

**EXPERIENCES OF FORENSIC NURSES REGARDING THE PROVISION
OF CARE TO VICTIMS OF SEXUAL ASSAULT IN SELECTED PUBLIC
HOSPITALS OF LIMPOPO PROVINCE, SOUTH AFRICA**

by

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submitted in accordance with the requirements for

the degree of

MASTER OF ARTS

in the subject

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UNIVERSITY OF SOUTH AFRICA

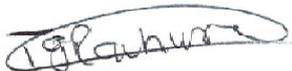
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JULY 2014

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DECLARATION

I declare that this dissertation titled “**EXPERIENCES OF FORENSIC NURSES REGARDING THE PROVISION OF CARE TO VICTIMS OF SEXUAL ASSAULT IN SELECTED PUBLIC HOSPITALS OF LIMPOPO PROVINCE, SOUTH AFRICA**” is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references. This work has not been submitted before for any other degree at any other institution.



Grace Tshilidzi Ravhura

July 2014

Date

EXPERIENCES OF FORENSIC NURSES REGARDING THE PROVISION OF CARE TO VICTIMS OF SEXUAL ASSAULT IN SELECTED PUBLIC HOSPITALS OF LIMPOPO PROVINCE, SOUTH AFRICA

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ABSTRACT

Purpose: The purpose of this study was to explore the experiences of forensic nurses when providing care to victims of sexual assault in selected public hospitals of Limpopo province.

Methods: A qualitative, explorative, descriptive and contextual research design was employed in this study. A sample of 7 registered nurses was purposively selected to partake in in-depth unstructured interviews.

Results: Four themes associated with the experience of providing care to victims of sexual assaults emerged during data analysis. These included (1) psychological experiences of nursing victims of sexual assault, (2) physical challenges associated with implementing the forensic nursing specialty in a clinical setting, (3) psychological coping strategies to deal with challenges experienced, and (4) the experience of managerial support.

Conclusion: Participants reported negative psychological and physical experiences of providing care to victims of sexual assault, which resulted to occupational stress. Recommendations of forensic nurses support guidelines and further research were made.

Keywords

Forensic nursing; sexual assault; victim; care; experiences; public hospital; South Africa.

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Dedication

To my late mother Josephinah Mukandangalo Nephumbada for bringing me up as a single parent and for providing for my basic education.

To my late father-in-law Mpandeli Wilson Ravhura for having interest in my studies, his encouragement and love.

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List of abbreviations

ADAA	Anxiety and Depression Association of America
DHSD	Department of Health and Social Development
PTSD	Post-traumatic stress disorder
SANE	Sexual assault nurse examiner
WHO	World Health Organization

List of annexures

- Annexure A Request letter to conduct research to Department of Health and Social Development (DHSD): Limpopo province
- Annexure B Ethical Clearance Certificate: Department of Health Studies, Research and Ethics Committee, University of South Africa
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CHAPTER 1

ORIENTATION OF THE STUDY

1.1 INTRODUCTION

The victims of sexual assaults present to hospital authorities with a number of problems. These may include physical injuries and they may exhibit various emotional experiences ranging from anger, fear to self-blame to mention a few. Such traumatic experiences may affect the victims immediately or as post-traumatic stress disorders (PTSD) and this may depend on many vulnerability factors, like genetic factor individuals (Taylor & Asmundson 2008:61).

The majority of victims of sexual assault visit health facilities like hospital and clinics to seek professional help. In many instances health care professionals were not well prepared to care for the special needs of the victims (Eldredge 2008:161). This led to victims of sexual assault not properly treated. Their care was not prioritised. They were always expected to wait in emergency rooms for a longer period of time before being attended to by health professionals (Changwa & Pather 2008:45). As a result, the Sexual Assault Nurse Examiner (SANE) programme was developed in 1970s to deal with the problem of poor quality care provided to victims of sexual assault. SANEs are forensic nurses trained to manage victims of sexual assault (Daigle 2012:182).

The duties of forensic nurses include the following activities, namely: objectivity in discovering facts by using scientifically proven principles and methods in recognising cases, perform forensic examination on victims, collect and preserve evidence, provide prophylactic treatment, document findings, make final remarks about their observations and make referrals of victims to other appropriate professionals for continuity of care (Turvey & Petherick 2009:99).

The availability of forensic nurses in health facilities has been observed to alleviate problems raised by victims like poor quality care and long hours of waiting at the health care facilities (Hoff 2009:94). Quality care is associated with holistic management of

victims of sexual assault by taking into consideration their physical, social, and emotional aspects of care into consideration. Quality care of victims has also been improved by the multidisciplinary team approach in their care that forms part of proper referrals for specialised care of victims (Hoff 2009:94).

