yes
2	60	Not yet
3	36	Not yet
4	18	Not yet
5	50	Not yet
6	20	Not yet
7	23	Not yet
8	63	Not yet
9	23	Not yet
10	19	Not yet

Finding ten suitable participants was a tedious task that took up a great deal of time and patience. As the researcher explained in Chapter 2, the participants' counsellors acted as mediators and telephoned the adult female rape survivors for whom they had been consultants during their stay in the A & E unit. Only those rape survivors who were willing to participate were referred to the researcher by the counsellor so that she could make mutually convenient arrangements for an interview. None of those rape survivors who had indicated their willingness to participate in the study when the counsellors phoned them, revoked their consent when the researcher subsequently telephoned them to arrange the interview.

In a study of the incidence and nature of the psychopathology of rape survivors undertaken by Faravelli, Guigni, Salvatori and Ricca (2004:1483), none of those who were approached refused their participation. All of the rape survivors who participated in this study regarded the experience of participation as a positive one, and all of them were extremely helpful in the way that they made time for the interviews and shared valuable insights and information from their experiences.

But during the search for these participants, both the counsellors and the researcher encountered numerous obstacles. Many of the previous survivors could not be reached by telephone because their contact information was not accurate or because it had changed since the incident. The only information provided by the hospital identification labels or stickers is that provided by the participants. Some of the counsellors also pointed out that no information about family or relatives or significant others were recorded elsewhere in the files. Merely trying to make contact with previous rape survivors was therefore described by the counsellors as very difficult and, at times, impossible.

The research of Boykins and Mynatt (2007:867) made a specific study of the assault history of rape survivors and the follow-up contacts with women who had survived recent sexual assault. These researchers state that, three months after the incident of sexual assault / rape and the initial examination, they only managed to contact 23% of the study participants by telephone for follow-up visits (2007:867). One could infer therefore that almost 75% of the survivors in that study had changed their contact details or had removed their personal listings from the telephone directory – no doubt because they feared further victimisation.

In this study, the rape survivors were telephoned mostly after about three months on the assumption that the intervening period would have given them sufficient time to internalize their coping strategies. Although the researcher had no desire to add to the trauma of the survivors, she was also aware that the more time that elapsed between discharge from the A

& E hospital unit and a follow-up interview, the more likely it would be that valuable information might well be lost to memory in the interim. The researcher therefore asked the counsellors to telephone the rape survivors between three and six months after the incident.

This timeframe proved to be a source of problems for this study. Boykins and Mynatt (2007:877) state that earlier studies had been conducted in which attempts had been made to contact survivors at various selected intervals. All of these studies indicated that attempts to contact rape survivors had frequently been unsuccessful, even when different methods of contact were used in the research. Boykins and Mynatt (2007:877) add that although referral programmes were provided and recommended to survivors, they were also unable to obtain accurate data about follow-up visits. Few of the programmes could provide rape survivor follow-up numbers, and many of them described the difficulties and problems they encountered when they attempted to make follow-up visits or update the information about patients who did actually keep their follow-up appointments (Ciancone, Wilson, Colette and Gerson (2000:356-357). All of these researchers noted that the follow-up programme was rarely completed and that few patients complied with the follow-up recommendations that had been made (Boykins & Mynatt 2007:870; Ferguson 2006:488). This research helps to explain why the contact information of rape survivors was frequently inaccurate or out of date, and why many of the patients never returned to the A & E unit for follow-up consultations.

One of the possible reasons why divulging contact details can be problematic or difficult for rape survivors is that many of the rapes or sexual assaults actually happen in the survivors' home. Sometimes survivors move away from the place of residence they had occupied before the rape incident because they may not want to be reminded of the incident or the circumstances in which it occurred. Or else they may have adopted the habit of not answering the telephone to unidentified callers (Boykins & Mynatt 2007:878).



## 3.2 Discussion of the research findings

The semi-structured interviews that the researcher conducted with the ten participants has already been described in Chapter 2. The data from these ten interviews was transcribed and checked by the researcher and by an external party so as to ensure the accuracy and quality of the constructions. The sets of data that were obtained from each interview were subsequently analysed and reviewed several times by the researcher. This was done in order to identify the themes, categories and sub-categories that the transcribed written data contained – a procedure recommended by both Burns and Grove (2005:548-549) and Brink et al. (2006:184). Burns and Grove (2005:549) point out that the “themes” here mentioned may also refer to the main topics that become evident in the written record when the interview data is repeatedly read, reread and analysed.

The process by means of which the researcher immersed herself in the data and studied the identified themes or topics is referred to as data analysis. The specific technique that the researcher used to accomplish the purpose of her data analysis in this study is also referred to in the literature, as the “coding” of the data (Burns & Grove 2005:548. Brink et al. 2006:184). Some sources referred to this process as “open coding”. Coding, and “open coding” in particular, means that the researcher uses an inductive approach for generating codes while reading through the series of transcribed interviews. These codes are selected by the researcher on the basis of what they mean to her (Henning et al. 2004:104).

The researcher identified the themes, categories and sub-categories of the study with the expert help of two supervisors and an independent qualitative research expert, all of whom reached consensus about the codes that were selected to represent the data. By comparing the individual themes or topics and the codes (the categories), the researcher



reduced the probability of including ambiguous, redundant and inadequately defined categories in this chapter. In order to discuss and analyse the research findings, the following terms were used in this study: theme, category and sub-category.

The following six themes emerged from the study findings:

- Patient management
- Family or significant other
- Timeframe
- Multi-disciplinary team
- Privacy and
- Communication

These themes were further subdivided into the categories and sub-categories illustrated in Table 3.2. Each theme, category and sub-category will be discussed systematically later in this chapter. The relevant data will also be analysed, and the results of the literature control relevant to each specific theme will also be discussed. Streubert-Speziale and Carpenter (2007:97) recommend that a review of literature should follow data analysis in qualitative research. Their rationale is that, by so doing, a researcher is able to produce a pure description of the phenomenon under investigation. The researcher did not conduct the literature review prior to collecting the data because she did not know at that stage which themes or topics would be most important to the adult female rape survivors during the interviews. This procedure is consistent with what is recommended by Strubert-Speziale and Carpenter (2007:97).

The researcher therefore conducted the literature review after the data had been collected and analysed in order to prevent any preconceived ideas from contaminating the research findings. This was one of the measures the researcher adopted to prevent bias (Green & Thorogood 2004:238). But once the data analysis had revealed the key themes, the researcher used the databases of CINAHL and MEDLINE to locate related

literature. The literature that proved to be relevant has been reviewed and integrated into the discussion of the results.

### **3.2.1 Theme 1: Patient management**

Apart from looking for immediate management in the wake of the rape incident, all of the participants experienced various challenges as they sought prompt medical assistance and authorisation for access, forensic examination and the prescription and use of medication.

Although a physical examination for the collection of forensic evidence might be regarded as a potentially traumatic experience, the view of the majority of the participants was that, although unpleasant, it was necessary. They therefore accepted, on the basis of their knowledge and experience, that such an examination was one of the necessary steps in the patient management process subsequent to the rape incident.

But because of their emotional state, the unfamiliar circumstances and the the distressing situations in which the rape survivors found themselves, they expressed concerns about the solicitation of inappropriate patient information about prophylactic medication.

Each of these categories is discussed in detail below.

**Table 3.2: Summary of the themes, categories and sub-categories**

Themes	Categories	Sub-categories
3.2.1 Patient management	3.2.1.1 Accessibility	<ul style="list-style-type: none"> <li>• Knowledge of available services</li> <li>• Medical insurance and government patients</li> <li>• Geographical location of service providers</li> <li>• Time</li> <li>• Referral</li> </ul>
	3.2.1.2 Forensic examination	<ul style="list-style-type: none"> <li>• Information</li> <li>• Examination</li> </ul>
	3.2.1.3 Medication	<ul style="list-style-type: none"> <li>• Family or significant other presence</li> <li>• Patient education</li> <li>• Simplicity</li> <li>• Side effects</li> </ul>
3.2.2 Family or significant other	3.2.2.1 Presence	<ul style="list-style-type: none"> <li>• Patient response to presence</li> <li>• Value and importance of presence</li> </ul>
	3.2.2.2 Encouragement	<ul style="list-style-type: none"> <li>• Attitudes</li> <li>• Supportive actions</li> <li>• Need for information</li> </ul>
	3.2.2.3 Information	<ul style="list-style-type: none"> <li>• Role in patient education</li> </ul>



(Table 3.2 continued)

Themes	Categories	Sub-categories
3.2.3 Timeframe	3.2.3.1 Waiting times	<ul style="list-style-type: none"> <li>• Reception area</li> <li>• A &amp; E unit</li> <li>• Laboratory results</li> <li>• Multi-disciplinary team</li> </ul>
3.2.4 Multi-disciplinary team	3.2.4.1 Attitude	<ul style="list-style-type: none"> <li>• Health care workers</li> <li>• Police</li> </ul>
	3.2.4.2 Competence	<ul style="list-style-type: none"> <li>• Educational level</li> <li>• Identification</li> <li>• Confidence</li> </ul>
	3.2.4.3 Presence	<ul style="list-style-type: none"> <li>• Team members</li> <li>• Importance of presence</li> <li>• Referral</li> </ul>
3.2.5 Privacy	3.2.5.1 Reaction to incident	<ul style="list-style-type: none"> <li>• Patient response</li> </ul>
	3.2.5.2 Personnel involvement	<ul style="list-style-type: none"> <li>• Number present</li> </ul>
	3.2.5.3 Examination environment	<ul style="list-style-type: none"> <li>• Room</li> </ul>
	3.2.5.4 Patient confidentiality	<ul style="list-style-type: none"> <li>• Emergency care environment</li> <li>• Files</li> </ul>
3.2.6 Communication	3.2.6.1 Effective communication	<ul style="list-style-type: none"> <li>• Patient preference</li> <li>• Patient education</li> <li>• Family or significant other</li> <li>• Counselling</li> <li>• Follow-up visits</li> </ul>
	3.2.6.2 Honesty	<ul style="list-style-type: none"> <li>• Information</li> </ul>

### 3.2.1.1 Accessibility

Inaccessibility to health care services was experienced by all the participants as one of their major concerns. Participants expressed concern about the fact that the available health care services were not within a reasonable distance from where they lived, that they were closed after office hours, that they were not properly equipped for the management of rape survivors, and that they were unable to effectively refer participants to suitable services. What follows below is a discussion of each of these concerns.

- **Knowledge of available services**

Rape survivors can only make use of the services that are available to them after the incident if they are aware that specific health care services exist that are actually equipped to provide a comprehensive service for the survivors of rape. More than one participant stated during the interviews that they could not identify the health care services that were in a position to provide a comprehensive patient management service for rape survivors. Some of the participants described how they had to struggle to find an appropriate health care service provider.

None of the participants were originally aware of the comprehensive service that the hospital in which this study was conducted, offered to rape survivors. They were also ignorant of the fact that this comprehensive service was offered free of charge, regardless of whether the patient had been contributing to a medical insurance fund or even whether they were financially able to pay for the service received.

The greatest challenges and obstacles described by the participants included the necessity to travel to and from various health care service locations for medical assistance because they had no idea of where to find help. Some of the participants decided to go to the nearest health care service that was familiar to them, while others considered going to the

hospital where this research was conducted because it offered its services outside of normal working hours.

The findings documented above are supported by the following statements made by the participants:

●...ons was eers Delmas toe gewees. Toe het ons 'n dokter gebel toe sê hy ons moet Springs toe gaan, hulle is reeds toe. [Translated: We first went to Delmas. Then we phoned as doctor and he suggested we must rather go to Springs, since they were already closed.]

●...dit was na-ure... [Translated: it was after hours]

●...nee, my ma het gesê daardie hospitaal en toe gaan ons maar net daarna toe. [Translated: No, my mother said that hospital, and so then we went there.]

●...onsekerheid oor wat mens moet maak en waarnatoe om te gaan... [Translated: uncertainty about what a person should do and where they should go]

●...ek het nie geweet wat en hoe nou nie. [Translated: I didn't know what to do and how to do it.]

Although the above statements paint a discouraging picture, some of the participants who contacted the police directly after the incident, spoke highly of their competence and effective assistance in finding an appropriate health care service that offered comprehensive management. This is reflected in the following statements:

•...*hulle (polisie) het gesê ons moet hospitaal toe gaan...* [Translated: They (police) said that we should go to hospital]

•...*die polisie het geweet waarnatoe (gesondheids diens) ek kan gaan...* [Translated: The police knew where I could have gone (the health service)]

### **Supportive literature:**

In a study conducted in the RSA by Christofides, Muirhead, Jewkes, Penn-Kekana and Conco (2006:1), accessibility was also identified as a deficiency. These researchers studied the experiences of women and their preferences for particular services that they had made use of after the rape incident. The findings of this research were based on the following features that emerged from their research design, which included issues of accessibility:

- >travel time to health care services
  - >availability of HIV prophylaxis
  - >number of returns to the health care service for follow-up
  - >medical examination
  - >counselling
  - >the attitudes of the health care service provider
- (Christofides et al. 2006:1-4)

Recommendations made by Christofides et al. (2006:4) included the institution of a multi-disciplinary team approach that would ensure optimal patient management. They also expressed their concern about deficiencies in the services offered to rape survivors, and expressed their belief that these should be urgently addressed.

Ahrens (2006:269) has noted that many rape survivors are unaware of the services that are available in their community, services offered by





places such as, for example, rape crisis centres. Ahrens carried out her research in Chicago, and noted that all of her respondents were of the opinion that no additional sources of support were available to them in the areas of Chicago in which they lived (Ahrens 2006:269). Kelly and Regan (2003:17) also note the need for making access to health care services as widely available as possible, and the necessity for targeting under-served populations with outreach efforts.

- **Medical insurance and government patients**

Financial concerns are a crucial concern for all forms of health care service provision because the costs of medical care have escalated enormously in the last two years. This was a concern that was shared by the participants. Those who were contributing to medical insurance at the time of the incident were in a position to access private health care services. But those who had made no provision for medical insurance were deeply concerned about costs. Even so, all the participants (whether insured or not) were unaware that the services provided by both the private and public health care services were free of charge.

These concerns are evident in the following statements by the participants:

- *...is toe verwys omdat ek nie mediese fonds gehad het en so aan nie.*

[Translated: (I) was then referred because I didn't have a medical fund and so on]

- *...ek het gedink omdat ek nie 'n mediese fonds het nie sal hulle (gesondheidswerkers) my nie wil help nie... [Translated: I thought that because I didn't have a medical fund, that they (the health care workers) would not help me]*



•...*maar die polisie het daarvoor betaal. Ek weet nie, iemand het want ons het nie 'n rekening gekry nie.* [Translated: but the police paid for it. I don't know. Someone must have because we did not get an account.]

The participants without exception expressed their gratitude for the free service provided by the hospital. Even the one participant who was a foreigner in the RSA, was surprised by the standard of service she received in the unit. Their gratitude was evident in the following statements:

•...*wat ek kan sê wat baie lekker was van die hospitaal, al hierdie groep privaat hospitale verskaf blykbaar verniet diens as jy dit so kan stel.* [Translated: I can say this, which was very good of the hospital, but all these private hospitals apparently offer the service for nothing – if you can put it like that]

•...*want baie mense, as hulle nie 'n mediese fonds het nie, dink daar is nou skielik ...daar is nie hoop nie.* [Translated: because a lot of people, if they don't have a medical fund, immediately think... that there is no hope]

•...*no one judged me, they all treated me with care – even though I am a foreigner in the country – they took care of me quite well. They put that aside and I was taken care of.*

### **Supportive literature:**

Carries, Muller F, Muller FJ, Morrioni and Wilson (2007:70) described how difficult accessibility to health care services provided for rape survivors was in the RSA. These researchers confirmed that the limited financial resources available to public and private health sector create obstacles for survivors as they try to find the prompt treatment that is vital to their health and wellbeing as survivors. Shin and Moon (2007:238) confirm these observations by stating that patients who have health insurance

enjoy more rapid access to care, and that they consequently end up with fewer unmet needs and delays in obtaining the necessary care and treatment. These difficulties might be judged in the light of the South African (KwaZulu-Natal Health Department) protocols for the management of rape survivors. These protocols state that under no circumstances may any rape survivor be turned away so that they are obligated to seek help from another institution (KwaZulu-Natal Health: Protocol for the Management of Rape Survivors at Primary Health Care Facilities 2008:1). Kelly and Regan (2003:3) also emphasise that it should be one of the fundamental aims of all health care services (regardless of whether they are public or private services) to guarantee that no rape survivor will be held responsible for the payment of any health care services that they might receive.

- **Geographical location of service providers**

The number of health care services in rural areas or other areas remote from urban development, that provide specialised patient management services to rape survivors in the RSA, are limited (Carries et al. 2007:70). This fact hampers the comprehensiveness of an effective management process for rape survivors.

Two participants confirmed this statement by describing the frustration they experienced at having to travel from one health care service to another without the offer of assistance from any of them. The initial problems experienced by survivors because of the extended geographical distribution of health care service units, were compounded by further problems in the dispensing of prophylactic medication, the forensic examination and by the absence of emotional support. Police stations were described as unfriendly environments which offered little privacy and support. The absence of a multi-disciplinary team approach to the management of rape survivors also no doubt contributes to the lack of comprehensive care in rural and other areas remote from urban centres.



Some of the corroborating remarks from participants included the following:

•...want die een plek (gesondheids diens) is toe en hulle (diens) kan my nie help nie, en dan gaan jy soontoe en hy (dokter) doen nie die ondersoek of enige iets nie. Hy (dokter) gee jou maar net pilletjies en 'n inspuiting om jou te kalmeer en dan moet jy huis toe gaan, en die volgende dag moet jy weer gaan en dan moet jy nou eers soontoe (na omvattende gesondheids diens verskaffer) gaan. En dan help hulle jou eventually eers. [Translated: Because the one place (the health care service) was closed, and they could not help me. And then you go there and he (the doctor) does not do the examination or anything. He (the doctor) just gives you some pills and an injection to calm you down, and then you must go home. And on the next day you must return there, and then only you have to go there (to the comprehensive service provider). And then, eventually, they help you.]

•...dis die kit (forensiese ondersoek benodigdhede), die kit wat hulle (gesondheidswerkers) het, hulle doen dit nie, hulle het dit nie by hulle nie. Toe gaan ons van daar af deur na .....(ander hospitaal) toe. Hy (hospitaal) is bietjie verder. [Translated: And that is the kit (the kit needed for the forensic examination), The kit that they (the health care workers) have. They don't do it, they don't have it with them. And so we went from there to (another hospital). That (hospital) was a bit further away.]

•...ons het sommer Secunda toe gegaan, want die ander polisie stasie nader aan ons was pateties. [Translated: We just went to Secunda because the station that was nearer to us was pathetic]

### **Supportive literature:**

Carries et al. (2007:70) identified the reason for poor adherence to medication and a failure to attend a minimum number of follow-up visits as a lack of financial resources sufficient even to cover recurrent travel costs. The geographical situation of service providers can therefore be directly correlated with the availability and quality of aftercare services for rape survivors. The Human Rights News (2008:2) state that, because of the inaccessibility of many medico-legal clinics (health care services that provide the necessary forensic examinations) and the cost of transportation to these clinics, disadvantaged rape survivors are clearly being denied appropriate and comprehensive health care services. Littel (2004:7) encourages health care services to make the public aware that they provide comprehensive services free of charge to rape survivors. Such awareness could serve to reduce the number of places that survivors have to visit in their search for appropriate care before they actually encounter the one they are looking for.

- **Time**

The timely management of rape survivors is of utmost importance. The participants experienced prolonged waiting times as a cause of major concern. While nearly all the participants mentioned a time constraint, they were referring mainly to the waiting times during the management process (these will be discussed in connection with theme 3 in Section 3.2.3). The remarks of two of the participants with regard to accessibility and time concerns have been included here. One participant was particularly concerned about becoming infected with infectious diseases such as HIV because of the time that elapsed before she was able to receive proper prophylactic treatment. These concerns are evident in the following statements:

•...en toe sê hy (dokter) ons moet hospitaal toe gaan en hulle (hospitaal se gesondheidswerkers) sal vir my die hele kursus (anti retrovirale medikasie) gee. Maar dit was al aand gewees so dit was bietjie laat en ons het nie toe deur gery nie. [Translated: and then he (the doctor) said that we should go to hospital, and that they (the hospital's health care workers) would give me the whole course (of anti-retroviral medications). But it was already evening and a bit late, and so we did not drive through.]

•...and then it takes the whole morning...

### **Supportive literature:**

Christofides et al. (2006:1) found that factors such as the availability of prophylactic HIV medication and the confidence that they would be treated by sensitive and sympathetic health care workers who were qualified to provide proper counseling, were more important in influencing women to seek professional care after rape, than the amount of time that they would have to spend on travel before they could access those services. The impact of the finding by Christofides et al. (2006:1) is somewhat qualified by a statement in Human Rights News (2008:2). They state that, for many of the women involved, the price of reporting a rape may be hours of travel and waiting for attention and an almost negligible chance of seeing an easily identifiable perpetrator convicted. The KwaZulu-Natal protocol for the management of rape survivors at primary health care facilities advises that the examination and treatment of a rape survivor should not be delayed beyond two hours after the incident – regardless of whether the police have arrived at the clinic within this two-hour period or not (2008:1).

The amount of time spent on travel is also discussed by Shin and Moon (2007:241) under the heading of accessibility to health care provision. Shin and Moon observe that many patients would have to travel for more

than 30 minutes before they could reach a health care service. Accessibility and the amount of time that elapses between rape and its treatment are also obviously matters of deep concern if health care services are closed after “normal” office hours (Shin & Moon 2007:241).

- **Referral**

Rape survivors are usually referred to various members of a multi-disciplinary team, such as counsellors, for management and treatment after an incident of rape. But referral is not always possible. Experts in various fields are not always readily accessible to rape survivors because of the distance that they have to travel before they can come into contact with experts of this kind. Referral was not investigated in this sub-category with regard to referral of the survivors after their initial visit to the A & E unit. Its implications were only investigated with regard to the referral of the rape survivors before and during the **initial** A & E visit, which might have included the police referring the patient to the hospital for example. Referral during the follow-up period (which is defined as extending from day two after the incident until one year later when the management program elapses), will be discussed under the theme multi-disciplinary team (see Section 3.2.4).

All the interviews make it clear that the participants were all referred in accordance with the established protocols of the hospital group to which the hospital and A & E unit belong. Such a referral requires the rape survivor to see a hospital counsellor before discharge after the initial visit. The initial referral might also include the presence of the police, either before or after the A & E visit as mentioned above.

In one case where it was impossible for the counsellor to attend to the survivor immediately, the counsellor made alternative arrangements for the survivor to meet him at a specific time later that day.



•...*hulle (gesondheidswerkers) het hom (berader) gebel maar hy (berader) was aan die ander kant van Boksburg gewees. Ek weet nie presies wie het hy (berader) later gebel nie, hy't gesê hy sal ons (pasient en vriend) ontmoet later die middag – waar ons ook al is – hy sal ons ontmoet. Hy het gesê hy is die hospitaal counsellor so hy ontmoet mense in die omliggende hospitale, so hy gaan nie eintlik uit na hulle (pasiente) huise toe nie, maar hy (berader) het vir my daai dag uitgegaan.* [Translated: They (the health care workers) telephoned him (the counsellor), but he (the counsellor) was on the other side of Boksburg. I don't know exactly who he (the counsellor) phoned later, he said that he would meet (our patient and friend) later in the afternoon – wherever we might be, he would meet us. He said that he was the hospital counsellor and that he had to meet people in the surrounding hospitals. Because of this, he explained that he doesn't actually go out to their (the patients') houses, but he (the counsellor) came out to visit me that day.]

All the other participants in the sample were referred to the counsellor after admission to the unit, and sometimes again between discharge after the one year management period elapsed, and the initial visit to the A & E unit. This is evident from the following statement:

•...*toe sê hulle (gesondheidswerkers) hulle kry 'n berader...* [Translated: then they (the health care workers) said that they were getting a counsellor]

Some participants also explained how police officers (who were the first professionals with whom they made contact after the rape) had referred them to the hospital for management because they did not know where they should go. Such recommendations on the part of the police obviously increased accessibility to appropriate management. Statements from the participants include:





●...ek het die verklaring afgelê voordat ek noodgevalle toe gekom het. By die huis, en toe by die hospitaal aangekom... [Translated: I made the statement before I came to emergency. I did it at the house, and then arrived at the hospital.]

●...toe kom die sersant eventually toe gaan hy en toe vra hy vir hulle (ander polisie offisiere) "wat doen julle?. Julle is nie veronderstel om haar te ondervra nie, sy moet by die hospitaal uitkom". [Translated: and then eventually the sergeant came. And then he went and asked them ( the other police officers), "What are you doing? You are not obliged to question her, she must go to the hospital."]

### **Supportive literature:**

Medical treatment offered to patients who have reported a rape should include prophylactic medication to prevent pregnancy and forestall sexually transmitted infections (STIs), as well as appropriate counseling about further referrals (Ferguson 2006:488). The hospital has a record of complying with these recommendations. Littel (2004:1-12) recommends that all parties in a multi-disciplinary team in the United States should offer optimal treatment to rape survivors. Littel also recommends that police and law enforcement agencies should be closely involved with all local A & E units. While such close cooperation between professionals cannot simultaneously address all the survivors' needs, they will increase the degree of comfort and care that is needed by the survivor and will also set the stage for her subsequent involvement with the legal system. Ciancone et al. (2000:356) state that the best care for survivors of rape requires the coordination of clinical medicine with forensic science, law enforcement and victim advocacy.

### 3.2.1.2 Forensic examination

The forensic examination is an indispensable link in the chain of events that make up the management process because rape survivors have been the victims of a serious crime, and unless legally unassailable evidence of the crime is collected while it is still available, the evidence will be lost forever and the perpetrator might be encouraged to commit further outrages. While the performance of this kind of forensic examination is time-consuming, stressful and exhausting, not only for survivors but also for health care workers, such an examination is vital for establishing that a crime has been committed, and it is one of the important categories under the general heading of patient management (a major theme).

- **Information**

The forensic examination is performed by an A & E nurse practitioner or by a doctor who has been trained to do so in the A & E unit. It involves collecting all the kinds of evidence from a rape survivor that will assist in the further identification and prosecution of the perpetrator.

The examination is carried out in accordance with specific guidelines and instructions and is collected in a specialised sexual assault evidence collection kit (SAECK) that has been pre-packed by the police department. Unless the A & E unit has an unused kit on hand, the police will be contacted to provide the A & E unit with a kit as quickly as possible. Since the forensic examination is unquestionably the most intimate and uncomfortable part of the management process, the researcher anticipated that many of the participants would be unwilling to talk about it. Contrary to expectations, many of the participants were willing to talk briefly about the examination. Most of them described it, as one might expect, as an uncomfortable experience even while they accepted it as a necessary part of the health care workers' duties. None of the participants in this study described the forensic examination as unnecessary, or felt

that it should be omitted from the patient management process. Some of the participants' statements that support this view include the following:

...•*dit is hoe hulle (regs geleerdes) hom (verdagte/beskuldigde) gaan aankla...* [Translated: that is when they (the legal officers) will lay a charge against him (the accused / the guilty party)]

•...*ek het geweet hulle (gesondheidswerkers) doen wat hulle moet doen.* [Translated: I knew that they (the health care workers) were doing what they had to do]

### **Supportive literature:**

Kelly and Regan (2003:3) state that the way in which a woman is treated after rape will determine the extent and quality of the forensic evidence that is gathered – not to mention the willingness of the survivor to cooperate and trust the legal process. Kelly and Regan have also noted that many survivors urgently need the medical response to include some degree of reassurance and information – rather than just the mechanical procedure that constitutes the forensic examination (Kelly & Regan 2003:4).

According to Ledray's comprehensive document on the forensic examination (2008:8), health care workers as well as the police must be willing and available to address another issue which is a matter of great concern to survivors. She continues that once the rape survivors' immediate needs have been properly attended to, they also have an urgent need to be properly informed about various other matters. These matters might include general information about the process and possible consequences of forensic evidence collection, as well as the role that each member of the multi-disciplinary team will play in the treatment process. It is at this stage, prior to initiating the examination that the health care worker should describe to the patient what the examination involves. The

patient should also be informed that the examination is totally voluntarily and that she has the power to stop it at any time (Littel 2004:4). Littel emphasises that this information should be given in clearly comprehensible language in a relaxed atmosphere, and at a pace that suits the needs of the survivor.

- **Examination**

Three of the participants described how the examination was actually performed, and in their descriptions they concentrated mainly on the methods that we used to collect the evidence. The following testimony bears this out:

•...soos hulle (gesondheidswerkers) het vir my presies verduidelik wat is die kit, hulle het die boks voor my oopgemaak om my te wys niks (inhoud) is voorheen gebruik of whatever nie. Hulle het gesê byvoorbeeld die skraap ding wat hulle moes gedoen het... [Translated: as they (the health care workers) explained to me exactly what the kit was. They opened the box in front of me to show me that nothing (the content) had been used, or whatever. They explained, for example, about the scraping that they had to do.]

•...en hulle (gesondheidswerkers) het vir my gesê hulle het 'n swab wat hulle nou soos die DNA opskraap om te sien of hulle enige iets kan kry. [Translated: and they (the health care workers) said to me that they had a swab that they used to obtain a DNA scraping, and that they were going to see if they could get anything.]

•...dit (forensiese ondersoek) was vir my bietjie ongemaklik gewees, veral met die swab ding, maar hulle (gesondheidswerkers) het vir my ook gesê dit gaan seer wees. Hulle het presies vir my gesê hoe ek moet lê.

[Translated: It (forensic examination) was somewhat uncomfortable, especially the swab thing. But they (the health care workers) also told me that it would be sore. They also explained to me exactly how I should lie.]

Once again, most of the participants regarded this part of the management as unpleasant but necessary. Here are some of their remarks:

•...*jy wil nie rerig naked uittrek en daar lê...* [Translated: One doesn't really want to strip naked and lie there]

•...*soos hulle (gesondheidswerkers) moet dit (forensiese ondersoek) doen..., dit (forensiese ondersoek) is hoe dit moet gaan en dit is deel van hulle werk...* [Translated: as they (the health care workers) had to perform it (the forensics examination). The (forensic examination) is what needs to be done, and it is a part of their work.]

•...*dit is 'n ding (forensiese ondersoek) wat jy voor lê en wag wat erger is as...dis erg – wat met jou gaan gebeur is erg.* [Translated: That is the thing (the forensics examination) that is waiting for you, and it is more serious than... It is serious. What is going to happen to you is serious.]

•...*dieselfde met die ondersoek, daar's 'n mate van angstigheid wat van boonop wat met jou gebeur het, bydra tot jou toestand...* [Translated: It's the same with the examination. There is an additional degree of anxiety about what is going to happen to you that contributes to your condition.]

•...*want die ondersoek op sy eie is 'n nagmerrie.* [Translated: because the examination on its own is a nightmare.]

The gender of the attending doctor or A & E nurse practitioner was a problem only for two of the participants. Although the first patient had specifically requested to be examined by a female, only a male doctor



happened to be on duty at the time and so it was necessary for him to perform the examination. This was an issue of enormous concern to her because she mentioned it repeatedly during the interview. It also constituted the substance of her only recommendation on how current patient management practice could be improved in the future. When the researcher probed gently into her reasons for emphasising this particular concern so strongly, she confessed that while the male doctor had done nothing to make her feel uncomfortable, she would have preferred to have been examined by a female doctor. She added that if the examining doctor had been a female, she would have experienced the whole situation differently, apart from feeling much more relaxed in the hands of a female practitioner. The significance of this remark will be referred to again below under the patient preference sub-category heading (see Section 3.2.6.1). The second participant also confirmed that the gender of the doctor had made a difference to how she experienced the forensic examination. Here are extracts from what they said:

●...*maar ek voel net hulle (gesondheidswerkers) kan...hulle moet vroue dokters daar kry, want ek was ongemaklik want ek moes....dit was 'n man-dokter en hulle (gesondheidswerkers) het vir my gesê daar is nie 'n vroue dokter daar nie. So dit het my maar net regtig ongemaklik laat voel met die man-dokter...* [Translated: But I just feel that they (the health care workers) could... They must get female doctors. I was uncomfortable because I had to... It was a male doctor and they (the health care workers) had told me that there was no female doctor. And so I felt really uncomfortable with the male doctor.]

●...*dit was 'n vroue dokter, wat nice was. Ek dink ek sou bietjie anders gevoel het as dit 'n man (dokter) was.* [Translated: There was a female doctor, which was nice. I think that I would have felt somewhat differently if it had been a male (doctor).]

### **Supportive literature:**

In general, a timely, well-performed medical forensic examination has the power to validate and address the concerns of rape survivors, to minimize the trauma that they undergone, and thus to promote their healing and restoration (Lewis-O'Connor, Franz & Zuniga 2005:269). Although none of the participants really objected to or actually refused the examination, they all understandably experienced it as uncomfortable, painful and very intimate. Kelly and Regan (2003:3) also refer to the examination as a daunting prospect. While the worst-scene scenario is that the forensic examination might be experienced by the survivor as yet "another assault", survivors' experiences was that it was mostly just uncomfortable and invasive.

Previous studies undertaken by Kelly and Regan (2003:11) on the reporting of rape have identified certain factors that can make this forensic examination less traumatic. These factors include the provision of a female examiner (for female rape survivors), the maintenance of a sufficient degree of privacy during the examination, the performance of the forensic examination in a non-institutional setting, and the presence of a caregiver who is qualified to talk the survivor through the process in a caring and sympathetic yet professional manner. Kelly and Regan (2003:17) are in fact of the opinion that having access to a female examiner should be a minimum standard with which every rape treatment unit should comply. Ledray (2008:2) states that the unique aspect of the forensic examination is the fact that although health care workers act as agents for the police investigation, a medical health care worker rather than a police officer performs the examination because of the intimate nature of the evidence that needs to be collected, and the specific expertise that is required to obtain valid evidence.

None of the participants in the study claimed during any of the interviews that the forensic examination had been inaccurately performed or that it was not in some way up to standard. The only issue that was of great

concern was that some of the participants had been forced to wait a long time before the examination was performed.

### 3.2.1.3 Medication

Medication emerged as a challenge in the management process. All the participants expected to be given the proper prophylactic and other medication because they realised that it was essential for their future physical health. The medications that were given to all of the survivors included prophylaxis for pregnancy, HIV transmission (anti-retroviral therapy or ARV medication) and STIs, as well as a brand of anti-emetic. The challenges that face the dispensing of medication are discussed below.

- **Family or significant other presence**

After extensive analysis of the interviews, the researcher was able to determine that those participants who had received information about the medication they were given *when they were alone*, neither understood, remembered nor actually listened to the instructions that were given to them about how to use the various medications. But all the participants reported that when a member of their family or a “significant other” was included in the education process, this helped them to cope with, remember and comply with the conditions for the use of the medication. This is evident from the following remarks:

• *...twee koppe is altyd beter as een.* [Translated: Two heads are always better than one.]

• *...die vrou (suster) het vir my baie mooi verduidelik, maar ek et vir haar gesê ek gaan vergeet...* [Translated: The woman (the nursing sister) explained everything to me very nicely. But I told her that I was going to forget]



•...ja en jy weet, ek dink nie ek sou regtig kon verstaan wat hulle (gesondheidswerkers) sê nie en dis hoekom sy (dogter) toe maar die pille gevat het en gevra het [Translated: Yes, and do you know, I don't think that I would really have been able to understand what they (the health care workers) would say, and that is why she (my daughter) took the pills and asked.]

•...hy (vriend) weet daarvan soos as ek – ek sal nie sê vergeet nie want ek het nie vergeet nie, ek het myself laat remind – maar as ek sou vergeet, was dit... [Translated: He (my friend), like me, knows about it. I would not say “forget” because I did not forget. I reminded myself later, but if I had forgotten, then there was...]

### **Supportive literature:**

According to Kgatlwane, Ogenyi, Cosmas, Madaki, Moyo and Modie (2004:21), forgetfulness and lack of support are two of the most common reasons why some patients missed out on their ARV medication dosages. These authors add that a supportive home environment improves the likelihood that a patient will adhere to the correct method of using ARV medication regimes (Kgatlwane et al. 2004:38). Fletcher (2000:1) states that members of the family and significant other have a right and an obligation to assist family members with certain aspects of the care that she might need help during their visit to an A & E unit.

- **Patient education**

The above remarks indicate that family participation is also obviously relevant to the process of all kinds of patient education. It is absolutely essential that certain medications (and anti-retrovirals in particular), be taken correctly. Education in the use and administration of these medications is therefore essential, and every reasonable means should be used to educate the rape survivor effectively. Although some of the

participants mentioned that they had received a paper that contained written instructions, this ironically though, created further problems for some of them. This is verified by the following extracts:

•...my *verduidelik van die pilletjies en hoekom ek dit moet drink en hoe lank dit gaan wees, 'n papier (inligtingspamflet) gegee van ure wanneer ek dit moet drink.* [Translated:....explained to me about the pills and how I had to take them, and how long it would be. I was given a paper (an information pamphlet) that explained the times when they (the medication) had to be taken.]

•...hulle (*gesondheidswerkers*) gee vir jou 'n papier (*inligtingspamflet*) wat hulle vir jou sê hoe laat moet jy watter pille drink, maar dan gee hulle vir jou meer pille as wat op hierdie papier geskryf is. [Translated: They (the health care workers) give you a paper (an information pamphlet) which tells you the times when the tablets should be taken. But then they give you more tablets than those described on that pamphlet.]

•...hulle (*gesondheidswerkers*) konsentreer net net op die anti retroviale middel, maar hulle sê nie vir jou van wanneer jy die ander pille moet drink nie. [Translated: They (the health care workers) concentrate on the antiretroviral treatment. But they do not tell you when you should take the other tablets.]

### **Supportive literature:**

Palmer and Midgette (2008:137) studied the manner in which patient education is sometimes delegated to other members of the multi-disciplinary team, and found that such delegation can provide a unique opportunity for improving the quality of service delivery. Such delegation might be an option that is well worth considering, because, as Shin and Moon (2007:243) have pointed out, some of the patients who participated in their research were less likely to receive explanations of their treatment

options when they were alone (without any family member or significant other being present). Littel (2004:4) also emphasizes that all the information that is given to a patient should be made as easy to understand as possible, and it also be presented in a written format so that the rape survivors will have the opportunity to review the information more than once if they need to do so.

- **Simplicity**

All of the participants remarked on the complexity of the medication usage regimen. They described the instructions they were given as confusing, complicated, poorly expressed and insufficiently comprehensive. Some of these sentiments are expressed in the words below:

• *...daar was bietjie onduidelikheid oor die medikasie, want ek dink hulle (gesondheidswerkers) het toe maar vir my dogter gesê en ek dink sy (dogter) het verkeerd verstaan en...* [Translated: There was some uncertainty about the medication because they (the health care workers) told my daughter, and I think that she (my daughter) did not understand what they had said correctly.]

• *...jy weet dis mos 'n vreeslike klomp goed (medikasie). Dit is 'n ingewikkelde storie.* [Translated: There is a most dreadful lot of stuff (medication). It is a complicated story.]

• *...en hulle (gesondheidswerkers) het vir my 'n boekie (inligtingspamflet) gegee wat verduidelik...* [Translated: And they (the health care workers) gave me a booklet (an information brochure) that explained...]

• *...ek het eers na 'n ruk bietjie duidelikheid gekry regtig.* [Translated: it was only after a time that I really acquired some clarity...]



•...so dit (riglyne tov medikasie gebruik) was bietjie confusing, want jy stel jou in op hierdie papier – so laat mag jy eet, so laat mag jy nie eet nie, dan moet jy die pil drink, dan moet jy daai pil drink – en daar was baie meer pille as dit en dit was vir my confusing oor wanneer moet ek nou watter pil drink. [Translated: And so they (the medical guidelines) were a little confusing because you rely on this pamphlet (which tells you that) at this time you are allowed to eat, at this time you are not allowed to eat, then you must take a tablet, then you must take another tablet. And there were many more tablets than that, and it was very confusing for me when it came to sorting out which tablets I had to take.]

•...so die gebruik van die medikasie was vir my baie, baie, baie deurmekaar. [Translated: And so the use of the medications was very, very, very confusing for me.]

•...en hulle (gesondheidswerkers) het ook my voorskrif verkeerd uitgemaak...so daar het hulle (gesondheidswerkers) ook 'n fout gemaak. [Translated:...and they (the health care workers) also made out my prescription wrongly. And so they (the health care workers) also made a mistake.]

### **Supportive literature:**

Collings, Bugwandeem and Wiles (2008:481) describe how the complexity of the manner in which ARV medications needs to be administered, can adversely influence the rate of adherence to the prescribed therapy. These researchers also note the low follow-up rates (which might also explain the low incidence of adherence to the requirements of the therapy). Kgatlwane et al. have also noted the complexity an effective ARV medication administration schedule (2004:38).

Bayam L, Bruce, Sampath, Bayam FB and Abernethy (2008:625) state that while the majority of negligence cases in medical practice are based

on allegations of poor quality clinical care, the failure to achieve high standards of quality clinical care may well be triggered in the first instance by inadequate or incomprehensible communication between practitioner and patient. One participant even described a situation in which she had been given the incorrect prescription. If all the doctors concerned were able to communicate more clearly and effectively with their patients (the rape survivors) and the pharmacists, such errors could be avoided. While medical error has been widely described in research and is caused by many factors, this topic will not be further delineated other than to note with concern that in the rushed and highly stressed medical environments of places such as A & E units, more errors occur than in other clinical settings. Hohenhaus (2008:21, 24) mentions that more than half of the respondents in her research reported the incidents of medication error in the context of an emergency environment. She continues to note that the reporting of such errors in most countries is inadequate, and that it is necessary to use the incidence and consequences of errors as an opportunity for educating health professionals to improve their clinical practice.

- **Side effects**

Almost all of the ten participants remarked on the unpleasant side effect profile of the medications they received – with ARV medications being singled out as the medication that produced the worst side effects of all. Two of the ten participants noted that they had to stop taking anti-ARV medication because they had been diagnosed as HIV positive by the blood tests taken prior to the incident, after confirmatory proof was obtained at the initial A & E visit. One of the participants experienced side effects within the first three days after beginning to take the medicine in anticipation of her blood results. The remaining participants all complained about the side effect profile and singled out nausea as the most unpleasant side effect of all. None of them indicated that they had ceased to use the medication merely because of its side effects. Those participants who were confirmed as being HIV negative after their initial



testing, might have continued to use the medication because of their fear of sero-converting to an HIV positive status. Some of the participants' remarks about side effects included:

●...ek het nie geëet nie en ek het nogsteeds opgegooi. Dit (anti retrovirale medikasie) is nie lekker pille nie, maar dis seker op die einde van die dag 'n goeie ding. [Translated: Even though I was not eating, I was still vomiting. It (the antiretroviral medication) is not a pleasant treatment. But no doubt it is a good thing at the end of the day.]