While the role of forensic nurses is critical during the investigation process and in caring for victims, the potential to develop emotional reactions to intimate encounters with sexual assault victims exist. Evidence from research conducted to evaluate the SANE suggest that the existence of vicarious trauma in forensic nurses is associated with the work they do (Maier 2011:165). This is always associated with the horrific descriptions of traumatic events, the constant observations and listening to shocking realities of violence on a daily basis that may result in fundamental negative effects on forensic nurses' lives which may alter their view of the world from positive to negative (Hoff 2009:193). The negative feelings that forensic nurses may exhibit include amongst others anger, sadness, horror and rescue fantasies (Chouliara, Hutchison & Karatzias 2009:49). The negative effects also have implications on the quality of care forensic nurses provides (Wies & Coy 2013:28). Regardless of the type of trauma work, research has consistently demonstrated that the presence of support system can mitigate the impact of vicarious trauma symptoms that forensic nurses suffer (Maier 2011:167).

Health professionals who provide care to victims of trauma are at high risk of being traumatised themselves. Social workers, trauma counsellors, doctors and nurses work closely with individuals who have lived through traumatic experiences. Hearing story after story of traumatic experiences may take a toll on health care professionals and those may lead to the development of vicarious trauma (Maier 2011:165). This is confirmed by Wies and Coy (2013:27) who measured vicarious trauma among Sexual Assault Nurse Examiners and found that 38.1% of them reported symptoms of vicarious trauma and such symptoms were due to the nature of their work.

Vicarious trauma was first originally studied in relation to clinicians working with victims of abuse or some types of trauma. Pearlman and Saakvitne (1995:279) cited in Martine (2006:31) define vicarious trauma as a process through which nurses "inner experience about the self and the world is negatively transformed as a result of empathetic engagement with trauma survivors".

Forensic nurses who provide care, counselling, crisis intervention and other needs services to traumatised people often work under highly stressful situations and these put them at a high risk of developing vicarious trauma (Maier 2011:166). Ultimately the results could be flooding of negative feelings such as hopelessness, exhaustion and frustrations and they often shift in their views of others, usually from being a caring to a non-caring person (Chouliara et al 2009:50); and those who reported vicarious trauma, describes some of the symptoms they experienced as crying, feeling sorry for themselves, feeling frustrated, feeling preoccupied with work, wanting to resign as SANE and having difficult in sleeping (Maier 2011:166). Health care providers lives may be masked by nightmares, sleeplessness, fear of intimacy and general anxiety or other symptoms, Individuals who are plagued with vicarious trauma view people as negative, focus on problems and are unable to provide positive feedback (Wies & Coy 2013:28).

Research on the experiences of forensic nurse caring for victims of sexual assault remains in its infancy and this leads to the necessity of further investigation. While sexual assault victims have emerged as a population of interest. The impact and the pain on forensic nurses who engage and help victims of sexual assault have received limited consideration. Among others experiences that were thought to play a role in the development of vicarious trauma on forensic nurses were: the nature, intensity, extensiveness and the time frame of forensic nurse working with victims of sexual assault (Tosene, Nuttman-Shwart & Stephans 2012:234).

Fewer studies have been conducted in the area of forensic nurses caring for victims of sexual assault. No research found forensic nurses' experience of providing care to victims with regard to the development of vicarious trauma has not been investigated. Lack of support is a construct that is thought to play a role in the development of a vicarious trauma (Maier 2011:168).

Inclusion of ways of distressing after hard cases in the initial training and the importance of reaching to others for support and taking care of emotional needs was seen as the coping strategies that are helpful to SANE (Maier 2011:168). Further research is needed in the area of support given to forensic nurses in regard to the experiences of providing care to victims of sexual assault.

In this chapter an orientation to the entire study is laid out, which includes the background to the study, the statement of the research problem, the formulation of the research purpose and objectives, and the significance of the study. The introduction also briefly introduces the research design and research methods used by the researcher. Means for ensuring rigor are expressed in terms of ethical considerations and measures for trustworthiness.

1.2 RESEARCH PROBLEM

As a forensic nurse working in one of the public hospitals and providing care to victims of sexual assault, the researcher was in daily contact with such victims as part of her work with victims of sexual assault. Some of the victims came being badly injured physically, whilst some had been physically and sexually assaulted and left half dead, some were children who had been sexually assaulted with a tear from the vagina to the anus. Victims were also brought to health settings after being assaulted by various perpetrators. Some of these victims had been assaulted by acquaintances, some by strangers, some by a mob and some by their intimate partners.

The researcher's experiences of providing care to victims of sexual assault coupled with the experiences shared by forensic nurses during the in-service trainings debriefing sessions highlighted some of the challenges that forensic nurses who are providing care to victims of sexual assault are confronted with in their daily work with victims. Forensic nurses need for professional support from management and the achievement of quality care provided to victims of sexual assault were the motivating factors for the study. This created a need to the researcher to understand forensic nurse's experiences when providing care to victims of sexual assault. This problem led to the following research question: What are forensic nurses' experiences of providing care to victims of sexual assaults in selected public hospitals in Limpopo province?

1.3 STUDY PURPOSE

The aim of this study was to explore the experience of forensic nurses who are providing care to victims of sexual assault in order to improve their work experiences in selected public hospitals in Limpopo province.