●...en dit (medikasie) het my so naar gemaak. Oh, ek was so siek! Toe het ek, ek weet nie hoe lank na ek dit begin gebruik het nie, toe kry ek blaasinfeksie. Was ek nou siek! [Translated: And it (the medication) made me so nauseated. Oh, I was so ill! And then ...I don't know how long it was after I had begun to use it... I got a bladder infection. Was I ill! ]

●...because when I'm doing (drinking) those tablets, they make me drunk!

●...en toe drink ek een aand alles (medikasie) gelyk toe was ek verskriklik naar! [Translated: And then one evening I took it (all the medication) at the same time. And then I was extremely nauseated!]

In contrast to the experience of those recounted above, one of the participants said that she had not really experienced too much nausea while taking the medications because, as she said:

●...want ek het Valoids gedrink en dit maak dat die naarheid weggaan. [Translated: I had taken Valoids, and they banished the nausea]

### **Supportive literature:**

Adherence to HIV prophylaxis after rape has been reported to be poor in a variety of developed world settings (Carries et al. 2007:68). These



authors have reached the conclusion that one of the reasons for non-adherence can be attributed to the side-effect profile of the HIV prophylactic medications (2007:70). This statement is, however, not supported by Kgatlwane et al. (2004:22) or by Weiser, Wolfe, Bangsberg, Thior, Gilbert, Makhema, Kebaabetswe, Dickenson, Mompati, Essex and Marlink (2003:287). Both these two groups of researchers note in their respective research that although both of the different patient groups had reported adverse side effects, these were not experienced as so severe as to motivate them to reduce their adherence of the ARV medication schedule of treatment. In *Science for Africa*, an online science magazine, Sunpath (2006:2) warns that, although they are “minimal”, some of the ARV medications’ side effects should not be lightly regarded, because they pose a serious health risk to some patient populations.

### **3.2.2 Theme 2: Family or significant other**

The rape survivors is the one patient population that has the greatest need of support, and because the family or the significant other are the ones who provide that support, they should always, wherever possible, be included in the management of rape survivors in the A & E unit. This conviction of the researcher was validated by the study findings. It is discussed in detail below.

#### **3.2.2.1 Presence**

All of the participants mentioned the presence of their family or their significant other, and the need they felt for that presence. None of them experienced feelings of rejection from their families or significant other. “Presence” here refers to the physical presence of a family member or a significant other in the A & E unit during the initial visit, or during subsequent follow-up visits. A “significant other” might be defined as any other person with whom the patient has formed an intense and supportive bond or a mutually committed relationship. A significant other is therefore

a person who provides the same degree of comfort and support that partners in a functional marriage or family relationship generally offer to one another.

- **Patient response to presence**

All of the participants in this study regarded the need to be in contact with their family or significant other as vitally important. This was mentioned as being valid in a variety of management phases that included the admission phase, the educational interventions, the forensic examination and the follow-up care.

The actual presence of a member of the family or the significant other demonstrated concrete physical and emotional support to the participants – something that the participants emphasised during the interviews. One of the participants expressed the need for her family or significant other, but these supportive individuals lived a great distance away, and her only supportive presence could be provided by the police. The presence of family or a significant other can be described as a vitally important element in a traumatic situation. The following remarks bear this out:

• *...my familie wat nou later aangekom het, was almal verskrik en die kindertjies wou vir ouma sien, en ek het net gevoel...ek sou graag wou gehad het om hulle (familie) te sien. Ek kan dink hoe hulle (familie) moes gevoel het..* [Translated: My family arrived later, and they were all in a state because the grandchildren wanted to see their grandmother. And I felt... I would have liked to have seen them (the family). I can imagine how they (the family) must have felt.]

• *...hulle (gesondheidswerkers) het alles verduidelik, met ...(vriend) gepraat.* [Translated: They (the health care workers) explained everything, they spoke to (my friend).]



•...*ek weet nie...(vriend) het alles gedoen, ek weet nie.* [Translated: I don't know... My (friend) did everything. I don't know.]

•...*my familie is saam met my...* [Translated: My family accompanied me...]

•...*dit was vir my belangrik. Om my ma by my te hê was vir my belangrik, en my pa.* [Translated: It was important to me. To have my mother with me was important, and my father.]

•...*ja, only the police.*

### **Supportive literature:**

Recent research advocates that family or significant others should be included in the whole gamut of information sharing, critical decision making, patient care and patient support (Lilly 2008:213). As the presence of family or significant others becomes increasingly more evident in the clinical setting, Madden and Condon (2007:33) suggest that the policies and guidelines of health care services should be revised to recommend the inclusion (wherever possible) of family and significant others in the management of all patients who have a clear need for family or significant-other support during post-traumatic examinations. All the participants in this study expressed positive feelings about presence and involvement of their families or significant others. Yamawaki (2007:512) has also observed that most rape survivors talk about their traumatic experiences with their family and friends.

- **Value and importance of presence**

The value and importance of the presence of family or a significant other should never be underestimated. Such presence may, in fact, assist the patient to make a fuller disclosure of the events of the incident. It should

be noted that family or significant others can also perform the function of being a “sounding board”, a leader, a reminder, a listener, or simply someone who remembers important things (such as medication schedules). These advantages are evident in:

●...*die dokter het haar (berader) nommer vir .....(vriend) gegee en gesê as ons belang stel kan ons haar (berader) daar bel.* [Translated: The doctor gave (the counsellor) the number to (my friend) and said that if we were interested, we could get hold of her (the counsellor) at that number.]

●...*hy (vriend) het alles gedoen. Hy het geweet wanneer moet ek gaan en dan se hy vir my ons moet byvoorbeeld woensdag weer gaan, nege uur moet ons daar (A & E eenheid) wees.* [Translated: My (friend) did everything. He knew when I had to go. And then he said to me that we had to go again, for example, on Wednesday, and that we would have to be there (at the A & E unit) at nine o'clock.]

●...*maar net nadat dit (insident) gebeur het, hulle (gesondheidswerkers) het hom (vriend) nie weggejaag nie wat vir my nice was.* [Translated: But just after it (the incident) happened, they (the health care workers) did not chase him (a friend) away. And that was (something) nice for me.]

It was mentioned above, one of the participants had no family support because all of her family lived a great distance away from the scene of the post-traumatic events. This participant resorted to calling on her employers in the place where she worked as a domestic helper. When talking about sensitive issues she began to cry and said that they:

●...*helped to support me.*

One participant indicated that the support of her family or significant other were not so important to her. This was evident from her statement that their absence:



•...het my nie gepla nie. [Translated:...did not bother me.]

### **Supportive literature:**

Lilly states in a personal reflection that “it is intuitive to believe that one of the key elements of positive patient outcomes is productive family involvement” (Lilly 2008:213). He continues to note that contributing to an understanding of the depth of the trauma sustained by the survivor, the mere presence of family or a significant other will have many positive repercussions, both immediately and in the months subsequent to the incident. While Mularski (2008:676) describes family communication as a complex intervention, she emphasizes that all recent and emerging data supports the inclusion of family or a significant other in the process of making acceptable decisions about patient care. Eckle and MacLean (2001:238) mention that in the course of the vital role that a family plays in the health and well-being of patients, they fully support family-centred care. It is important to remember that members of the patient’s family or his or her significant other are obviously also secondary victims in the aftermath of rape, and that they too might require counselling and assistance in order to cope with the situation.

### **3.2.2.2 Encouragement**

The expression of encouragement during this post-traumatic phase is essential to the well-being of the rape survivor. This category is discussed in this study because some of the participants mentioned how the attitude of their family or significant other made a difference to the ways in which they supported themselves by, for example, complying with the follow-up schedule. In other words they found the courage and will to do “the right thing” when their family or significant other supported them and encouraged them by accompanying them.



- **Attitudes**

A positive attitude of family or a significant other contributes to the overall success of the participants' management programme. The remarks below indicate that one of the participants only sought help from a hospital after she had spoken to her mother and that another was positively influenced to attend follow-up visits through the influence of her family. The remarks below reflect the impact that family or significant other attitudes can have on a rape survivor:

- *...en toe het ek vir my ma die Sondag aand vertel en toe se sy (ma) dis beter as ons polisie toe gaan en hospitaal toe gaan, net vir 'n ondersoek.* [Translated: And then I told my mother on that Sunday evening, and then she (the mother) said that it would be better if we went to the police and the hospital, just for an examination]

- *...so hy (vriend) was saam in (A & E eenheid) gewees, en al daai goed. Opvolge ook, ek het ook nie alleen gegaan nie.* [Translated: And so he (a friend) was together with me in (the A & E) unit, and all that stuff. For follow ups as well. I did not go alone.]

- *...maar terwyl ons (pasient en familie) wag...* [Translated: ...but while we (the patient and her family) waited...]

One participant explained how the rape and the fact that she was HIV positive resulted in the development of an abusive personal relationship with her partner. This participant was therefore unable to enjoy the benefit of being supported in a loving and caring positive home environment. It may be for this reason that she now suffers from severe panic attacks. She said:

•...and then I actually told him (the counsellor) that the other thing except the rape that got my boyfriend to assault me was because he also found out that I was HIV positive.

### **Supportive literature:**

“Women who had been raped were more likely to have been non-sexually abused by relationship partners and were more likely to fear asking partners to use condoms” (Kalichman & Simbayi 2004:681). This explains the dynamics of the situation reported above. The negative reaction of support providers will also be discussed in more detail below in the discussion about the theme of the attitudes of multi-disciplinary teams. It could also, however, be relevantly incorporated here. Carries et al. (2007:70) mention that the research that they have undertaken in another of the provinces of the RSA (KwaZulu Natal), they noted that the service provider had seen an average of 26 patients per month. This rate is not inconsistent with most of the monthly statistics for the unit in which this study was performed. More importantly, many of the women in that study were young (as they are in this study), and 36% of them had already been infected with HIV at the time of their presentation to the service provider after the rape had occurred. In this research, two of the participants admitted that they were already HIV positive before the rape. This is just slightly less than the findings of Carries et al. Yamawaki (2007:512) also states that positive social and emotional support from family and friends rather than from any other source, is consistently associated with a better recovery rate.

- **Supportive actions**

Some actions performed by the family or significant other were specifically mentioned by participants, and could therefore also be dealt with under the discussion of the attitude sub-category. Their mere presence and the

fact that they were able to give advice and guidance and make arrangements is a factor of the greatest importance, as is evident from:

•...hy (vriend) het gesê ons moet polisie toe gaan en jy moet dit aanmeld... [Translated: He (a friend) said that we should go to the police and report it.]

•...sy (ma) was heelyd saam met my, behalwe hulle (gesondheidswerkers) het gesê toe ons die ondersoek gedoen het mag sy (ma) nie daar (in ondersoek kamer) gewees het nie. Maar dis fine met my – dit het my nie gepla nie. [Translated: And so my (mother) was with me, except when they (the health care workers) said that they were going to perform the examination, they said that my mother should not be there (in the examination room). But that was alright with me. It did not bother me.]

Other members of the multi-disciplinary team such as the police also provided support by taking care of all the arrangements. One of the participants described this in the following way:

•...die sersant was die heelyd daar. Hy't alles gereël. Ek hoef nie fisies in te gegaan het (in A & E eenheid) of niemand van ons familie hoef in te gegaan of iets reel nie, hy't alles gereël. Wat baie nice was. [Translated: The sergeant was there the whole time. He arranged everything. I did not have to go physically (into the A & E unit), and no one in my family had to go there to arrange anything because he had arranged everything. It was very nice.]

### **Supportive literature:**

Yamawaki (2007:512) reports that high levels of support from both family and their friends encouraged survivors to seek the services of mental health professionals and counsellors. In his research, Yamawaki noticed

that Japanese people tend to seek help after rape within the family setting itself, as opposed to Americans who encourage rape survivors to contact both the police as well as outside counsellors (Yamawaki 2007:511). The benefits of the comfort and support provided by the presence of the family or by a significant other in the patient care environment when the patient herself as been critically injured or seriously assaulted, is well described in the research conducted by the Emergency Nurses Association (2008:1); by Farah, Thomas and Shaw (2007:587), and by Meyers, Eichhorn, Guzetta, Clark, Klein, Taliaferro and Calvin (2004:61).

### **3.2.2.3 Information**

The exchange of information should be beneficial and useful to all three of the parties involved in the management setting: the survivor, the family or the significant other, and the health care workers. Health care workers should provide the family with all of the information that they will need in supporting, reminding and helping the survivor throughout the treatment period. The family or the significant other can in turn provide health care workers with valuable information about the survivor's contact details. The family or the significant other can also give an opinion about the survivors' emotional progress or regress during follow-up visits. But the survivor remains the central source of all information, and this should be taken into account in all situations.

- **Need for information**

Some of the following remarks demonstrate the family or the significant other's need for information:

• *...toe hy (vriend) saam my wou ingaan...* [Translated: Then he (a friend) wanted to go in with me...]



●...dan sê ek vir haar (suster) ja, my familie is saam met my, almal is saam met my... [Translated: Then I said to her (the nursing sister), "Yes, my family are all with me. Everyone is with me."]

●...en as die susters hom (vriend) moés wegjaag, baie keer....ek weet nie, hulle (gesondheidswerkers) laat nie....ok, met my counseling en al daai en my bloed toetse, hy (vriend) sit daar (wagkamer) en ek gaan in (A & E eenheid). Ek weet hy (vriend) is in die hospitaal so dis oraait. [Translated: And if the nursing sisters have to chase him (a friend) away, then often... I don't know: they (the health care workers) do not allow... OK, during my counselling and all those blood tests, my (friend) was sitting there (in the waiting room) while I went in (to the A & E unit). I knew that he (my friend) was in the hospital, and so that was alright.]

### **Supportive literature:**

In a study undertaken by Bailey, McVey and Pevreal (2005:324) that examined the experience of patients and family members during a patient's experience of surgery, they reported that family members were unsure about how they could obtain information about their loved ones while they waited. This indicates that although family members need information about the condition and progress of their relative, the patient, they frequently did not receive it in a satisfactory form. Spetz, Henriksson and Salander (2008:18) confirm that the initial conversations that take place between health care workers and the family or significant other might be crucial to the successful prognosis of an injured or sick relative. Lilly (2008:213) also notes that families suddenly experience their own fear, turmoil, imbalances and a host of surprisingly deep emotions when a relative is suddenly injured or becomes critically ill. Given the fact that many nurses cite family distractions as an obstacle to the quality of care giving, Lilly (2008:214) suggests that informing the family or significant other proactively will give the health care worker the needed space in which to perform his or her job. Lilly continues by saying that all



necessary information should be used in a timely and tactful manner, and that this in itself will result in less gratuitous interference from the family or the significant other. He notes that the proactive dissemination of information in this way will confirm in the health care worker's mind that he or she has also made a significant contribution to the care given to the family or significant other.

- **Role in patient education**

The remarks below make it evident that the family or significant other plays an essential role in helping the participants to listen accurately, especially during the course of educational interventions. This is vitally important because the participants themselves usually do not remember all the details.

• *...luister nie regtig wat hulle (gesondheidswerkers) vir my sê nie. Toe het hulle (gesondheidswerkers) meer met hom (vriend) begin praat. [Translated: I was not really listening to what they (the health care workers) were saying to me. And so they (the health care workers) began to speak to him (my friend).]*

• *...ja hy (vriend) as....sê maar basically die pasient, behalwe ek moes die pille drink en al die goed doen. [Translated: Yes, he (a friend) as... you can say basically the patient, apart from the fact that I had to take all the tablets and do all that stuff.]*

• *...daar was iets wat ons (pasient en dogter) toe verkeerd verstaan het of wat sy (dogter) nie gehoor het nie. [Translated: There was something that we (the patient and her daughter) understood wrongly, or something that she (the daughter) did not hear.]*



•...ek het nie regtig hulle (gesondheidswerkers) iets gevra of regtig belang gestel om iets te vra nie. Ek het maar net gedoen wat hulle (gesondheidswerkers) gesê het. [Translated: There was nothing really that I asked them (the health care workers) or that was a sufficient matter of concern for me to ask them.]

### **Supportive literature:**

Mularski (2008:678) states that the optimisation of care must involve the contribution that can be made by the patient's family or significant other, and that it requires a multi-disciplinary team to facilitate an effective "patient-family-centered" style of communication. This assertion is supported by Curtis and White (2008:835) when they note that family members are able to act as surrogates for the patient when decisions are made about the goals of care and therapy, if the patient herself is unable for whatever reason to exercise this capacity. Eckle and MacLean (2001:238) also confirm the importance of family and significant others in health care services and state that the inclusion of these people in, for example, patient education, requires significant changes to the paradigms that influence current philosophical, practice and environmental medical orthodoxies.

### **3.2.3 Theme 3: Timeframe**

The amount of time that participants spent in the emergency care environment emerged as one of the main themes during the interviews, with the mention of waiting times specifically. The researcher categorised this theme internally according to the different areas in which the survivors were managed so that she would be able to establish exactly where improvement could be made in future practice.

### 3.2.3.1 Waiting times

The waiting times endured by patients throughout the management process have been described by all of the participants as a trying experience. Some experienced it to be of concern only in one of the management areas, but most of the participants agreed that the overall waiting time was too long.

- **Reception area**

Two of the participants described how they had to wait in the reception area before they were attended to by an A & E nurse practitioner or doctor. They said:

•...jy het jou nagklere aan want jy mag nie ander klere aantrek nie, en jy is in so 'n toestand. Toe was ek by die ontvangs gewees en hulle het vir my gesê ek moet daar in die wagkamer sit. En toe het hulle (gesondheidswerkers) my later na 'n familie kamertjie toe gevat. [Translated: You have your nightie on because you may not put on other clothes, and you are in such a state. Then I was at reception and they said to me that I must wait in the waiting room. And then later they (the health care workers) took me to a small family room.]

•...ek het nie dadelik deurgegaan (na A & E eenheid) nie. Hulle (gesondheidswerkers) het vir my koffie gebring terwyl ons (pasient en familie) gewag het. Toe sê hulle (gesondheidswerkers) hulle kry 'n berader en hulle het die dokter gebel. Dit was omtrent sewe uur die oggend. Toe later toe kom hulle (gesondheidswerkers) toe sê hulle vir my ek kan maar deurgaan na die kamer toe waar hulle die ondersoek doen. [Translated: I did not immediately go through (to the A & E unit). They (the health care workers) brought me coffee while we (the patient and her family) waited.]

They (health care workers) said that they will get a counsellor and that they have phoned the doctor. It was about seven in the morning. Later they (health care workers) came and told me that I can go through to the examination room.]

Another participant, by contrast, participant was taken immediately into the A & E unit:

•...*ek is dadelik ingevat.* [Translated: I was taken in immediately.]

### **Supportive literature:**

Sharon (2008:1) states that there is a correlation between how long patients have to wait to see a physician, and the nature of the outcome. But waiting time is a problem in health care services throughout the world. CBC News (2007:1) states that the Prime Minister of Canada addressed the problem of waiting times after the medical profession in his country had drawn his attention to it at a local conference.

- **A & E unit**

The participants remarked that waiting times were frequently extended, often without any apparent purpose, and with no explanations as to what was causing the delays. The following remarks offer more details:

•...*die dokters het baie werk en is almal nie altyd beskikbaar nie en dan wag jy nou maar lank.* [Translated: The doctors have a great deal of work and they are not always available, and then you must just wait a long time.]

•...*ek het eendag verskriklik lank gewag en regtig ek wou naand huil. Ek verstaan, maar dit was nie so lekker nie.*

[Translated: And then one day I had to wait an awfully long time, and afterwards I just wanted to cry. I understand, but it was not so pleasant.]

●...jy sit net baie lank en wag vir die mense (gesondheidswerkers) om jou bloeddruk te neem. [Translated: You just sit for a long time and wait for people (the health care workers) to take your blood pressure.]

◇...en toe los hulle (gesondheidswerkers) my daar. Jy lê net daar (A & E eenheid) en nou wag jy. [Translated: And they they (the health care workers) left me there. You just lie there (in the A & E unit), and then you have to wait.]

●...dit was omtrent sewe uur die oggend....En die dokter het seker hier by tien uur eers, het sy gekom en met die ondersoek begin. So daai hele tyd lê jy daar (A & E eenheid). Hulle (gesondheidswerkers) doen eintlik niks nie. Jy weet volgens wat jy nou sien op TV en wat jy lees, jy mag nie toilet toe gaan nie, maar... [Translated: It was about seven o'clock in the morning. And the doctor first came at about 10 o'clock to begin the examination. And so for that whole time you have to lie there (in the A & E unit). They (the health care workers) actually do nothing. What you know is what you see on television and what you read. You are not allowed to go to the toilet, but...]

●...maar daar was lang rukke wat ek alleen was. [Translated: But there were long periods when I was alone.]

●...ek weet nie hoekom die wagtydperk so lank is nie. [Translated: I don't know why the waiting period is so long.]

Although one participant mentioned that she had not waited long to be treated, she had presented with an acute anxiety attack without being able to express its origin. And this particular participant also did not have to undergo the forensic examination because too much time had already passed since the rape incident. She reflected as follows:

●...I didn't wait long because I wasn't speaking at first, I was struggling to talk but they (health care workers) were patient with me. At that moment (on arrival) I was unconscious. So no, like I said, everything was quick, nothing was delayed.

### **Supportive literature:**

It was noted earlier in the text that a timely examination can confer specific benefits on the rape survivor: it can minimize trauma, promote healing and help to address their immediate concerns (Lewis-O'Connor et al. 2005:269). It can be therefore concluded that this is one theme that suggests a most needed and feasible improvement in management procedures.

While the reasearch of Shin and Moon (2007:244) showed that many patients with disabilities received delayed care when a little extra effort on the part of the health care workers could have speeded up the process, the reasons for this are not discussed by them. The Avalon Sexaul Assault Centre (2008:2) reports that because the forensic examination itself usually takes at least two hours to complete, health workers should ensure that the waiting time before the examination commences is minimal.

Milanian (2008:1) noted that, in one health care service, the waiting times in the A & E unit varied from one to seven hours, depending on factors such as the weather, the influx of patients, the age of patients and the type of disease that needed to be treated. Pitts (2008:1) notes that although a waiting time of one hour or more has come to be expected during the last few years, this may not be typical of the experience of every patient. Even though many patients know that emergency rooms everywhere are notorious for their long waiting times, many patients nevertheless decide to leave before being assessed by health care workers (Mackey & Cole 1997:1).

- **Laboratory results**

The waiting time for blood test results after a rape cause rape survivors to experience significant distress. They also kindle a whole set of other emotions that might not be directly related to the rape itself. Participants described experiencing feelings of anger, anxiety, uncertainty and despair before a feeling of relief receiving favourable test results returns. This is supported by the following statements:

- *...ek meen jy is so nervous as jy daarso (in A & E eenheid) sit, jy weet nie....* [Translated: You are so nervous while you are sitting there (in the A & E unit). You do not know...]

- *...’n dokter het met my kom praat en vir my gesê die uitslae (bloed uitslae) is negatief – wat natuurlik vir my heel verblydend was – want daai dag gaan jy om ’n doodsvonnis te kry.* [Translated: A doctor came to speak to me and tell me that the results (of a blood test) were negative. This naturally made me feel very happy because on that day you go to get a death sentence.]

- *...so vir ’n jaar lank het jy daai idee van HIV positief wees. Dan sê sy (suster) vir my "het jy support?. Ok, ek weet hulle (gesondheidswerkers) moet dit doen, dan sê ek vir haar ja, dan sê sy vir my "nou wat gaan jy doen as hierdie ding (bloed uitslag document) wys jy’s HIV positief?"* [Translated: And so for a whole long year, you have the idea that you are HIV-positive. Then she (the nursing sister) said to me: "Do you have support?" OK, I know that they (the health care workers) have to do it. Then I said to her, "Yes." Then she said to me, "Then what are you going to do it that paper (the blood test results) show that you are HIV-positive?"]



•...en in my mind was ek oppad om HIV positief getoets te word....Jy weet dis wat jy aan dink.....nou's dit jou lewe, gaan jy HIV positief toets? En al die tyd lê jy daar (in A & E eenheid) alleen met hierdie gedagtes en hulle (gesondheidswerkers) gee vir jou niks om jou gedagtes stop te sit nie."

[Translated: In my mind I saw being listed as HIV-positive. You know that that is what you think about. Now this is your life. Are you going to test HIV-positive? And all the time I was lying there alone (in the A & E unit) with these thoughts, and they (the health care workers) do nothing to change your thoughts.]

•...hulle (gesondheidswerkers) sê HIV kan in die tiende maand opduik iewers. So jy kan dalk vir nege maande dink jy's fine en dan skielik sê hulle (gesondheidswerkers) dis daar. So hulle sê dit vir jou, maar dan kom jy daar (by A & E eenheid) om jou resultate (bloed uitslae) te kry dan laat hulle jou voel...jy weet, is jy nou, is jy nou nie? Wat gaan aan?"

[Translated: They (the health care workers) say that HIV can emerge somewhere in the tenth month. And so you can think that you are fine for nine months, and then suddenly they (the health care workers) will say that it is there. And so they tell you. And then you go there (to the A & E unit) to get the results (of your blood test), and they may make you feel.... Are you, or are you not? What is going on?]

•...toe ek daar (A & E eenheid) uitgestap het toe het ek gehuil toe ek uitvind dis (bloed uitslae) negatief. [Translated: Then when I left there (the A & E unit), I was crying when I found out that it (the blood test result) was negative.]

•...jy dink in jou agterkop miskien is dit (bloed uitslae) positief, dalk weet sy (suster) iets wat ek nog nie weet nie! [Translated: In the back of your mind you think that perhaps it (the blood test) is positive, and that perhaps she (the nursing sister) knows something that I don't know.]



### Supportive literature:

Queenan (2008:744) states that patients should not have to wait as long as they often do to receive their laboratory results from the physician. Such delays engender feelings of frustration and dissatisfaction on the part of the rape survivor, and such feelings stimulate their anxiety. Sharon (2008:1) also discusses long turn-around times for laboratory results and observes how harmful they can be to a patient. He mentioned examples of waiting up to four hours in the A & E unit for a test that should take no more than ten minutes to perform. He lists some of the factors that influence waiting times as being the fact that specimens sometimes do not get to the laboratory in time (or else that they arrive later than expected), and that most laboratory facilities are incapable of delivering on the demand (Sharon 2008:1-2). Castro (1993:1) also identified laboratory tests as one of the main variables in his research because of the prolonged waiting times in the emergency care environment.

- **Multi-disciplinary team**

Waiting time was also an issue for some of the other parties in the multi-disciplinary setting. One participant mentioned having to wait for the police, and another mentioned having to wait in the pharmacy during a follow-up visit. The first participant reported it thus:

•...baie lank ook hoor, het hulle (polisie) my besig gehou. Ek moes als vertel en... [Translated: It was for a long time that they (the police) kept me busy. I had to tell him everything and...]

One participant described her waiting times in the following way (the researcher has summarised her experiences because direct communication was difficult). She arrived at the police station at about half past eight in the evening and waited there until after midnight. She



then went on to wait in the A & E unit until past three o'clock the following morning. In both the police station and the A & E unit she experienced significant waiting periods.

While an initial amount of medications is given to all participants in the A & E unit after the first consultation, the statement (below) by a participant describes her experience in one of her follow-up visits:

•...ek moes apteek toe gegaan het en hulle (aptekers) het baie lank gevat om die pille vir my te gee! [Translated: I had to go to the pharmacy and they (the pharmacists) took a very long time to give me my medication!]

Waiting times like this suggest that enormous improvements could be made in A & E procedures.

### **Supportive literature:**

Cronin (2005:87) made a particular study of emergency assessment times and his conclusion was that a variety of improvements could result from more efficient team work and having a direct referral process in place for expediting the care of emergency patients. In Sharon's report on emergency room waiting times (2008:1-3), he states that current patient-flow rates leave a lot to be desired. Sharon notes that if one patient is forced to wait for something to be accomplished by management for two hours, then two hours needs to be added onto the waiting time of the next patient (who is also waiting in the reception area for attention and treatment). Waiting times thus become incremental and each patient in a line is affected adversely by delays in treating patients who precede him or her. It is for this reason that improvements in the performance of every member of a multi-disciplinary team are essential if one is eager to implement more efficient treatment and care of people who present with medical conditions (Sharon 2008:1-3). Littel (2004:4) urges all health

care workers to give rape survivors priority in emergency care treatment and thus to respond to them as quickly as possible.

### 3.2.4 Theme 4: Multi-disciplinary team

The multi-disciplinary team members, which includes anyone who is involved in the management process after a rape, emerged as a major theme during the interviews, and their attitudes, competence and presence emerged as important thematic categories in the study.

#### 3.2.4.1 Attitude

The attitude of the various members of the multi-disciplinary team will be discussed here because many participants commented on it.

- **Health care workers**

The health care workers in the study included all those who were involved in the management of the physical, mental and social health of a participant. They thus include the reception personnel at the A & E unit, the A & E nurse practitioner, the doctor and the counsellor. (The police are not included in this category and will be described separately.)

#### **The reception personnel**

The personnel at reception were experienced by participants as both friendly and compassionate:

• *...die mense by ontvangs area was ook baie nice en hulle het ook gesê ons (pasient en ma) moet eers gaan eet en wat ook al, en gaan dink daaroor.* [Translated: The people in the reception area were also very nice, and they also said to us (the patient and her mother) that we should first go and eat and do what ever, and think over it.]



•...by die hospitaal gekom en die personeel (gesondheidswerkers) was baie gaaf... [Translated:...got to the hospital and the staff (the health care workers) were very nice.]

### **The A & E nurse practitioner**

Most of the participants experienced A & E nurse practitioners as sensitive, caring and friendly, and they should be commended for these qualities. Some of the following participant remarks made this clear:

•...almal (gesondheidswerkers) was vriendelik, daar was net bietjie baie (gesondheidswerkers) gewees... [Translated: Everyone (the health care workers) was friendly. There were just a large number of them (the health care workers).]

•...hulle (susters) was regtig baie sag en simpatiek en hulle het ook elke keer gesê wat hulle (susters) gaan doen met die toetse, hulle het mooi vir my gesê, so ek het presies geweet. [Translated: They (the nursing sisters) were really very soft and sympathetic, and they (the nursing sisters) also explained every time what they would do with the tests. They told me so nicely that I knew precisely what was happening.]

•...ja, they gave me something at the hospital, they give me the shower, they give me the panty.

•...die suster was by was, sy het my regtig laat beter voel oor die hele saak. Sy (suster) het mooi alles verduidelik en al dit." [Translated: The sister that was with me, she really made me feel better about the whole matter. She (the nursing sister) explained everything nicely, and all.]

•...toe ons (pasient en familie) daar (A & E eenheid) aangekom het was die susters baie nice. En hulle (susters) het die healtyd...ek het koud gekry



*– soos ek het gesit en bewe – en hulle het vir my soos 'n kombes gebring en my toegemaak... [Translated: When we (the patient and her family) arrived there (at the A & E unit), the nursing sisters were very nice. And they (the nursing sisters) the whole time... I became so cold that I was sitting and shivering, and they brought a kind of blanket and put it around me.]*

• *...dan sê hulle (susters) vir my hulle weet ek sien counsellors en hulle weet dis vir my moeilik, is daar iets waarmee hulle kan help... [Translated: Then they (the nursing sisters) said to me that they knew that I was seeing counsellors and that it was difficult for me, and was anything they could help me with?]*

• *...and just the smile on her (A & E nurse practitioner) face, just the smile on her face made me feel so comfortable.*

• *...she (A & E nurse practitioner) held my hand and said...*

• *...all that time I told her (A & E nurse practitioner) what had happened and she listened. She (A & E nurse practitioner) also took a chair and sat down with me and she listened.*

• *....weet jy, die suster wat daar by my was het baie mooi met my gepraat – die kere wat sy met my gepraat het – het sy regtig baie mooi met my gepraat. Sy het net Engels gepraat want sy kon nie Afrikaans praat nie, so ek moet regtig sê, sy was baie caring as sy daar was, maar sy het net gedoen wat sy moes doen. Sy het nie meer gedoen om my te kalmeer of om vir my eers 'n glas water aan te bied nie. [Translated: Do you know, the nursing sister that was there with me spoke to me nicely, the number of times that she really spoke with me. She only spoke English because she could not speak Afrikaans. But I must really say that she was very caring when she was there, even though she was only doing what she had to do. She did nothing extra to calm me or to offer me a glass of water.]*



There were only two of the participants who experienced the A & E nurse practitioners in a more negative way. These respondents reported as follows:

•...jy lê daar, hulle (gesondheidswerkers) gee nie vir jou iets om te drink nie, en hulle behandel jou nie vir skok nie. [Translated: You are lying there. They (the nursing sisters) give you nothing to drink and to treat you for shock.]

•...die een suster, dis die enigste een - maar dit was nie daai dag (eerste besoek) nie, dit was na die tyd (opvolg besoek) gewees - toe was daar een suster wat ek nie... [Translated: The one nursing sister, she was the only one. But it was not that day (of the first visit); it was after the time of the follow-up visit. Then there was one nursing sister that I did not...]

•...as ek nou gaan vir my check up, en ek gee my kaart, dan kry ek nou my bloedtoets uitslae en wat ook al. Maar terwyl ons (pasient en vriend) wag vir die bloedtoets uitslae moet hulle (gesondheidswerkers) nou ...hoe kan ek sê... soos 'n counseling sessie met my hê. Die counseling sessies wat hulle doen met jou...die een suster was ek nie so baie fond of nie, sy het my op 'n manier laat voel dis my skuld. [Translated: When you go for a check up, and you hand in your card, then you get the blood test results and whatever. But while we (the patient and her friend) wait for the blood test result, they (the health care workers) must... How can I say? Have like a counselling session with me. The counselling sessions that they do with you... I was not so fond of the one sister. In a certain way she made me feel that it was my fault.]

### **The doctor**

Although the doctor was described by those participants who mentioned him/her as being friendly and patient, it should however be noted that the A & E nurse practitioner was repeatedly identified in all the interviews as



the main caregiver throughout the management process. Most of the participants only identified a doctor for his or her role in the forensic examination. They remarked on the doctor's attitudes as follows:

- ...*dokter is altyd vriendelik*. [Translated: The doctor was always friendly.]
- ...*dan smile sy (dokter) net en vra hoe gaan dit...* [Translated: Then he (the doctor) smiled and asked how it was going.]
- ...the doctor was patient...

### **The counsellor**

As was the case with the reception personnel, the participants experienced the counsellors in a positive light. Only two of the participants mentioned the counsellor, and subsequently made the following observations:

- ...*maar sy (berader) was nice*. [Translated: But she (the counsellor) was nice.]
- ...*ja, he's (counsellor) a nice guy*.

### **Supportive literature:**

Ahrens (2006:263) says that rape survivors who speak about their assault experiences often feel "punished" for doing so when they encounter negative reactions from their support providers. When rape survivors are subjected to victim-blaming behaviour or attitudes, they may experience these verbal attacks and attitudes as a "secondary assault" that adversely affects their prognosis for recovery (Ahrens 2006:264). Ahrens notes that merely speaking out may therefore have severely detrimental consequences for rape survivors if they are subjected to further trauma at

the hands of the very people to whom they have turned for help. It is therefore imperative for all health care workers to take time to review the way in which they approach rape survivors, and the appropriateness of their methods of conveying results and general information.

One of the A & E nurse practitioners reacted negatively, as the participant felt that she had been blamed and insensitively treated and that she had received inappropriate support. Lewis-O'Connor et al. (2005:268) also emphasize that rape survivors should be the object of compassionate and understanding care. Khantzian (2008:1355) points out that one of his colleagues is convinced that the "connection" that is established with the patient (i.e. the rapport between the practitioner and the patient) is the most important element in working with that patient, regardless of their condition or any other extraneous factor. The researcher is of the opinion that a friendly, relaxed and sympathetic but businesslike attitude will dramatically increase the regard that rape survivors feel for health care workers and that this will improve treatment outcomes.

Garimella, Plichta, Houseman and Garzon (2002:1262) investigated the attitudes and feelings engendered in physicians when they treat the female survivors of partner violence inflicted by someone with whom they have been intimate. It is interesting to note that most physicians entertained very negative feelings towards the treatment of rape survivors when the rape has occurred in a domestic setting. Garimella et al. did not report on whether their attitudes towards the treatment of people who had been raped in non-domestic situations were also so strongly negative.

Since any treatment of the survivors of violence is frequently stressful, difficult and fraught with negative emotions, one may tentatively assume that the treatment of rape survivors (whatever their history) also engenders negative feelings and attitudes in the physicians who treat them in the A & E setting – although this hypothesis would have to be proved by further research. Girardin (2005:130) also reports on this topic and supports the assumption that emergency department staff are often





hesitant to offer care to rape survivors. This may happen for many different reasons which include the length of the contact time during the forensic examination, frustration at having to comply with the requirements for the collection of valid evidence, the possibility of having to give evidence at a rape trial, and the way in which the amount of time that has to be dedicated to rape survivors diminishes the amount of time that physicians can offer other patients in need of other types of care. This might explain why the participants make far more mention of the A & E nurse practitioner than the attendant physician in this study.

According to the Avalon Sexual Assault Centre (2008:4), the attitude and response of emergency health care workers might vary in a designated aftercare facility for rape survivors for reasons that include the stress and frustration that can be engendered by each of the following factors:

- > the number of personnel on duty
- > the urgency of other emergencies being treated at that time
- > difficulties in obtaining forensic evidence collection kits
- > the responses of police
- > the availability of someone who is qualified to perform the examination.

- **The police**

The participants' experiences with the police ranged from extremely positive to extremely negative. Arrogance and insensitivity were mentioned in the continuum of negative attitudes:

- *...toe ons daar (polisie stasie) kom toe is hulle (polisie offisiere) nou baie arrogant.* [Translated: When we got there (to the police station), they (the police officers) were very arrogant.]
- *...want ....(dorp) polisie stasie was pateties.* [Translated: Because the (town) police station was pathetic.]

•...en toe die polisie nou daar aankom in die hospitaal in die ondersoek kamer sodat ek nou seker maar die vervolgingsklag moet onderteken, hulle was slap daarin. Hulle (polisie) moes dit gedoen het toe ek die verklaring afgelê het. [Translated: And when the police arrived in the examination room at the hospital (probably so that I could sign the prosecution allegation), they were very casual. They (the police) should have done it when I laid the charges.]

When the researcher probed the latter participant about her attitude to the police, she confirmed the researcher's comment that they could have been more sensitive to her specific case because it also involved a murder.

Another one of the remarks from a participant was:

•...soos ek gesê het, hulle (polisie stasie) was useless.... [Translated: As I have said, they (the police station) were useless.]

This same participant nevertheless experienced the attitude of the police as being totally different when the police from another station later arrived at the scene of the crime. The positive attitudes engendered by this different set of police personnel doubtless helped to increase cooperation between the participant and the police and contributed to a considerable improvement in the management process. Two other participants also offered the following appreciative remarks:



•...hy (polisie sersant) was, ek dink vir my, ek kon nie gevra het vir 'n beter ou om hierna toe te kom nie. [Translated He (the police sergeant), I thought to myself, I could not have asked for a better person to come here.]

•...ja, it was nice, because it was a lady (police officer). She was so nice to me. Because that lady (police officer) was not at work that time, but she was on stand-by so they phoned her to come.

•...ja wel daar was een vrou (polisie offisier) wat ook die heeltyd soos die hele storie (verklaring) neergeskryf het en alles gedoen het, en sy was redelik vriendelik en behulpsaam. [Translated: Yes, well, there was one woman (a police officer) who wrote down the whole story (the charge), and she was reasonably friendly and helpful.]

### **Supportive literature:**

The lack of a professional attitude on the part of the police has been described by Abdool and Brysiewicz (2008:5). They have observed that the police are sometimes unable to provide a forensic examination kit and they fail to provide health care workers with case numbers and even with any details that might identify them. These difficulties were also mentioned by a participant during the interviews in which she described how she had struggled to obtain routine information from the police when she had followed up on the progress of the case a few days afterwards (this is more fully described in the communication and honesty section later in a this chapter). This problem with indifference and inefficiency on the part of many police personnel seems to be as widespread nowadays as it was when Saunders and Size described it many years ago (Saunders & Size 1986:25). While they note that law enforcement agencies and the police are sometimes able to be of the greatest service to abused women, they are all too often criticised for the manner of their response towards

survivors of abuse. These authors even observed how the victim was frequently blamed and further abused even then.

### 3.2.4.2 Competence

It is important to mention competence because some of the participants referred to it. The problem that these participants identified was that some of the health care workers seemed to be unsure of their actions and didn't always appear to understand how they should handle the situation. Fortunately, however, they were always accompanied in these situations by someone who was more experienced than they were (this is corroborated in information about the interviews). It was often difficult for some participants to identify the personnel involved in care and management. The level of self-confidence displayed by the health care workers during the management process was also remarked upon by participants during the interviews.

- **Educational level**

Two of the participants specifically mentioned that they had obtained the impression that one or more of the health care workers were either new to the job, in training or else that they lacked experience in the management and handling of rape survivors. These are remarks from two of them:

- *...ek weet nie of die ander een (suster) besig was om te leer of wat nie, maar sy was... [Translated: I don't know whether the other (nursing sister) was in the process of learning or what, but she...]*

- *...maar ek het so half die idee gekry dat hulle (gesondheidswerkers) is nog nie baie lank...hulle is taamlik nuut. Want hulle (gesondheidswerkers) het oor en weer gevra. [Translated: I more or less gained the impression*



that they (the health care workers) hadn't been long... ..that they were relatively new (to the job) because they asked a great number of questions to each other.]

### **Supportive literature:**

Kelly and Regan (2003:12) feel that it is particularly important for forensic examinations to obtain useful evidence, to offer comfort and reassurance to survivors, and to ensure that trained and skilled practitioners are on hand to perform these examinations. Kelly and Regan regard these abilities as basic prerequisites in the management of rape survivors. The harsh reality of the situations experienced by some rape survivors is, however, noted by Abdool and Brysiewicz (2008:4). They state that A & E nurse practitioners often fail to perform the basic forensic tasks required of them and that, because of this, many of the respondents in their research were never properly examined by a qualified health care worker using the forensic examination kit that is provided by the police department for the collection of forensic evidence. At the conclusion of their research into the attitudes and practices of nurses towards abused women, Häggblom, Hallberg and Möller (2005:235) recommended that a comprehensive in-service training programme for nurses would educate them to offer more effective interventions, that would promote the health of these victims of violence.

Other aspects of management such as, for example, the introduction of errors into the prescription of medications for patients, may well be ascribed to the inadequate education and training of health care workers. This assertion is confirmed by Elnour, Ellanham and Qassas (2007:182, 185) who specifically identify years of experience as a factor how well health care workers understand what they are doing, the quality of the service that they are able to render, and a reduction in the number of errors which are attributable to them.

- **Identification**

The identification of differences between various health care workers was a source of frustration and difficult for most of the participants. Although they did not mention it as a specific problem, most of the participants (in their later questions about forensic examinations and the follow-up visits) mentioned their uncertainty and inability to identify the function or status of the health care providers who were dealing with them at different times. This is reflected in the following extracts from their remarks:

- *...ek dink dit was 'n vroue dokter...* [Translated: I think that it was a female doctor.]

- *...die dokter, sy was daar gewees dink ek.* [Translated: I think that the doctor was there...]

- *...ek het nie geweet of hulle almal susters was nie...* [Translated: I didn't know whether they were all nursing sisters...]

In answer to a specific question that the interviewer asked about the doctor who had performed the forensic examination, it became evident that while one of the participants was unsure whether it had in fact been the doctor who performed it, two of the others confirmed that the doctor had indeed performed the examination.

- *...ek kan jou nie antwoord op daai vraag nie, ek weet nie of dit die suster of die dokter was nie. Daar was 'n hele paar van hulle (gesondheidswerkers).* [Translated: I can't answer that question of yours. I didn't know whether it was the nursing sister or the doctor. They were a whole lot of (health care workers) there.]



•...een suster en 'n dokter het fisies die toetse – daai kit – het die dokter gedoen, nie die suster nie. [Translated: One nursing sister and a doctor were busy with carrying out the physical tests. But it was the doctor – and not a nursing sister – who performed them.]

•...toe die dokter my ondersoek het en al dit. [Translated: Then the doctor examined me, and all that...]

### **Supportive literature:**

Monaghan and Kenny (2008:13) emphasise that the ability on the part of the rape survivors to identify the staff and their respective functions is one of the most important factors implicated in the improvement of the quality of survivor care. While the researcher does not regard the ability of the survivors to identify the particular caregiver who is performing the examination as crucial to the issue, she was concerned that participants were unable to feel any confidence in the specific health care workers who managed them in the emergency care environment. Numerous sources in the literature describe the development of education and training that is specifically designed to furnish Sexual Assault Nurse Examiners (SANE) or Sexual Assault Forensic Examiners (SAFE) with all the requisite skills and competence that they need.

The benefit that flows from having a designated health care worker who coordinates the management and referral of rape victims is described by Kelly and Regan (2003:14). They state that when examiners are highly skilled and dedicated, and when they are better situated to provide a female examiner for female rape survivors, these factors increase the likelihood that service will be prompt and that the treatment of the survivor will be better managed. Littel (2004:6) supports the development of courses that will be able to improve the knowledge, skills and attitudes of post-traumatic examiners. She further recommends advanced education, a period of supervised clinical practice and the specific



recognition of properly trained nurses, in the form of certification for those who have completed an accredited course of theory and practice that has been especially designed for examiners (2004:6).

- **Confidence**

The confidence that is required to manage and handle a rape survivor is not a skill that is easily taught. As each case is unique and therefore different from any other case, many health care workers have admitted to the researcher that – even after extensive experience in this field – they often feel uncomfortable and unsure of themselves when they are required to treat rape survivors. Two participants deduced this lack of confidence from the observation that the attendant health care workers asked one another for information and assistance, that they sometimes seemed unsure about what to do, and that others were simultaneously preoccupied with other problems that also required their attention. This is what they said:

• *...ja, dat hulle (gesondheidswerkers) nie gekonfyt is met die storie (mediese hantering van oorlewendes) nie....miskien een nuwetjie...* [Translated: Yes, they (the health care workers) were not familiar with the story (the medical treatment of survivors). There was just one new one who might have been...]

• *...maar eintlik was ek beseer. Ek is met die pistol teen my kop geslaan. Niemand het my ondersoek om te kyk of ek enige beserings het of soos ek sê, vir skok behandel nie. En dit is vir my 'n ding wat hulle (gesondheidswerkers) definitief moet na gaan kyk.* [Translated: But I was actually injured. I had been hit with a pistol against my head. No one examined me to find out whether I had sustained any injuries or (as I said) whether I had been treated for shock. That is something that they (the health care workers) should definitely look into.]





### **Supportive literature:**

Baker and Sommers (2008:228) states that the detection of physical injury is one of the most important requirements of the forensic examination because of its potential role in subsequent criminal justice proceedings. But, as was noted earlier in the discussion about the forensic examination itself, the stress inflicted on the physician by the necessity of working with an unfamiliar but nevertheless crucially important forensic examination kit, might well cloud their ability to describe and manage other injuries that might seem less important in the context of what has happened. Ledray (2008:18) notes that observations have shown that very few survivors of rape have also sustained other injuries, and that in those cases where such injuries had been sustained, they are in all probability less serious than the physical injuries inflicted by the rape itself. These observations have been confirmed by Rosay and Henry (2008:5), who note that non-genital injuries often secure a more satisfactory conviction rate for perpetrators than genital injuries, as genital injuries can also occur in the context of consensual sexual activity. But because consensual sexual activity will rarely precipitate non-genital injuries, the forensic examiner's documentation should clearly identify all injuries that are observed on the body of the patient.

Abdool and Brysiewicz (2008:1) note that the care of crime victims in the emergency care environment in the RSA have given rise to new challenges for A & E nurse practitioners, and that these new challenges involve the acquisition of the necessary skills and knowledge to provide comprehensive care for the victims of violence, and for rape survivors in particular. Abdool and Brysiewicz (2008:1) note that the Gauteng Department of Health (which is responsible for the same geographical area as that in which this study was conducted) is currently prioritizing the training of forensic nurses (2008:4) – a form of training that will ultimately imbue such nurses with the necessary confidence and knowledge to manage the survivors of rape. Raising the confidence levels of the personnel that perform this kind of work would obviously reduce the

severity of the problems that are being encountered with forensic examinations at the present time. Ledray (2008:4) describes these problems as:

- >being inadequately trained
- >being insufficiently experienced to offer and maintain acceptable levels of proficiency
- >the failure on the part of the staff to recognise, collect and preserve vital forensic evidence
- >the failure of the staff to recognise and document subtle physical manifestations that may nonetheless proved to be extremely important at a later stage.

### **3.2.4.3 Presence**

“Presence” in the context of the multi-disciplinary team setting described here, refers to the actual physical presence of any member of the team in the A & E unit during the initial visit, and thereafter at follow-up visits as well. The research identified the fact that it was the counsellors, the police and the health care workers who formed the core of contact staff during that first few hours after the incident. Although these contact sessions might have seemed fragmented to an outside observer, most of the participants described how all the members of the team mentioned above, were in some way or another, involved in the management process.

- **Team members**

Different members of the team were involved in the initial management of the participants. The core of this group included the health care workers, counsellors and the police. The remarks below bear this out:



- *...ons het counsellors gesien. Ons het eers 'n man (berader) gesien en toe na die tyd...* [Translated:] We saw the counsellors. We first saw a man (a counsellor), and after that...]
- *...en dan het die beradertjie toe later ingekom en met my gesels.* [Translated: And then a young counsellor came in later and spoke to me.]
- *...ja, die sersant was heeltyd daar (A & E eenheid).* [Translated: Yes, the sergeant was there the whole time (in the A & E unit)]
- *...ja, the police. They (police) take me to the hospital.*
- *...ek moes hulle (polisie) als vertel en toe kom hy (polisie offisier) nou daar by die hospitaal aan.* [Translated: I had to tell the police everything, and then afterwards he (a police officer) arrived again at the hospital]

### **Supportive literature:**

Kelly and Regan (2003:6) state that research in United States has identified best practice. This includes the fact that the initial statement taken from the survivor should be given in the presence of the police, the medical examiner and the patient's advocate. This helps to eliminate the increasing exhaustion that might overwhelm the survivor if she has to repeat her account of events a number of times to different members of the team.

- **Importance of presence**

The value and importance of the presence of the counsellors were discussed with the participants in the interviews. Two participants felt that no counselling at all had actually taken place during the counsellor's first visit. These two participants reported that they were merely requested to describe what had happened. They also added that follow-up sometimes

fails to take place or remains uncompleted. Extracts from their remarks include:

•...*ek moes vir die counsellor verduidelik...* [Translated: I had to explain everything to the counsellor]

•...*weet jy, sy (berader) het nie vreeslik uitgebrei nie, ek dink sy het gesê sy kom ons sien by die huis of waar ook al, so sy het nie regtig...* [Translated: Do you know, she (the counsellor) did not give very many details. I think that she said that she would come to see us at our house or wherever, and so she did not really...]

In contrast to what was said by the two participants above, other participants regarded the visit of the counsellor as both beneficial and helpful. Although one of these participants in fact acknowledged that no detailed counselling about the incident occurred during the counsellor's initial visit, it had been comforting to her to know that the opportunity to consult a counsellor would have been there in the future. She also added that the counsellor had given her some general information about HIV transmission. Here are extracts from what they said:

•...*maar dit was goed. Jy weet, die gedagte dat daar is iemand (gesondheidswerkers) wat aan daai sy (emosionele ondersteuning) ook aandag gee...* [Translated: But it was good. You know, the knowledge that there is someone (the health care worker) who is giving her attention to that side of things (emotional support)...]

•...*ok jy praat baie daarvan (insident). Dit is nie maklik nie. Dit was vir my...ek weet nie, ek dink hoe meer ek daaroor (insident) praat hoe beter raak dit vir my.* [Translated: OK, you are talking a lot about that (the incident). It's not easy. For me it was, I don't know, the more I think about it (the incident), the greater it gets for me.]



### **Supportive literature:**

The importance and value of utilising a multi-disciplinary team approach in patient management is undeniable. Lawley and Bestly (2003:464) list the advantages of the multi-disciplinary team approach as providing: additional quality and depth in the clinical discussions, greater job satisfaction for all concerned, and an overall improvement in the quality of service. While Lowe and O'Hara (2000:269) also describe the benefits of a multi-disciplinary team approach in the framework of client-focused service provision, but they warn health care workers that adapting their ways and methods to incorporate these novelties, would require a fundamental reappraisal of the roles of all those who are involved.

- **Referral**

After the initial A & E visit, further referrals are possible. Some of the members of the team who have something to contribute to the post-rape management process will not be present in the A & E unit when the initial contact between the rape survivor and the unit is made. Such people might, for example, include members of important support groups. The referral options after the initial A & E visit will be discussed under this particular sub-category. The participants might have contact sessions with health care workers such as counsellors at a later stage during the follow-up period. But since the counsellors are only remunerated by the hospital for their initial visit to the rape survivor, any additional follow-up visits by counsellors will have to be arranged between the counsellor and the rape survivor, at the cost of the rape survivor. These additional counsellor contacts that occur at the rape survivors' expense will not however be discussed under this sub-category because they are not form part of the normal referral procedure that has been adopted by the A & E unit.

The availability of support groups came to the fore in interviews when one of the participants mentioned that she had joined one. Some of these support groups can be extremely beneficial when other counselling options



are limited, as it might be applicable in most health care services. The participant explained it thus:

•...jy voel as dit met jou gebeur almal (ander oorlewendes) gaan nou vir jou vertel van hulle stories, maar jy voel "wat van my"? Dit het met my gebeur! Maar vir my was dit op 'n manier beter om ook van ander mense (ander oorlewendes) te hoor dan voel jy jy's nie alleen nie. [Translated: You feel that if it happens to you, then (other survivors) will also tell their stories. But then you feel, "What about me?" It happened to me! But for me it was also better, in a way, to hear the stories of the other people (the other survivors). Then you feel that you are not alone.]

It has already been mentioned that the follow-up counselling sessions after the initial A & E contact have to be initiated by arrangement between the counsellors themselves in the rape survivors, if a counsellor feels that a particular patient urgently needs additional sessions, or if a patient actually requests additional counselling. The remarks below indicate that some of the participants were given an opportunity to see a counsellor again while others were not. It was the researcher's observation that most of the participants would have preferred to see a counsellor again after their initial to the A & E unit. One participant described how she had the opportunity to see the counsellor again after the initial contact on the day of the incident. While she described that this second contact experience had been positive, other additional visits might have been prevented by difficulties caused by distance and time schedules.

•...ons het haar (berader) gaan sien eenkeer, en dit was nogal OK, maar dis bietjie ver en hy (vriend) werk en ek kan nie elke keer soontoe ry nie. [Translated: We went once to visit her (the counsellor), and it was really OK. But it is a bit far, and he (the friend) works, and so I can't travel there every time.]



•...seker so vier keer het ons die counsellors gesien. [Translated: We probably saw the counsellor four times.]

•...ja, this counsellor told me if I want support I must phone her, but I have got no number for her.

Further questioning on the benefits of counselling on the part of the researcher elicited the remark from the participant mentioned above, that she would have liked to have made further contact with the counsellor who had made the initial contact with her. (Although he was a male, the participant referred to him as "her".)

Other referral options might include the sketch artist from the police services. Two of the participants mentioned this during their interviews. Extracts from their remarks are recorded below:

•...after that thing, the police phoned for me to go there (police station) to draw the face....but they (police) didn't phone me again until now.

•...ek wil nie die heelyd oor en oor vir mense sê wat het gebeur nie. Ek moes dit hier (tuis) verduidelik het, ek moes dit by die hospitaal verduidelik het, ek moes vir die polisie verduidelik het, ek moes vir die sketch vrou verduidelik het, en so na dit is jy nie meer lus hiervoor nie. Ek moes vir die counsellor verduidelik... [Translated: I don't want to keep having to repeat to people what happened to me. I had to tell the whole story here (in the house); I had to tell the whole story to the police; I had to tell the story to the woman who does the (forensic) sketches. And so, after all that, you have no further inclination to repeat the story yet again. And I had to tell the whole story to the counsellor...]

### **Supportive literature:**

Referral has become less frequent as almost all specialities have become more developed, with the result that doctors and health care workers are less likely nowadays to need experience in specialities outside their own fields of expertise (Bayam et al. 2008:623). Bayam et al. add that the communication between the practitioners of various branches of medical science continues to be important. They remind us that the success of the team approach is based on the ability to communicate constructively and respectfully with all other members of the team (Bayam et al. 2008:625).

The Fort Wayne Sexual Assault Treatment Center (2008:1) also emphasises the importance and benefits that flow from the kind of comprehensive patient care that can only occur when various kinds of health care service providers cooperate in a team. While Ledray (2008:10) also recognises the importance of the multi-disciplinary team approach, she emphasises that the advantages of conducting joint interviews with rape survivors. Such interviews might include, for example, a variety of health care workers and the police. The purpose of the joint interview (rather than a number of serial one-on-one interviews) is that they will reduce incidence of discrepancies in the survivor's account of events, and will also reduce the number of times that the survivor has to submit herself to questioning (which, in itself, is a source of additional stress for those who have been a raped).

### **3.2.5 Theme 5: Privacy issues**

Since the theme of privacy is important to people who have been criminally violated and injured in the most private and intimate part of their human nature, the researcher fully expected that this theme would prove to be a source of major concern and interest to the participants. Their reactions are discussed below.



### 3.2.5.1 Reaction to incident

Since each person's reaction to a traumatic incident is unique, one can only understand the reaction of individuals to violent crimes such as rape by trying to understand how the trauma to which they were subjected, has violated their sense of privacy and integrity. A discussion of the various aspects of the participants' responses to the rape incident follows below.

- **Patient response**

The symptoms with which the participants presented in the hospital in the aftermath of the rape included varying degrees of withdrawal, confusion, dissociation, irritation, shock and despair. If a health care worker were to fail to recognise and acknowledge the normality of symptoms such as withdrawal, for example, and if she did not make allowance for such manifestations, then the health care worker might react to the survivor in a way that the survivor might interpret as insensitive, invasive, callous – or worse. It is therefore vitally important to evaluate the symptomatic reactions of an individual survivor and to adapt one's approach to make allowance for such symptoms. Here are some of the remarks made by participants on this topic during interviews with the researcher:

• *...ja wel ek was bietjie kortaf gewees. Nie regtig geantwoord nie, net ja en nee gesê. Nie op daai stadium lus om vrae te antwoord nie.* [Translated: Well, yes, I was a bit irritable. I wasn't really answering, but just saying "yes" and "no". At that stage I didn't feel inclined to answer questions.]

• *...kan nie onthou nie.* [Translated: I can't remember.]

• *...party mense wil hê jy moet hulle troos as hulle huil. Ek is nou net een van daai tipe, as ek huil los my uit. Jy weet?*



[Translated: Some people want you to comfort them when they cry. But I am one of those people who, when I am crying, you must just leave me alone. Do you know (what I mean)?]

- ...*ek het my maar toe gehou...* [Translated: I just kept myself closed.]
- ...*onthou mens is geskok. Jy's verward, jy's...* [Translated: Remember that a person is shocked, you are confused, you are...]
- ...*ek weet nie of dit nou maar eintlik toe is wat die ding my eers eintlik getref het, maar toe ek daar instap toe begin ek huil....En nêrens in die proses – hulle(gesondheidswerkers) sê vir jou jy moet berading kry, maar hulle (gesondheidswerkers) gee nie vir jou 'n kalmeer pil of so iets nie.* [Translated: I don't know whether it was at that point that the whole thing finally hit me, but when I walked in there, I just began to cry... But nowhere during the process do they (the health care workers) tell you that you must get counselling. They (the health care workers) don't even give you a pill or something to calm you down.]

### **Supportive literature:**

It is apparent that the participants are describing their initial reactions and feelings in the extracts recorded above. It is important to note that other symptoms and syndromes might make their appearance during the latter stages of coping with the consequences of rape. These might include signs and symptoms of post-traumatic stress disorder (PTSD) and severe depression. Boykins and Mynatt (2007:876) support this assertion, and claim that the use of a weapon used during rape tends to increase the likelihood of the development of PTSD and severe depression in survivors. This fact has also been documented by other studies. It is important to take these factors, like whether a rape survivor has been extensively threatened by weapons, into account when evaluating the emotional state and the mental health of rape survivors from as early as the first

visit that the survivor makes to the A & E unit, as well as on follow-up visits.

Given the high incidence of female rape in the RSA (the highest per capita incidence of rape in the world for any population), and the consequent likelihood that the survivor will present with the symptoms of PTSD and severe depression, effective treatment at an early stage of care might reduce the incidence of severe problems at a later stage (Resnick, Acierno, Waldrop, King L, King D, Danielson, Ruggiero & Kilpatrick 2006:2433). Resnick et al. have also warned that rape survivors who do not seek treatment after the rape event are placing themselves at an increased risk of developing distressing and disabling symptoms and conditions at a later stage. For many women, the initial A & E visit is the best time and place for reducing this risk.

Gutner (2006:813) states that many rape survivors develop a whole range of PTSD symptoms, and that the best time to forestall the appearance of PTSD is within the first week after the rape. Gutner (2006:814) explains that the various coping strategies that survivors use to deal with the effects of their trauma can be broadly categorized as **cognitive** (in which the survivor attempts to change the way in which she thinks about reality by, for example, blaming herself for the rape), and **behavioural** (in which the survivor attempts to reduce the impact of the stress and injury by engaging in, for example, withdrawal and avoidance). Street, Gibson and Holohan (2005:245) confirm that avoidant coping is one of the symptoms of PTSD.

It is evident from the discussion above that most of the responses of rape survivors seem to be behavioural (symptoms such as withdrawal, crying, avoidance and closing up). Each of these states should send an urgent message to the attendant health care workers that they need to maximize their care and support of the survivor. Gutner (2006:814) has also produced evidence to suggest that the most common coping reactions that survivors display when the perpetrator is well known to the survivor,

is sexual distress, whereas if it perpetrator is a stranger, then fear and anxiety will be the most prominent symptoms. Vinagre and Neves (2008:87) have observed that the emotions displayed by survivors, and patients in general as well, exert a definite effect on the morale and degree of satisfaction experienced by the service providers.

The recognition and treatment of the emotions that survivors manifest should therefore be a matter of priority to the health care workers during the first visit of the rape survivor to the A & E unit. Success in this area will increase the level of professional satisfaction felt by the care-giving team.

### **3.2.5.2 Personnel involvement**

The number of personnel who become involved in the management of a survivor is a matter of valid concern because it affects the amount of privacy that a survivor might expect, and, as we have already seen from the discussion above, privacy is one of the most important issues for survivors.

- **The number of people present**

Participants mentioned the presence of one to three health care workers in the room (not including the participant herself). In the following sub-category, the size of the room was also designated as a matter of concern to survivors. We may therefore deduce that the use of a small room with the presence of too many health care workers is bound to have a highly negative effect on an already-traumatized survivor, and this should therefore be a matter of serious concern to those involved in the management of survivors. The following extracts from participants referred to this problem:



- ...o ja, daar was 'n klomp mense (gesondheidswerkers) daar binne. Susters. Ja dis bietjie uncomfortable gewees. [Translated: Yes, there was a crowd of people (health care workers) in there. Nursing sisters. Yes, it was a bit uncomfortable.]
- ...dis seker maar nodig maar drie is bietjie baie. [Translated: It is probably necessary, but three (people) are quite a lot.]
- ...daar was 'n paar (gesondheidswerkers) gewees, ek weet nie of hulle almal susters was nie. [Translated: There were quite a few (health care workers) there, but I don't know whether they were all nursing sisters.]
- ...toe ons uitstap ook toe sê ek vir hom (vriend) daar was drie susters en 'n dokter. Toe sê hy (vriend) vir my "ek weet ek was daar". Ja maar drie susters! [Translated: When we were walking out, I said to him (a friend) that there had been three nursing sisters and a doctor there. Then he (my friend) said to me, "I know. I was there." Yes, but three nursing sisters...]
- ...there were two.
- ...daar was elke keer net een suster by my. Een suster en die dokter. [Translated: There was only one nursing sister who was there each time. One nursing sister and the doctor.]
- ...I was never alone in that room, I always had someone (a health care worker) by my side.

Here are two extracts from remarks made by the participants when the researcher asked them what the various health care workers were doing in the room while they were being examined:

- *...een (suster) wat geskryf het en die ander een (suster) het bloed getrek en daai ander goeters gedoen. En ek weet nie of die ander een (suster) besig was om te leer of wat nie, maar sy was... [Translated: one of the (nursing sisters) was busy writing, another was taking blood samples and doing other things, and I don't know whether the third was busy learning, but she was...]*
- *They (the A & E nurse practitioners) were helping the doctor there.*

As most of the participants mentioned that more than one health care worker was involved and present in the room with them during their management, the interviewer asked them whether the presence of so many people in the room made them feel even more uncomfortable than they already were. As seen above, some did feel as if it as a problem to them. One of the participants contrarily replied that the presence of the health care workers in the room had a calming effect on her. Another replied that their presence did not particularly bother her.

- *...nee wat, dit het my soort van kalm gemaak. [Translated: Oh no, (their presence) made me feel, sort of, calm.]*
- *...ek het nie gevoel daar is te veel mense om my nie. [Translated: I didn't feel that they were too many people around me.]*

### **Supportive literature:**

Littel (2004:35) strongly recommends that the number of people who are present in the examination room during the forensic examination should be severely limited. Littel says that she makes this recommendation because the protection of the patient's privacy should be given priority, and that, because of the physical size of the examination room, it can usually only accommodate a very small number of people without undue crowding. But she qualifies her remarks by stating that health care

workers should always bear in mind that the forensic examination is an interactive process that must also make allowance for patient's needs. One such need is frequently that the patient request that a member of her family or her significant other be present during the forensic examination.

The representatives of law enforcement agencies and police personnel should not be allowed to be present during the forensic examination. It would also be highly inappropriate to allow a group of students (whether medical or nursing) to view the examination process – even though the survivor may have consented to their presence (Littel 2004:35). Very few sources in the literature make any reference to the number of people who are present during forensic examinations, and the significance of the number of people present for the health and treatment of the rape survivor.

### **3.2.5.3 Examination environment**

Another facet of the privacy issue related to the size of the room and the amount of additional equipment in the room where the assessment and forensic examination took place in the A & E unit.

- **Room**

Although most of the participants recalled that the size of the examination room was small, none of them complained about it. But if one takes into account the fact that most of the participants wanted a member of their family or their significant other to be present during the management process, and that such a presence is regarded as beneficial, the actual size of the examination room might be a matter for concern. The remarks below referred to this problem:



- ...*die spasie is maar klein.* [Translated: The space was small.]
- ...*meeste van die tyd maak hulle (gesondheidswerkers) die deur toe in elk geval, en dis maar 'n klein plekkie...."* [Translated: In most cases, they (the health care workers) close the door, and the place is small.]
- ...*en toe het hulle (gesondheidswerkers) my later na 'n familie kamertjie toe gevat.* [Translated: And so they (the health care workers) later took me to a small family room.]
- ...*daar is nie 'n klokkie of iets nie...* [Translated: There is not even a bell in the room...]

### **Supportive literature:**

Kelly and Regan (2003:12) note that some of the basic requirements for performing the most useful and best possible forensic examination include an optimal size for the examination room. They advise the use of a private and dedicated room that is sufficiently well equipped to manage rape cases, but which has enough space for the health care workers to discuss the process and undertake whatever forms of crisis intervention the survivor and her family or significant other may need. Some health care centres such as the Fort Wayne Sexual Assault Treatment Centre, which are exclusively dedicated to the management of the survivors of rape, have every kind of specialised equipment on hand – equipment that is not available in South African A & E units (Fort Wayne Sexual Assault Treatment Centre 2008:1). Their examination room has been designed to incorporate the greatest possible level of comfort for the rape survivor, with added convenience for the examining health professional as their forensic examinations and subsequent patient education program is extremely thorough and lengthy. Ledray (2008:4) notes that the lack of appropriate equipment is one of the traditional problems that hamper thorough and conclusive forensic examinations.



Sharon (2008:3), who practises as an A & E nurse practitioner, states that it is an unfortunate fact that the dimensions of almost all the examination rooms of emergency units are too small. He is of the opinion that if patient safety, comfort and dignity had headed the list of planning priorities, all these rooms would have been larger. Larger and more comfortable rooms make it possible for the A & E nurse practitioner and all other members of the multi-disciplinary team, to manage the patient and her family or significant other more effectively, with greater convenience and with better outcomes.

#### **3.2.5.4 Patient confidentiality**

Confidentiality proved to be an issue of the greatest importance to all the rape survivors.

- **Emergency care environment**

Although the outlay of the emergency environment was described in Chapter 2, it will once again be briefly summarised here. It should include a reception area, the A & E unit itself, and all places in which the management of the rape survivor take place. The following extracts from remarks made by the survivors make it clear that they entertained contrasting views about whether or not their case had been managed with an acceptable level of confidentiality in the emergency care environment:

•...*hulle (ontvangs personeel en gesondheidswerkers) moes baie keer lank soek en hulle het my nie dadelik geplaas en geweet nie... en vir my gewys "kom mevrou, hier kan ons gesels" nie.* [Translated: They (the reception staff and the health care workers) had to spend a long time looking for things, and they didn't immediately accommodate and identify me, or say to me, "Come, Ma'am, here (is a place where) we can talk."]



●...moes elke keer by ontvangs die hele ding weer verduidelik. [Translated: I had to repeat the whole thing over again every time at reception.]

●...toe sê hulle (gesondheidswerkers) vir my as ek weer daar (by A & E eenheid) kom dan stap ek net deur, ek hoef vir niemand iets te vra nie. En toe ek die derde dag daar kom toe kon ek nie deurstap nie! Toe vra die meisietjie by die ontvangs toonbank vir my waarvoor is ek daar. Toe moet ek die hele storie vir haar sê. [Translated: And then they (the health care workers) told me that whenever I came there (to the A & E unit), I could just walk through. I didn't need to ask anyone for anything. But then, on the third day, when I arrived again, I was not allowed to walk through! (When I tried to walk through), the young lady at reception wanted to know the reason why I was there. Then I had to tell the whole story again.]

●...toe sit hulle (susters) 'n ding op die deur dat niemand daar kan ingaan nie. [Translated: Then they (the nursing sisters) placed a sign on the door that no one should enter.]

●...niemand het geweet nie. [Translated: No one knew.]

●...and all the information was kept confidential. Because even if they (counsellors) look for me at work, they (counsellors) refuse to tell them (my employer) what the problem was.

### **Supportive literature:**

Iyer (2008:1) points out that, patients should be aware of and accept the fact that, some personal information about them will be shared within the confines of the health care team, and patients should be appraised of the reasons for doing this. This study produced examples of this kind of necessary information. Thus, for example, it is necessary for an A & E

nurse practitioner to inform the people at reception that a particular patient will appear for a follow-up visit on a particular day, and that it would be a G-file case. The reception personnel will then be aware of the survivor's identity and the reason for her visit. The researcher is of opinion that neither the participants in this study, nor any future survivors, would object to the sharing of this kind of information once they had been informed of the reasons for it. It is anyway necessary to share certain kinds of information within a large institution such as a hospital in order to facilitate administrative arrangements. Such sharing is not meant to be of a personal nature, or to compromise the confidentiality of a patient.

The scene of the forensic examination is probably the one place where rape survivors feel most exposed and where they are concerned about their privacy and confidentiality. Such concerns might even deter some survivors from asking for the care that they urgently need (Ledray 2008:4). Schoenberg and Safran (2000:322) discuss the issues surrounding the availability of patient information in the current health care environment. They state that while patient information is readily available in the context of a practice to a traditional family physician, larger service providers such as hospitals are more likely to have patient information stored on a general network that would be accessible to all members of the multi-disciplinary team. Schoenberg and Safran (2000:322) also note that some patients might expect their records to be available wherever they present themselves on the occasion of later visits.

The arrangements that have been described above are controversial, and the researcher would prefer patient preference to be the determining factor in accessibility for rape cases. Some patients who follow-up at the same health care service might not need their information to be made available to the attendant health care workers, while those participants who live a great distance from the treatment facility, might feel different. Those in the latter category might be more open to follow-up care it were possible for their case information to be confidentially transferred to a

health care provider who is more accessible to them. This is an issue that might benefit from further research.

- **Files**

Three of the participants who had opinions about their personal files and the identification process, had clear ideas about their preferences. They felt that the process undertaken for the reporting of follow-up visits needed to be streamlined, and that clear communication between those involved would best serve all those concerned. Two of the participants experienced embarrassment when they reported for the second time to the unit after their initial visit. One described her shame and humiliation at having to explain her situation to the people at reception in a semi-public place. Since this participant's eyes filled with tears when she mentioned this, the researcher concluded that it was totally unacceptable for survivors of rape to be further traumatized by the shoddy administrative arrangements of a rape management unit.

It was noted earlier that it was extremely stressful for a participant even to report for a follow-up visit. They should never be subjected to a further embarrassment and humiliation by thoughtless administrative arrangements that could quite easily be reviewed and redesigned. In contrast to this, one of the participants noted how the process of locating her file was executed efficiently and without any embarrassment to herself, as a result of the effective communication and education that had taken place initially. Here are extracts from some of the participants' remarks:

•...dit was 'n gesoek na die leer, en jy weet, ek dink hulle (gesondheidswerkers) kan daar bietjie iets doen om mens beter te gemoed te kom. [Translated: They were searching for the file. Do you know, I think that they (the health-care workers) could actually do something to accommodate people better.]

•...toe sê sy (ontvangs dame) vir my oh, ek moes net vir haar gesê het dis 'n G-file, dan het hulle geweet waarvoor om te kyk – dan hoef ek nie alles te vertel nie.” [Translated: Then the receptionist said to me, “Oh, I should just have told her it was a G-file and then she would have known what to look for. Then I wouldn't have had to tell her everything.”]

•...jy het 'n kaartjie wat – ek weet nie, my kaartjie sê dis G-ietsie, die hositaal het gesê die G beteken “sexual assault” – jy gee hom net vir die vrou (ontvangs dame)of die man wat daarso sit voor, en hulle reel alles. [Translated: You have a card... I don't know... The card says that it is about a G-something, and the hospital had said that the “G” indicates “sexual assault”. You just give it to the woman (the receptionist) or the man who is sitting there, and they arrange everything.]

### **Supportive literature:**

According to Iyer (2008:1), all patients have a right to expect that information about them will be held in confidence by their doctors, and that the consent of the patient should be obtained before any information about them is disclosed. But the reality of the situation, as Schoenberg and Safran (2000:321) point out, is that all this information is no longer contained in a bundle of papers that had been collected between the covers of a single folder: it is actually dispersed between several archives and various places of storage. Schoenberg and Safran further note that while storing very sensitive information in a locked cupboard which contributes some degree of confidentiality, the information in these locked cupboards remains within reach of any health care worker who needs it to further the management of the patient (Schoenberg and Safran 2000:321). One participant actually mentioned during an interview that the rape survivors' files had been locked away in the unit. This confirms the hospital's current good practice.

### **3.2.6 Theme 6: Communication**

Effective communication between any member of the health team and the patient is essential if the patient's visits to an A & E unit are to achieve their desired purpose. Any health care worker within an emergency care environment will be able to confirm that sensitivity to the patient's problems and a well thought out programme of patient education, are elements that are most likely to achieve the goals of treatment.

#### **3.2.6.1 Effective communication**

Lay people may believe that communication is "easy" because human beings do it all the time and every day. But the kind of communication that is required to manage rape survivors successfully is a highly complex skill that can only be learned through serious application over a long period of time. During the course of the interviews, the researcher came to the realisation that the participants urgently needed to be able to communicate more effectively about a number of issues which included their preferences with regard to management interventions, the way in which they handled their follow-up visits, their questions and difficulties about the use of medication for instance, the way they felt about continued counselling and the extent to which they would like their family or significant other to be involved. Each of these sub-categories will now be discussed individually.

- **Patient preference**

Throughout this research, the researcher has proceeded from the conviction that allowing a rape survivor to exercise her own choices in as many matters as possible, will begin the process of returning to her power that had been so violently taken from her during the rape. The researcher therefore felt that it was a matter of the utmost importance to incorporate the rape survivors' preferences into the management process's,



interventions and decisions wherever possible. Some of the participants remarked upon the fact that including their preferences proved to be a positive experience for them:

•...en hulle (gesondheidswerkers) het vir my gevra is dit 'n probleem vir my om 'n man (berader) te sien, so dit was nie vir my 'n probleem nie. Maar hy (berader) sê baie mense trek hulle self terug. [Translated: They (the health care workers) asked me whether it would be a problem for me to see a male counsellor. But (I told them that) it wasn't a problem for me. But he (the counsellor) said that many people (women) closed themselves up (with a male counsellor).]

•...hulle (gesondheidswerkers) het nie vir hom (vriend) gesê hy moét uit die kamer gaan nie. Hulle (gesondheidswerkers) het vir my gevra moet hy (vriend) uit die kamer uit of was dit oraait as hy daar bly, toe sê ek ek verkies dit dat hy daar bly. [Translated: They (the health care workers) didn't tell him (my friend) that he should leave the room. They (the health care workers) asked me whether it was all right if he (my friend) remained there, and I said that I would prefer to have him remain.]

•...toe sê sy (suster) vir my dis reg, dis jou keuse. [Translated: Then she (the nursing sister) said to me that it was alright, that it was my choice.]

◇...ja, hy (berader) het my gevra of ek hom wil sien, toe sê ek nee, ek het... [Translated: Yes, he (the counsellor) asked me whether I would like to see him. And so I said, "No", I have...]

•...and there was also a black nurse who I felt free to speak to and then we spoke.

•...and then she (doctor) sat down with me and she called the nurse and said: "If you are not comfortable to speak to me, here is someone else", and that's when I spoke to that other black nurse.

One participant noted how not having the option of asking for a female doctor to examine her made her feel even more uncomfortable than she was already feeling. This issue was obviously a matter of great concern and importance to the participant because she mentioned it within the first minute of the interview. In her words:

•...maar ek voel net hulle (gesondheidswerkers) kan....hulle moet vroue dokters daar kry, want ek was ongemaklik want ek moes...dit was 'n man dokter. [Translated: But I just feel that they (the health workers) could... They must get female doctors because I was ill at ease, because I had to... It was a male doctor who examined me...]

### **Supportive literature:**

Boykins and Mynatt (2007:877) state that although crisis intervention is composed of a number of factors that include support, education, anticipatory guidance and referrals, practitioners continue to say that "it should be individualized to the client". Gacia-Moreno (2002:1509) strongly supports the idea that the patient's experiences should be taken into account in the design of the relevant health services. Ferguson (2006:488) also emphasizes that it is important to ask the patient before the examination whether she would like an advocate or a member of her family or a significant other to be present in the room for support during the forensic examination.

This is a clear example of respecting patient preference in practice. Since all the researchers who have conducted research into the treatment and care of rape survivors, regard patient preference as a matter of central importance, Curtis and White (2008:836) feel that it is a matter of the greatest urgency to conduct more research into the issue of patient preferences and the way in which it influences medical decision making. They also point out that deficiencies in this aspect of patient care



constitute one of the most commonly missed opportunities for effecting improvements in emergency and critical care environments.

WHO (2003:19) states that the gender of the health care worker may be a crucial issue in many emergency and critical care settings. They suggest that the directors and managers of health care facilities should ensure that female nurses and physicians should be made available whenever possible. This same source continues to regard the recruitment of female examiners as a matter that should receive the highest priority, as do Kelly and Regan (2003:13).

- **Patient education**

Most of the participants were all the opinion that patient education left a lot to be desired because it was either not done at all, it was not effective, or it was not remembered by the patient afterwards. The researcher has already noted that there is great need for improvements in patient education, especially with regard to the problems and difficulties surrounding the proper use of medications over long periods of time. These are extracts from what the participants had to say:

•...*hulle (gesondheidsorg werkers) het vir my net 'n papier gegee met 'n klomp goed op maar ek is nie seker nie.* [Translated: They (the health care workers) gave me a paper with all kinds of things on it, but I wasn't sure...]

•...*because I started experiencing those only after the rape. Because I didn't know what it was and that's when the doctor told me...*

•...*dit het hulle (gesondheidsorg werkers) nie vir my gesê nie. Nou ek voel hulle moes dit gedoen het toe ek ontslaan is. Dan hoef ek nie voor 'n wagkamer vol mense te gesê het waarvoor ek daar is nie.*



[Translated: They (the health care workers) did not tell me. Now I feel that they should have done so when I was discharged. Then I wouldn't have had to say, in front of a whole waiting room full of people, why I was there.]

Communication also includes simply informing the patient about why certain things are done or are not done. Health care workers sometimes tend to forget that the routines at which they become so familiar, are opaque and inexplicable (and a source of confusion and anxiety) to their patients. One of the remarks below makes it clear that the he patient was upset with the A & E unit personnel for not giving her something to drink – even though they were following the correct procedure by not doing so. A short explanation would allow the patient to feel comfortable. It was obvious that the patient was unaware that the drinking of fluids at that juncture might have contributed to the destruction of possible evidence. But because she did not know this, she experienced the nursing personnel as harsh and uncaring.

•...*hulle (gesondheidsorg werkers) het nooit vir my kom vra kan hulle vir my iets gee om te drink nie. Nou tipies as 'n ou in skok is, dan gee jy die pasiënt vog. Jy doen iets!* [Translated: They (the health-care workers) never came to ask me if I wanted anything to eat or drink. Now it is typical that when someone is in shock, one gives that patient fluids. One does something!]

### **Supportive literature:**

Queenan (2008:744) discusses the importance of effective patient-physician communication. He states that a physician should be available, if need be, from the very beginning of the process to educate and advise patients. It is part of the education of a patient (in this case, the rape survivor) to provide her with the blood test results for instance in good time, and to explain in clear and concise terms what those results mean

(Queenan 2008:744). Chen, Tao, Tisnado, Malin, Ko, Timmer, Adams, Ganz and Kahn (2008:1157) agree that effective physician-patient communication is a key factor for enhancing clinical outcomes, for improving the quality of the patient's life, for increasing the degree of satisfaction experienced by the patient, and for decreasing rates of morbidity and mortality. Bayam et al. (2008:625) add that while lapses and even a total breakdown in communication between physician and patient is not uncommon in the context of the consultation process, such failures to communicate effectively undoubtedly exert a negative effect on the quality of patient health care, patient education, and the cost effectiveness of the procedures and treatment being applied.

- **Family or significant other**

Communication with the family or the significant is undoubtedly beneficial for all those concerned. One of the participants remarked that she would probably forget what the health care worker was telling her at that stage and that this problem (her forgetfulness) could easily be remedied by including a member of her family or significant other in the situation, because they would be able to remember what the health care worker had said. The value of such inclusions was discussed in detail earlier in this text. It is important also to remember that the family or significant actually need to be involved in the management of the patient. Their inclusion in the management process enables them to feel informed, involved and supportive of the survivor. The participant mentioned above expressed her dilemma in the following way:

• *...die vrou (suster) het vir my baie mooi verduidelik, maar ek het vir haar gesê ek gaan vergeet.* [Translated: Although the woman (the nursing sister) explained everything to me very clearly, I told her that I would forget it.]



### **Supportive literature:**

The members of the rape survivor's family or her significant other should be contacted directly with a view to including them in the care process and the management of the survivor. Mularski (2008:676) states that previous research has shown how effective the quality of provider-family communication has been in the past. Boykins and Mynatt (2007:877) describe the difficulties they encountered in attempting to locate rape survivors after the initial examination, and stated their opinion that this process could be facilitated by the inclusion of the family or the significant other at a time when vital information is being given to the survivor. The importance of keeping appointments for follow-up visits should also be explained to the family or significant other. Then, when specific problems arise that require the survivor to seek immediate assistance, they can ask their family or significant other to make the necessary arrangements on their behalf.

When the family or significant other is included in the treatment programme, it is also important to obtain their contact details so that arrangements for future contacts can be facilitated. This could be a great help if the rape survivor should change her own contact details without informing the hospital. The research conducted by Spetz et al. (2008:18) also established that the health care worker can become more than a mere provider of information if she establishes good lines of communication with the family or the significant other. Once effective and sympathetic communication has been established between the health care worker and the family or significant other, they themselves also begin to feel motivated and supported and this ultimately increases the benefits that become available to the patient in the long term. It should always be remembered that it is not only the rape survivor who is adversely affected by the rape. It is also her family or significant other who is adversely affected by feelings of anger, grief, outrage and helplessness after their loved one has been raped, and so it is vital also to address their needs

and to give them a useful and meaningful role in the treatment and care of the patient.

- **Counselling**

Initial and follow-up counselling preferences and benefits should be clearly communicated to all the survivors of rape. While some participants had no wish to talk initially, others felt that they would prefer to follow up with someone of their own choice (an outside counsellor). Since counselling is regarded as an intensively intrusive process by some, it should be done with utmost discretion and sensitivity, and yet never enforced. See some remarks of the participants:

•...*ja, ag ek voel nie altyd gemaklik om met mense te praat nie, ek sal eerder met my ma praat want sy ken die hele storie.* [Translated: Yes, well, I don't always feel comfortable speaking to people (about it). I would rather speak to my mother because she knows the whole story.]

•...*hy (berader) het my daai dag gesien, maar ek was nie reg om dan soos daarvoor te praat of dit nie, ek was eintlik maar net stil....Ek sou daar van gehou het as ek self die mens kon gekies het wat....soos na my eie sielkundige toe gaan. Ek dink hulle het dit so half op my afgedwing om met hom (berader) te praat.* [Translated: He (the counsellor) saw me that day, but I wasn't ready then to talk about it. I was still actually, still... I would have preferred it if I myself could have chosen the person concerned... If I could have gone to my own psychologist. I think that they half forced me to speak to him (the counsellor).]

•...*maar omdat dit 'n wit man (berader) was was dink ek dit was vir my makliker.* [Translated: But because the man (the counsellor) was a white man, it was easier for me.]

•...want hy (berader) het my 'n sprankie hoop gegee dat die toetse kan negatief wees. [Translated:...because he (the counsellor) gave me some hope that the tests would be negative.]

•...nee, weet jy ek het 'n sielkundige wat ek sien en ek het na haar toe gegaan. [Translated: No, because I have a psychologist that I'm seeing, and I went to her.]

### **Supportive literature:**

Even though counselling is essential for a rape survivor's future health and well-being, patient preference should always be taken into account. One of the participants stated quite firmly that she would prefer to see her own psychologist whom she had been seeing before the rape. Most of the participants stated that the counsellors had given them the opportunity to visit them again after the initial counselling session had taken place. While some of the participants accepted this offer, others declined to accept it for reasons of their own. Roy-Byrne, Berliner, Russo, Zatzick and Pitman (2003:164) emphasise in their research that the survivor's perception of a threat to life, which is a core defining feature of PTSD, is what counsellors usually focus on in their sessions with rape survivors.

It was noted in the section that dealt with participant information at the beginning of this chapter, that eight out of the ten participants had had their lives threatened by the weapons that the rapist used to facilitate the rape. Because of this and other factors that compound the physical and emotional injury inflicted on the rape survivor, the importance and value of referring the participant to a counsellor after the initial examination should not be underestimated. While the counsellor might also ask the survivor during a follow-up visit whether she is seeing the hospital counsellor or some other external counsellor, she should be guided in all these matters by the patient's preference.

Roy-Byrne et al. also note that the avoidance of treatment and contact with other sources of support strengthen the symptoms of PTSD and make survivors even more reluctant to seek treatment (Roy-Byrne et al. 2003:164). Because counselling improves the survivors' self-esteem and coping abilities, and reduces the anxiety and other symptoms associated with PTSD (Yamawaki 2007:512), it is vitally important to communicate the crucial importance of counselling to the survivor herself and to her family or significant other.

- **Follow-up visits**

Communication in the context of follow-up visits has also been discussed under the heading of the themes of privacy and patient confidentiality in the emergency care environment. It was pointed out there that many of the the participants regarded the communication process to which they were subjected, as inadequate and unhelpful. The participants noted that the information that they were given about the follow-up process at the initial visit, was incomplete, misleading and inaccurate. While the researcher will therefore not discuss this issue again, the vital necessity for communicating effectively should be noted here. Many of the participants also experienced the follow-up visits as negative and unpleasant experiences because of their emotional state at the time. The acknowledgement of these painful emotional states by means of effective, tactful and focused communication might also make it easier for rape survivors to have a more positive attitude towards later follow-up visits.

These were some of the responses that participants made about the emotions engendered in them by the prospect of follow-up visits, and the kind of communication they expected if they were to return to the unit:

•...en dan probeer jy nou die ding verwerk en alles nou klaar kry maar oor drie dae moet jy weer terug gaan. Dan is jy nou maar net weer daar. Dit maak dit bietjie....ja moeilik. Om eerlik te wees, mens wil nie... [Translated: And then you try to arrange things so that everything has been dealt with, but within another three days, you have to return. Then you are simply there again. It makes it a bit... yes, difficult. To be honest, a person doesn't want to...]

•...dit was maar swaar hoor, dit was maar swaar. Ek het altyd opgesien om te gaan. [Translated: It was difficult, you know, it was really difficult. I always dreaded going.]

•...die enigste ding wat ek nie van gehou het nie was die check ups na die tyd. [Translated: The only thing that I didn't like were the checkups after the event.]

One of the participants noted that she felt much more at ease if encountered by the same health care worker whenever returned to the unit:

•...en elke keer as ek terug gegaan het was sy (suster) daar. [Translated: Every time I returned, she (the nursing sister) was there.]

### **Supportive literature:**

The need for follow-up care should be clearly communicated and emphasised to all patients, but to rape survivors in particular (Ferguson 2006:488). Since patient education forms a vital part of the daily duties of all health care workers, it is essential also for them to educate survivors about the importance of follow-up visits, and explain the purpose of these visits and why they are needed to ameliorate the effects of the trauma experienced by survivors. Boykins and Mynatt state (2007:870) state quite clearly that follow-up at specific intervals after an assault is



necessary to prevent further morbidity. They add that follow-up is also necessary to reduce the incidence of physical, emotional, psychological and behavioural problems, and to foster the optimal health of a survivor, after they had been raped. The problems that counsellors experienced in trying to contact survivors after their initial visit, demonstrated the need for improved follow-up care.

Boykins and Mynatt (2007:877) feel that "follow-up care should be as important as the evidentiary exam and crisis intervention". Ferguson (2006:488) is of the opinion that if follow-up visits are missed, rape survivors will also miss whatever treatment or psychological service opportunities they might have had in the aftermath of the incident. This assertion is supported by Ledray (2008:28) when she states that most rape survivors want to "go home and forget" about the experience. Unfortunately, the likelihood of this happening is zero. She continues to say that the information given to the survivor, and the referrals made on her behalf at the time of the forensic examination during the initial A & E visit, is crucial for helping the survivor in her long struggle to recover from rape.

### **3.2.6.2 Honesty**

Honesty is a necessary precondition for all communication between the members of the multi-disciplinary team and rape survivors.

- **Information**

The participants' need, and the need of the family or significant other for that matter, for honest information is reflected in the following remarks:



•...hy (vriend) wou nie vir my sê nie want hy het geweet ek sal nog erger kwaad raak en so aan. [Translated: He (my friend) didn't want to tell me what he knew (because) I would have become even more angry and so on.]

•...het die polisie gebel omdat ...(stasie) uitgekom het, dis nie ons area nie so dit moes oorgegee word na ...(ander stasie) toe. Sy (ma) het toe...(laasgenoemde stasie) daai Maandag gebel om uit te vind wat nou gedoen gaan word aan die saak. Hulle (polisie) het nie die saak nommer gehad nie, hulle het niks gehad nie. Hulle het nie eers geweet van die insident wat gebeur het nie. En dan voel jy na die tyd: wat word daaraan gedoen? [Translated: We telephoned the police because they had initially come out. But they said that it wasn't in their area, and so we had to be referred to another (police) station. His (mother) then phoned (the latter police station) that Monday to find out what had been done about the case. They (the police there) did not have a case number. They had nothing. They did not even know that an incident had happened. And then you think after the event: what is being done about all this?]

### **Supportive literature:**

Lilly (2008:213,216) asserts that it is vitally important for the whole multi-disciplinary team to be honest with the patient and her family or significant others in order to demonstrate the value and importance of the therapeutic benefits offered by the team to the survivor. Lilly advises health care workers and members of the team to be absolutely honest with the patient, her family and her significant other. The research undertaken by Sale, Bellamy, Springer and Wang (2008:263) demonstrates that when a rape survivor experience high levels of trust, mutuality and empathy in their relationship with health care workers, they begin to show significant improvements in social skills such as, for example, cooperation. According to Pembroke NF and Pembroke JJ (2008:321), honesty, respect, sensitivity and tact contribute significantly

to the helpfulness in interactions between the health care team and survivors.

### **3.3 Conclusion**

This chapter reviewed and discussed the findings of this research study, and identified and described the views and needs of the participants. All this information will now be used to make the recommendations that are set out in Chapter 4 about ways of improving current clinical practice so that it begins to approximate international standards of excellence in this field. The findings were accompanied by a thorough literature control that was used to validate, support and confirm the data that emerged from the study.

## 4 Recommendations, limitations and conclusion

*"It is never too late – in fiction or in life – to revise."*  
(Nancy Thayer)

### 4.1 Introduction

Since the background, methodology and research findings of the study have already been discussed in the previous chapters, the researcher will conclude the research by making recommendations in this chapter to enhance patient-centred care in the emergency care environment for female survivors of rape. Once the recommendations have been made, the researcher will reflect on the process of doing this study. In the last part of this chapter the researcher will reiterate the limitations of this study and possibilities for future research.

### 4.2 Realisation of study objectives

The purpose of this research study was to explore the experiences of adult female rape survivors in an emergency care environment, and thereafter to make recommendations about how the process of patient centred care for rape survivors can be enhanced. The empirical part of the study involved interviewing ten selected participants who were all adult female rape survivors who had been attended to in the specific hospital in which this study was conducted. The recommendations that follow in this chapter are based on the research findings that were detailed in chapter 3.

The specific study objectives that guided the researcher in her pursuit of the goal of the research were, as was first stated in Chapter 1, to:

- Explore the lived experiences of adult female rape survivors regarding the care they received from health care workers in the emergency care environment, and to
- Make recommendations based on the adult female rape survivors' needs expressed through the lived experiences to enhance patient-centred care in the emergency care environment.

As was noted in the research findings, the experiences regarding care of the adult female rape survivors in the emergency care setting, have been explored and disseminated by mentioning their own words recorded during the semi-structured interviews between each of the participants and the researcher. The recommendations will be made in the hope of enhancing clinical practice in this area, and improving on patient-centred care. If these recommendations are implemented, they will improve the way in which the patient-centred approach is applied in the management of rape survivors in the future.

### **4.3 Recommendations to enhance patient-centred care**

The recommendations that were compiled by the researcher will be set out in the same format as the research findings were set out (see Table 3.2). All the recommendations are based on the conclusions that were drawn by the researcher after she had reviewed and reflected on the research findings.

### **4.3.1 Patient management**

“Patient management” included accessibility to a health care service, the forensic examination and the use of medication. Since there were matters for serious concern in each of these three categories, recommendations for improving each of these categories and sub-categories will follow below.

#### **4.3.1.1 Accessibility**

The researcher concluded that rape survivors were at an enormous disadvantage when attempting to find comprehensive patient-centred care for themselves after the rape incident. Recommendations to improve the accessibility will be made for each sub-category of the research findings.

- **Knowledge of available services**

It is recommended that the hospital in which the study was conducted and all other health care services that provide comprehensive care should devise methods of making various communities and the general public aware of the services that they offer. This can only be done by devising methods for disseminating information about these services in the media or by public education in, for example, schools, colleges and universities. The public should also be made aware that there are alternative places where health care services are offered to rape survivors should future survivors be unable to attend the specific trauma units that are mentioned during the dissemination of information. Such awareness programmes should be designed to make the public aware that such services do exist, and that they are provided free of charge at specific places in the RSA.

- **Medical insurance and government patients**

When the information mentioned in the previous paragraph is disseminated to the public at large, it should be emphasised that the after care for rape survivors is offered free of charge. At the same time, however, the extent and limits of the service that is provided should be described clearly so as no one will be tempted to misuse of the services that these hospitals offer rape survivors.

- **Geographical location of service providers**

Since the particular places or locations where a comprehensive health care service is provided cannot be changed, the possibility of increasing the number of treatment centres so that comprehensive health will become more easily available to all population groups, is highly unlikely. The researcher therefore recommends that certain measures be put in place to at least make follow-up visits feasible. Among the benefits that survivors will obtain from such visits, follow-up blood tests, support and emotional evaluation will be among the most prominent. The rape survivor should be able to obtain such health care services from an established health care centre that is closer to the survivor's residence than the place in which she was treated immediately after sustaining the trauma.

- **Time**

The researcher recommends that the amount of time that is currently wasted before rape survivors are able to locate a service that provides comprehensive after care, should be substantially minimised. This concern could be addressed by publicising the existence of the service that the hospital offers to the general public among the public at large. The researcher also recommends that there should be much closer collaboration between the personnel in the police stations of a particular district or region and functionaries of the health care services in those

regions, in order to maximize the effectiveness of multi-disciplinary referrals between different services.

The researcher also recommends that all general practitioners and pharmacies in the drainage area of the hospital (which is the area that the hospital takes responsibility for medical referrals) should be well informed in order to advise the general public about the existence of post-traumatic services. This information could be disseminated to all pharmacies and general practitioners by means of a suitably designed and informative brochure. It would be necessary for such a brochure to include the nature of other services that are available, as well as up-to-date contact numbers for the relevant health care worker at the local hospital. These health care workers would also be able to assist rape survivors with the kind of additional information and general advice that all rape survivors urgently need before they present themselves for medical assessment.

- **Referral**

Since the hospital in which the study took place currently handles all immediate referral needs, the counsellor, other medical specialists and the police are all currently involved in the referral system that has been set up by the hospital. The researcher, however, recommends that patient preference should be taken into account before the referral is made. Since many patients have no wish to see a counsellor in the early post-traumatic stage immediately after rape has occurred, they should not be compelled to do so. Some rape survivors might prefer to see their current psychologist or psychiatrist before committing themselves to further contacts and treatment. And if the survivor accepts the offer of counselling by the accredited counsellor appointed by the hospital, the hospital counsellor should make herself available to continue to counsel with the survivor without charging any fee.



#### 4.3.1.2 Forensic examination

Although a proper forensic examination is both necessary and uncomfortable, it cannot be made compulsory. The researcher came to the conclusion on the basis of the evidence that although the patients had a good understanding of the need and importance of the forensic examination, the actual performance of the examination needed to be revised in certain ways and that the examination should always only be performed after the consent of the survivor has been obtained.

- **Information**

The researcher recommends that the hospital in which the study took place should continue to provide complete and relevant information about the forensic examination that will be performed. It might also be helpful to present the forensic examination pamphlet that is included in each SAECK kit to every patient after the completion of the examination. Rape survivors might find this particular source of information valuable and informative once they have been sufficiently emotionally stabilised to benefit from the knowledge that they will encounter in it. The discretion of the health care provider should be used when considering this option.

- **Examination**

The researcher recommends that the forensic examination should only be carried out with the consent from the survivor, regardless of whether the survivor has already reported the case at a police station or not. Payment for the care given to the rape survivor should also not be influenced by whether an examination has been performed or not, and the health service should continue to bear all costs in the usual way regardless of whether the forensic examination was undertaken or not.

The researcher also strongly recommends that female examiners should be on call at all times to perform forensic examinations on the rape

survivors who present themselves to the A & E unit. Finally, the researcher urges the hospital's A & E unit to keep at least two unused SAECK kits on hand at all times. This recommendation was not made by participants specifically, but clinical experience within the A & E unit allows the researcher to suggest this action. By having two readily available SAECK kits at hand when a rape survivor present herself to an A & E unit, the possibility of prolonged waiting periods and further emotional upset to the rape survivor will be minimised.

All health care workers who are involved in the management of adult female rape survivors should attend regular professional in-service programmes that will update their knowledge, stimulate their interest and dedication, and will ensure that their skills and knowledge of the correct procedures to follow in a forensic examination compare with the best that are available in the world.

#### **4.3.1.3 Medication**

A great deal of confusion surrounded the issue of the use of medication in the post-rape period. This is a disturbing feature of the care programme because the correct and timely use of medication is a prerequisite for maintaining the optimal physical and mental health of the survivor. The prevention of infection by HIV and other STI's in the wake of the rape incident is but one of the reasons why the meticulous administration of the correct medications is vitally important. This issue should be addressed as a matter of urgency.

- **Family or significant other presence**

It was evident from the research findings of this study that the family or significant other of her rape survivor played a major role in supporting the survivor in her use of the prescribed medication. Because of this, the researcher recommends that the family or significant other of the survivor should also be given all the necessary information about the

recommended medications and how they are to be used. Apart from this, the role of the family or significant other in the provision of care, comfort and encouragement in the daily life of the survivor should be acknowledged and accepted.

- **Patient education**

The researcher recommends that all information pertaining to the use of various medications should be documented in a clear, concise and easy-to-understand document. The research findings made it abundantly clear that the survivors did not remember the information and advice about how to use the medications, that was orally imparted to them. Because of this, the researcher recommends that the family or significant other be included in all patient education interventions.

- **Simplicity**

The researcher notes that the document that describes the medication that is handed out by the A & E unit urgently needs to be revised and rewritten. This document needs to be made clearer and more comprehensive (but concise), and it should contain easily comprehensible information about all the medications that might be given to a patient. It should also draw a clear distinction between which medications are indispensable for the maintenance of health, and which can be used on a discretionary basis (such as medications that prevent nausea or pregnancy). Dispensing information should also be included in this document. It should describe, for example, the exact number of tablets of a particular medication that will be given to the patient, the times at which they should be taken, and the amount of time that should elapse before the patient's next visit to hospital (which should be mentioned by date). Because it is likely that the patient will suddenly be using a large number of different medications when she is already under severe psychological pressure, these aspects of care should be explained in the simplest and most concise possible language.

- **Side effects**

While the evidence of interviews shows that the survivors did complain about the side effect profile of the medication, none of them expressed any desire to discontinue the medication in general and the ARV treatment in particular. The researcher therefore recommends that the hospital continue to educate survivors about possible side effects and how to cope with them, and to explain categorically to the survivors that the side effects will pass as soon as the medication regime has been completed. A sufficient number of anti-emetics that will not interact with any of the other prescribed medications, should also be given to rape survivors for the duration of the treatment.

### **4.3.2 Family or significant other**

What follows below is a recapitulation of the research findings and the recommendations that emerged from the researcher's analysis and consideration of the findings.

#### **4.3.2.1 Presence**

It was concluded by the researcher that the role that family or significant other play in the after care of a rape survivor is undeniable, and that these important people can be a supportive and useful asset in the management of the rape survivor.

- **Patient response to presence**

All of the participants in this study viewed the presence of their family or significant other at the A & E unit as supportive because they were able to demonstrate their concern for the health and wellbeing of the rape survivor. It is therefore strongly recommended that the family or significant other be given a more prominent role in the treatment

processes offered to the rape survivor. While it is essential to take patient preference into account, the evidence that emerges from this study reveals that none of the participants objected to having family or significant other present with them during crucial events in the management process.

- **Value and importance of presence**

The involvement of the rape survivor's family or significant other makes many aspects of care easier. The survivor will receive more comfort and support than the health care staff are able to give, the family or significant other will feel valued because they will feel that they are playing an important role in the treatment of their relative, and they might feel that they themselves, as a relative to the rape survivor, are being supported as well through their interactions with the health care worker. There are so many potential benefits that flow from the involvement of the rape survivor's family or significant other that the researcher believes that they should actually be recognized and accepted as a part of the management team during the treatment of the survivor.

#### **4.3.2.2 Encouragement**

It was concluded by the researcher that because a positive attitude and involvement of on the part of the family or significant other was deeply encouraging to the rape survivor, their potential for assisting the process of recovery and the rape survivor's return to everyday life, should not be underestimated. The researcher therefore recommends that the survivor's family or significant other be included in every possible and practical way so that the restoration of the rape survivor to a state of normality can be expedited.



- **Attitudes**

Although most members of a family or significant others will have a positive attitude towards providing assistance to their relative by any possible means, there are always those members of a family or significant others will react with hostility, blame and negativity. Because the existence of such people is a constant in society, the researcher suggests that it is necessary for a health care worker to inquire into and evaluate the relationship that exists between the survivor and her family or significant other, and that they should only be invited to be involved in the patient's treatment programme if their attitudes towards the survivor is positive and helpful.

- **Supportive actions**

Being present and involved with the rape survivor has been demonstrated to be the most valuable supportive action that a family or significant other can offer. Other helpful actions include helping the survivor to remember important matters such as faithful adherence to a medication schedule, and alerting them to the imminence of forthcoming follow-up visits. Any of these actions (or any others) that seem to support and comfort a survivor should be both encouraged and promoted.

#### **4.3.2.3 Information**

The researcher came to the conclusion on the basis of the findings that the family or significant other also needed information about the treatment and progress of the survivor, and that by providing them with such information, they would be enabled to play a prominent and useful role in patient education and care.



- **Need for information**

The researcher believes that by their persistent presence, the family or significant other not only supports the survivor, but that they also take on the role of a concerned person that needs information about the care, progress and status of their loved one. This became evident to the researcher during the research when participants mentioned that members of their family or their significant other wanted to be present in the treatment room itself – and were not satisfied by the boredom, passivity and anxiety engendered by having to pass the time in the waiting room outside. The researcher therefore recommends that the family or significant other be provided with the information that they need, and that they be included in their relative's treatment plan.

- **Role in patient education**

As was discussed earlier, the family or significant other should be included as part of the management team in the treatment of a rape survivor because their presence and support will almost always exert a beneficial influence on the patient's progress.

### **4.3.3 Timeframe**

Since waiting times experienced by the rape survivor during the post-rape management process was a matter of great concern to the researcher, her recommendations in this regard will be dealt with at some length below.

#### **4.3.3.1 Waiting times**

The researcher soon came to the conclusion, on the basis of her experience and the evidence that emerged from the study, that the time that elapsed before survivors received proper care was too long – and

often unnecessary and avoidable. This is one aspect of the management of rape survivors that should be improved as a matter of great urgency.

- **Reception area**

The researcher recommends that a rape survivor should immediately be taken by the reception personnel into a room set aside for rape survivors in the A & E unit, and that a health care worker should attend to the survivor as soon as she enters the unit.

- **A & E unit**

The time which the rape survivor has to spend in the A & E unit can and should be minimized by arranging duty schedules in such a way that a specific A & E nurse practitioner will always be on duty, whether during the day or the night, and that a previously identified female trauma doctor who has been trained in the management of a rape survivors will make herself immediately available. While a doctor might not actually be on duty at the time of the rape survivor's admission to the unit, a call list of available skilled female physicians should be kept on hand so that one of them will always be on call to offer her services when the rape survivor presents herself to the unit. When a doctor is called to the unit to attend to the management of a rape survivor, she must respond within a reasonable time, and if she is delayed by circumstances beyond her control, she should take time to explain such circumstances to the survivor.

Since forensic training is still an area of medicine and nursing that is profoundly underdeveloped in our country, the researcher recommends that at least one of the designated health care workers (who would be either an A & E nurse practitioner or the doctor) needs to be a skilled and experienced forensic examiner.



As was mentioned earlier, it is also necessary to keep at least two unused SAECK kits in the unit because the police are often unable to deliver them as quickly as they are needed. The researcher also recommends that an A & E unit should compile a step-by-step operational plan, and that it be drafted inclusive of both the clinical experience of the health care workers, as well as input from other members of the multi-disciplinary team (like the police). This will facilitate the execution of the management process without any undue delays. This can be illustrated by the following example. When a survivor arrives at the unit, the first interview with the patient will reveal whether the patient is currently being treated by a personal psychologist or psychiatrist. Should it become evident that the patient consents to talking to hospital counsellor, the counsellor can be contacted by telephone by the health care worker in attendance before the forensic examination will commence. A specific time could be agreed upon for the counsellor to arrive at the A & E unit directly after, or as soon as possible after the completion of the forensic examination (as it usually takes the best part of two hours to complete the examination properly) in order to minimise time delays.

The participants mentioned it to be important for the same A & E nurse practitioner who was involved in the initial assessment of the survivor, to be on duty at the time of the follow-up visit because she will already be familiar with the circumstances of the case. The feasibility of this recommendation is however challenged by personnel shortages and shift schedules.

The priorities of taking blood tests without delay and to evaluate the emotional status of the survivor should not be forgotten. The necessity for counselling should once again at this stage be emphasized to the survivor and to her family or to her significant other so that it can immediately be determined whether or not the survivor is currently seeing a specific counsellor. The researcher is of the opinion that there is no absolute necessity for the patient to see a doctor as well if the A & E health worker who is performing the preliminaries is a skilled forensic examiner.

Once all these necessary tasks have been accomplished, the survivor and the family or significant other can then return home. But it is also important to note that the A & E nurse practitioner who has been involved with the case should telephone the results of the blood tests to the survivor within three hours, or provide it to the patient by other means of preference.

- **Laboratory results**

The researcher has observed that the period during which the rape survivor has to wait for the results of the HIV blood test invariably generates a great deal of post-rape anxiety. The researcher recommends that it should not take longer than three hours for the results of the blood tests to be relayed to the survivor. If it is possible, the health care worker should inform the rape survivor of the results in less than three hours, then so much the better. They could even be obtained telephonically in cases where the survivor can, for instance, prove the authenticity of the personal G-file identification number.

- **Multi-disciplinary team**

Situations in which the rape survivor has to wait for members of the multi-disciplinary team should be avoided at all costs. The researcher has given examples earlier in the text of the waiting times in the A & E unit. As far as waiting for the police is concerned, this is not a factor that a health care worker can control. The researcher nevertheless emphasizes the crucial importance of close collaboration with the local police, because the nurturing of relationships of trust and respect with the local police will enable them to be more responsive in cases of acute need.

### 4.3.4 Multi-disciplinary team

The importance of a multi-disciplinary team approach is essential for the correct management of a rape survivor, and this theme also proved of great concern to the participants in the study. The following conclusions and recommendations which were made by the researcher will further illustrate the importance of this aspect of survivor management.

#### 4.3.4.1 Attitude

The attitude of the health care workers should embody support, concern and friendliness. It is also the opinion of the researcher that the attitudes of the health care workers involved in the rape survivor's management definitely exert a strong influence on the quality of the after care that is offered to survivors.

- **Health care workers**

Since most of the participants commented specifically on the caring and compassionate attitudes of the health care workers, the researcher feels that the health care workers concerned should be congratulated and urged to continue to incorporate these crucial attitudes into their work. One of the survivors did, however, mention that one of the health care workers had spoken in an intimidating manner to a specific survivor. The researcher therefore wishes to add the supplementary recommendation that every health care worker who works with rape survivors should constantly reflect on her feelings about and her attitudes towards rape survivors by practising disciplined introspection on a regular basis.

Although it is inevitable that not everyone is capable of expressing a high degree of empathy and compassion, especially where the person in need of care and attention has been the survivor of a violent and traumatising criminal act, it is essential for health care workers to examine the

attitudes towards the survivors of rape, and, if they feel negatively about these people, they should under no circumstances work as caregivers and managers of rape survivors. This is vitally important because if a caregiver entertains negative emotions and attitudes toward rape survivors, their negative attitudes will inevitably be sensed by the survivors on an unconscious or even on a conscious level, and such realisation will add significantly to the stress experienced by the rape survivor.

- **Police**

It was observed that the attitude of the police varied on a continuum between very supportive and extremely indifferent. The researcher wishes also to urge police personnel to make conscious effort and to evaluate their personal feelings about rape survivors. The researcher would also like to salute and thank those police officers who have made such a positive and helpful impact on the lives of some of these survivors on account of the compassion, kindness and sensitivity that they have demonstrated while working in such stressful environments.

#### **4.3.4.2 Competence**

The evidence that emerged from the study inevitably lead the researcher to conclude that the professional competence of the health care workers could be improved by means of formal training and programmes of in-service education.

- **Educational level**

It is the recommendation of the researcher that all health care workers involved in the management of rape survivors be given further training in the hospital setting. Apart from this, the researcher would like to see specialised trauma nurses who are willing to dedicate their professional lives to this rewarding work, being given the opportunity to complete accredited forensic training courses at accredited institutions. Any training



or bursaries that are invested in the training of forensic nurse specialists now will benefit future rape survivors. The corollary to this is that inexperienced health care workers and students should not be allowed to manage rape survivors.

- **Identification**

It is an important good practice in any institution nowadays for health professionals to wear a name tag for easy identification. All health care workers should also wear identifying devices when they are on duty. It is recommended that health care workers should be identified as qualified specialist forensic nurses after they have completed their specialised training. Such nurses would then play a prominent role in the management of rape survivors, and the distinctive identification of the nurses' speciality will enable the survivors to relate to them with confidence during the course of the management process.

- **Confidence**

Specialised forensic training and practical clinical guidance will boost the confidence of all the health care workers who are involved in managing a rape survivor. It was mentioned earlier that health care workers should not neglect to document and treat what may seem to be insignificant injuries that are observed during the forensic examination. The researcher also recommends that medical and nursing staff should compare notes before they discharge a rape survivor from the unit. It is at this stage that the survivor should be asked once again if she is aware of any other injuries on any part of her body that the health care workers may have failed to notice at the time of the physical examination. If the patient answers in the affirmative, a confirmatory examination should be undertaken and appropriate notes should be made and certified because such apparently minor injuries can provide useful evidence in any subsequent legal proceedings in which the onus is on the state prosecutor and the survivor herself to prove the guilt of the perpetrator.

#### 4.3.4.3 Presence

While the researcher concluded that the presence of the different members of the multi-disciplinary team was beneficial to the rape survivor, more effort should be invested in effect of communication between all the members of the team. It is also important to align and coordinate the various management processes so that the rape survivor will be in a position to obtain the best possible outcome. Proper coordination and cooperation will also allow the team to organise and arrange the most advantageous referral options for the survivor.

- **Team members**

The research findings set out in Chapter 3 show that many of the multi-disciplinary team members were personally present in the A & E unit at some or other time during the course of the management process. The number of team members who are actually present should, however, be limited to those whose presence is needed to optimise the success of the management process for the rape survivor.

- **Importance of presence**

Most of the participants were of the opinion that the hospital does in fact provide a comprehensive service. The researcher wishes to emphasize that the patient's preferences should be considered and honoured when it comes to matters such as, for example, counselling and the subsequent reporting of the incident concerned.

- **Referral**

Since the hospital makes use of whatever referral options are available to them, it is important to maintain the viability of the referral system and to use every means to extend its effectiveness. Other outside service organisations, whose members might be able to assist and support the

survivors of rape, are groups that campaign for example, against women abuse and rape. If the rape survivor has a strong faith, they should not be denied any comfort or reassurance that counsellors from their local churches, mosques, temples or synagogues might be able to provide. But the personal wishes of the rape survivor should obviously be taken into account before any religious leader or counsellor is invited into the rape management situation. Whether or not such visitations will add to or alleviate the stress and discomfort of the survivor will depend entirely on the personal context of the survivor herself.

### **4.3.5 Privacy**

It is understandable that the issue of privacy emerged as a matter of very great concern to the survivors. Because of the stress, shame, guilt, grief and anger that emerge in the aftermath of rape, it is essential to take every possible measure to ensure that the rape survivor will be granted whatever level of privacy the hospital is able to offer to make her feel most comfortable. The following sections contain the recommendations made by the researcher to improve on the degree of privacy that is experienced by the rape survivors who are treated in the unit.

#### **4.3.5.1 Reaction to incident**

The researcher came to the conclusion on the basis of the evidence and her own experience that not all rape survivors react in the same way to the circumstances of the rape incidence to which they have been subjected. All health care workers should therefore be sufficiently flexible to acknowledge the variability of such reactions, and should work with the rape survivor in order to identify methods of communication that are optimal for the survivor concerned.

- **Patient response**

As one may expect, each person's response to a trauma is unique, and rape survivors are no different in this regard. The researcher recommends that the reactions of survivors should always be accepted and acknowledged as "normal" (which indeed they are under the circumstances), and that health care workers should, wherever possible, include the family or the significant other of the survivor in order to increase the survivors levels of comfort and support.

#### **4.3.5.2 Personnel involvement**

The researcher concluded that all health care workers who are involved in the management of rape survivors should possess all the knowledge, tools and expertise that are needed for them to be effective during the treatment processes.

- **Number present**

The experience and observations of the researcher lead her to suggest that only one A & E nurse practitioner and a doctor be present during the survivor's initial visit to the A & E unit. These two health care workers, if they are properly trained and skilled, should be able together to give the survivor a timely, efficient, accurate and comprehensive service. While it is may be necessary to call on other health care workers outside the examination room for assistance if someone needs to be telephoned, for instance, the only other people who should be present inside the examination and interview room with the survivor are members of the survivor's family or her significant other – if (and only if) the survivor expresses a desire to have them there.



#### **4.3.5.3 Examination environment**

The researcher reached the conclusion on the basis of the findings and her personal observation that there were areas that could be significantly improved so that they would be better suited to the needs and difficulties that arise during the management process. These areas that the researcher considered to be in need of improvement were the physical examination room and the environment in which the patient is interviewed.

- **Room**

The physical examination room should be large enough easily to accommodate two health care workers and the family or significant other of the survivor. This room should be comfortably but discreetly decorated with a normal hospital bed and one or two comfortable chairs. The room should be decorated so that it creates an atmosphere that is both feminine and relaxed, and all the necessary equipment and disposables should be ready to hand inside the room itself. There should also be a shower and bathroom attached en suite to the examination room so that the survivor can clean herself after the examination has been completed.

#### **4.3.5.4 Patient confidentiality**

Since the issue of patient confidentiality was a serious concern for most of the participants in this study, the researcher has concluded that the follow-up process should be urgently revised.

- **Emergency care environment**

It is the opinion of the researcher that more effective communication is needed between the members of the multi-disciplinary team so as to ensure the utmost degree of confidentiality and so that the management

process can be streamlined to produce efficient results. If it is possible to implement the researcher's recommendation of having only **one** A & E nurse practitioner involved in the management of each rape survivor, this would go a long way to improving the assurance of confidentiality that all of the rape survivors so urgently desire in the emergency care environment.

- **Files**

The researcher recommends that the A & E unit continue to keep patient files in a locked cupboard from which authorised health care workers will be able to retrieve the files they need easily and quickly. It is also important to organise and categorise these files in such a way that no time will be wasted when they need to be retrieved for professional purposes by authorised health care personnel.

### **4.3.6 Communication**

Effective communication plays an essential part in the successful management of a rape survivor. Since this theme proved to be problematic and was a cause for concern to both the rape survivors and to members of the team, the researcher has made various recommendations which, if acted upon, will improve on communication between the health care worker and the rape survivors.

#### **4.3.6.1 Effective communication**

Although healthcare workers are constantly engaged in communicating with patients on a daily basis, communication can only be effective and productive if it involves mutual understanding and respect between the two parties involved. The researcher concluded that there are several areas in which effective communication is clearly lacking. Unless communication is improved, these are areas in the care of the rape

survivor that will be less effective and beneficial than it might otherwise have been.

- **Patient preference**

Patient preference should be treated with the utmost respect and accorded the greatest possible measure of compliance in all management processes, and patient preferences should direct the manner in which health care workers approach any rape survivor. Rape is described in the literature as a crime of force, coercion and violence. It is therefore fundamentally important to allow the patient herself to make as many decisions as possible during the management processes because, by doing this, the survivor is once again given opportunities to make her own decisions and feel the self-respect that accompanies the power to give consent or to withhold it. It is for this reason (but not for this reason alone) that such enormous emphasis is placed on giving the rape survivor as many choices as possible about the course of her treatment.

- **Patient education**

Patient education has already been discussed in the context of the medication category. The recommendations that were made there are equally valid here, although the researcher would like to recommend that all communications about patient education should be recorded in a written format. A booklet or pamphlet could be compiled for the survivor and the family or significant other to take home with them, where they will have the opportunity to examine and discuss the recommendations and information in the booklet at their leisure. This would minimize the confusion and embarrassment that are generated by forgetfulness and uncertainty, and would ensure that all the important information that the survivor needs for the improvement of her health will be available in an easily accessible format.

- **Family or significant other**

The researcher recommends that the family or significant other be included, valued and recognised during all communications that take place if the rape survivor needs them to be present.

- **Counselling**

The importance of counselling for rape survivors should be emphasised during the initial A & E visit, and during follow-up visits, it should be emphasised once again. It is recommended that health care workers ascertain whether the survivor is currently engaged in a process of outside counselling, or whether she prefers not to receive counselling. This same re-assessment of the survivor's needs should be carried out on the occasion of every follow-up visit.

- **Follow up visits**

Although these points were touched upon at an earlier stage in the study, it is necessary here to repeat that the follow-up process should be streamlined and that communications about the follow-up procedures and processes should be repeated to the rape survivor as often as is necessary. Although the importance of follow-up visits was explained earlier in the study, measures should be put in place to make follow-up visits to a nearby health care service possible should the survivor prefer not to come back to the hospital where she was originally treated. If she does wish to return, communication (between the reception personnel and the health care workers) about the rape survivors' re-entry into the unit for follow-up visits should be greatly improved.

#### **4.3.6.2 Honesty**

The researcher concluded from what emerged in the study and her own experience that being honest with rape survivors about important matters

will facilitate the establishment of a trusting and open relationship between health care workers and the rape survivor.

- **Information**

The researcher recommends that all health care workers and other members of the multi-disciplinary team should be nothing but honest with the rape survivors with whom they communicate. They should also encourage the family or significant others to be honest as well, and not to support any statements that might eventually be proved to be untrue.

## **4.4 A personal reflection on the research study**

While myself, as the researcher, was engaged in the management of rape survivors in clinical practice prior to the commencement of this study, and although I was always alert to the needs and concerns of the survivors under my care, I never imagined that their needs would cover such a broad spectrum of concerns. It was always my practice to give patient preference priority in the approach to management while remaining within the guidelines and protocols set out by the hospital. By reflecting on my past experience and by studying the data that emerged from this study, I came to the realisation that there is much more that the health care community can do to help rape survivors to recover and to once again live normal lives in the community. This research also made me aware that a seemingly insignificant change in the environment, practice and procedures of the health care community could sometimes make all the difference to the way in which survivors experience their management. These realisations in turn put myself, as a qualified trauma registered nurse, in a position to make a valuable contribution to the establishment of a far more comprehensive and evidence-based standard of rape survivor care in A & E units.

The methodology of the research, or any research for that matter, challenges one's understanding to the uttermost. As a first time researcher, I needed a great deal of guidance from my supervisors in order to develop a suitable and effective research methodology. Even though I realized right from the beginning that the ethical aspects of conducting research into such a sensitive and intimate topic of study would be a matter of concern to all the consenting institutions, I underestimated the time that I would actually need to combine the necessary explanations with the requirements for the confidentiality and anonymity that are essential aspects of the methodology of this study.

Conducting the interviews with the participants proved to be a time-consuming task. Obtaining the names of possible participants from the counsellors proved to be a prolonged process. In spite of the fact that all of the counsellors have their own jobs to do, they all nevertheless graciously undertook the physical journey to the hospital to examine the relevant patient information and then telephone their patients for their informed consent before they were able to refer them to me. This phase of the research generated a great deal of frustration. But the patients who actually consented to take part in the study when the counsellor telephoned them were all very helpful when I subsequently approached them. None of the participants who agreed to cooperate at that initial stage subsequently revoked her consent.

The actual interview process brought home to me the truly horrible nature of this crime, and prolonged reflection enabled me to realise that there were definitely a number of areas in which we as health care workers, and the community as a whole, could make valuable contributions on improving the care and treatment of those who had been raped. The interviews were useful because they directed my attention to those specific aspects of the management of rape survivors where management has proved to be less than satisfactory. These areas include problems connected with accessibility and the comprehensiveness of the care that is given to rape survivors.

Since I am a professional trauma expert, the challenge to identify and describe those ways in which patient-centred care can be improved by using patient preference as the basis for all operations and procedures, was gladly undertaken in order to solve a problem – which seems to be a skill trauma qualified A & E nurse practitioners have mastered.

The participants offered me valuable information in the context of the interviews, and I wish to thank them all for their unselfish input and their willingness to relive the memories of their traumatic experiences in the interest of improving conditions for future rape survivors. It was also interesting to me to note that, in spite of everything that was said during the interviews, all of the participants (without exception) felt the need to recount the actual rape experience once again after the completion of the interview. All of them provided further graphic details about the incident – even though I had made no mention of the incident or given any hint whatsoever that I would be interested in hearing a first-hand account of the actual rape experience. The respondents were of course given a comfortable space and ambience in which to recount these stories, and these talks subsequent to the interview gave myself as the researcher many useful opportunities for finding out more about the gruesome realities of rape as experienced by a survivor, as well as the many troubles and difficulties that survivors have to face in their everyday life after having been subjected to a violent crime of such an intimate nature.

I was surprised by the volume of recent data, protocols and guidelines on the field of forensic nursing in general when I performed the literature control for the research findings. Interestingly enough, I also found that websites and patient advocacy literature from abroad were very much attuned to what we, as healthcare professionals, are doing here in the RSA to manage rape survivors. This in itself was a source of great satisfaction to me, because the emphasis in most of these documents and websites was on the quality of the management that is provided for survivors. All that now remains is for us as health care workers to

collectively campaign for an improvement in the standards of the management of rape survivors throughout the country.

I was also gratified to realise that some of the aspects of the management process that I myself had intuitively regarded as deficient in clinical practice situations, were confirmed by the data as being in need of improvement. The aspects of management that I knew needed to be improved upon included issues of accessibility to care, the use of medication, the importance of the family or significant other in the management process, and the degree of respect that should be accorded by counsellors to the patient's preferences.

This first time researcher now feels a sense of satisfaction at having completed this study in spite of all the obstacles that stood between me and the study's successful completion. I also feel that if I ever embark on research of this magnitude again, I will be able to do so with open eyes and no illusions. This study has served to heighten my own knowledge, awareness, development and appreciation of the rape survivors' experiences and dilemmas in the emergency care environment; and in spite of its limitations, I am confident that this research will make a useful contribution to the existing body of knowledge in forensic nursing.

## **4.5 Limitations to this study**

It is not possible to guarantee the generalisability of the findings of qualitative research because each research project is unique to the population that it studies and all research populations are different. This limitation is of course also applicable to this study.

For practical reasons, this study was deliberately limited to include only adult female rape survivors and to exclude any of the views or experiences of male or paediatric rape survivors. It was also conducted in a highly developed urban area where there were numerous opportunities



for referral. This is also obviously a limitation because such opportunities would be unavailable in other geographical locations such as rural areas.

## **4.6 Possibilities for future research**

These research findings also described the significance to the rape survivors of the role of gender in the management of rape survival. Since the rape survivors were especially concerned with the gender of the doctor who performed the forensic examination, this has been faithfully recorded and discussed in the text. Many sources in the literature have commented on the availability and preferences that rape survivors have for having a female health care worker to perform the forensic examination. But the actual feelings and emotions that survivors experience when a female medical practitioner is not available to perform the examination, have not yet been fully explored and described in this study, and future research might make a valuable contribution in this field to the description of this problem.

## **4.7 Conclusion**

This chapter focussed on the conclusions that the researcher reached on the basis of the research findings in her own experience both in clinical practice and in the interviews with the survivors. It has also offered a variety of recommendations for effecting improvements to the patient-centred care of rape survivors in future.

It is the researcher's hope that this research study will contribute substantially to the understanding of the experiences that the adult female survivors of rape have to endure in the emergency care environment, and that the findings and recommendations that have been made will serve as a basis for improving the quality of patient-centred care. Contributions that future research might make to an understanding



of this crime of violence, that is so prevalent in the RSA and throughout the world, have been mentioned.

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# **ANNEXURE A**

**Ethical consent from  
University of Pretoria: Faculty  
of Health Sciences Research  
Ethics Committee**



# **ANNEXURE B**

**Ethical consent from  
The Hospital Group**





# **ANNEXURE C**

## **Ethical consent from The Hospital**



# **ANNEXURE D**

## **The Hospital Group: Sexual Assault Crisis Centre Standard Operating Procedure 2006**



# **ANNEXURE E**

## **Participant information leaflet and informed consent**



# **ANNEXURE F**

## **Example of transcribed interview**



# **ANNEXURE G**

**Example of data analysis  
process through coding**



# **ANNEXURE H**

**Letter from the editor**



# **ANNEXURE I**

**Letter from the transcriber**