1.4 STUDY OBJECTIVES

In order to achieve the above stated study purpose, the objectives for this study were to

- identify and describe the socio-demographic characteristics of forensic nurses providing care to victims of sexual assault in selected public hospitals of Limpopo province, South Africa
- explore and describe the experiences of forensic nurses when rendering care to victims of sexual assault in selected public hospitals of Limpopo province, South Africa
- recommend relevant measures to address the work experiences reported by forensic nurses in selected public hospitals in Limpopo province, South Africa

1.5 DEFINITIONS OF KEY CONCEPTS

For the purpose of this study the following terms are defined as used in the study beginning with forensic nurse.

1.5.1 Forensic nurse

Forensic nurse refers to a nurse who has advanced knowledge in forensic evidence collection and preservation, treatment protocols for victims of sexual assault, domestic violence, child and elderly abuse, human trafficking, legal proceedings and legal expert court testimony (Hamme, Moynihan & Pagliaro 2013:4).

In this study forensic nurse refers to a nurse who has received a specialised forensic nursing training and has advanced knowledge in forensic evidence collection and preservation, treatment protocols for victims of sexual assault, legal proceedings and legal expert court testimony, working in public hospitals in Limpopo province, South Africa.

1.5.2 Forensic nursing

Forensic nursing refers to the application of the nursing process to public or legal proceedings, the application of legal health care in the scientific investigation of trauma

and/or death related to abuse, violence, criminal activity, liability, and accidents (Lynch 2004 cited in Hammer et al 2013:3).

In this study forensic nursing refers to the application of the forensic health care by a forensic nurse towards victims of sexual assault in the scientific investigations of sexual assault cases in the public hospitals in Limpopo province.

1.5.3 Sexual assault

Sexual assault refers to any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home or work (WHO 2003:par 2.1).

In this study sexual assault refers to all non-consensual sexual actions intentionally committed to an individual, involving touching, visual and penetration of any sort by the perpetrator/s.

1.5.4 Victim

A victim refers to a person who has suffered some kind of misfortune (Walklate 2007:27). In this study a victim refers to an identifiable person who has been sexually assaulted individually and directly by the perpetrator/s who is receiving care at the selected public hospitals in Limpopo province.

1.5.5 Experience

Experience refers to the knowledge that one has gained from life and from being in a lot of different situations (*Macmillan Dictionary Online* 2009a, "experience"). In this study experience refers to the forensic nurses' happenings, direct personal participation or observation; actual knowledge or contact in the caring of victims of sexual assault in selected public hospitals of Limpopo province, South Africa.

1.5.6 Support

Support refers to the approval of an idea of a person or organisation and helps them to be successful (*Macmillan Dictionary Online* 2013, “support”). In this study support refers to the agreeing with and giving of encouragement by structures like hospital management, Department of health Limpopo province, South African Nursing Council, friends and family towards forensic nurses to help them emotionally and in a practical way.

1.5.7 Vicarious trauma

Vicarious trauma refers to the general stress and conflicted feelings that may be aroused from working with victims/survivors of violence” (Hoff 2009:191). In this study vicarious trauma refers to the general stress and conflicted feelings by forensic nurses that have aroused from working with victims of sexual assault in selected public hospitals in Limpopo province, South Africa.

1.5.8 Public hospital

A public hospital is a hospital which is owed by a government and receives government funding (*Wikipedia, the Free Encyclopedia* 2013, “public hospital”). In this study a public hospital refers to a hospital in Limpopo province, South Africa which is owned by a government and receives government funding.

1.5.9 Caring

Caring refers to the taking of serious attention, especially to the details of a situation or something (*Cambridge Advanced Learners Dictionary* 2007, “caring”). In this study caring refers to the feeling, exhibiting concern and empathy by forensic nurses towards victims of sexual assault.

1.6 RESEARCH DESIGN AND METHOD

In this section the researcher discusses the research design and methods used in the study, such design and methods are comprehensively discussed in chapter 3.

1.6.1 Research design

Polit and Beck (2008:66) argue that a research design is the researchers overall plan for obtaining answers about the phenomenon under study and for managing the problems that may arise during the research process. In this study the researcher adopted a qualitative, explorative, descriptive and contextual research design, because it attempts to describe human experiences as provided by people who lived them (Polit & Beck 2008:17).

1.6.2 Study setting

The study was conducted in Limpopo province which is one of the rural provinces of South Africa; it is situated at the north-eastern corner of South Africa with the population estimation of 5.5 million people.

Limpopo province has five districts, which are Vhembe, Capricorn, Sekhukhune, Waterberg and Mopani. The total numbers of hospitals are 40, with two tertiary, five districts, five regional, five community and three specialised hospitals. Capricorn district has a total of nine hospitals, Vhembe eight, Waterberg eight, Mopani eight and Sekhukhune seven (Limpopo Department of Health and Social Development [Sa]).

The setting of the study was the hospitals where participants come into contact with victims of sexual assaults. The hospitals where the study was conducted are Mankweng tertiary hospital in Capricorn district, Lebowakgomu district hospital Capricorn district, Letaba district hospital in Mopani, Seloam district hospital in Vhembe district and Kgapanne district hospital in Mopani district. As a result this inquiry was undertaken at the casualty department, trauma centres and Thuthuzela care centres where participants met victims. The map below shows the map of Limpopo province and districts.

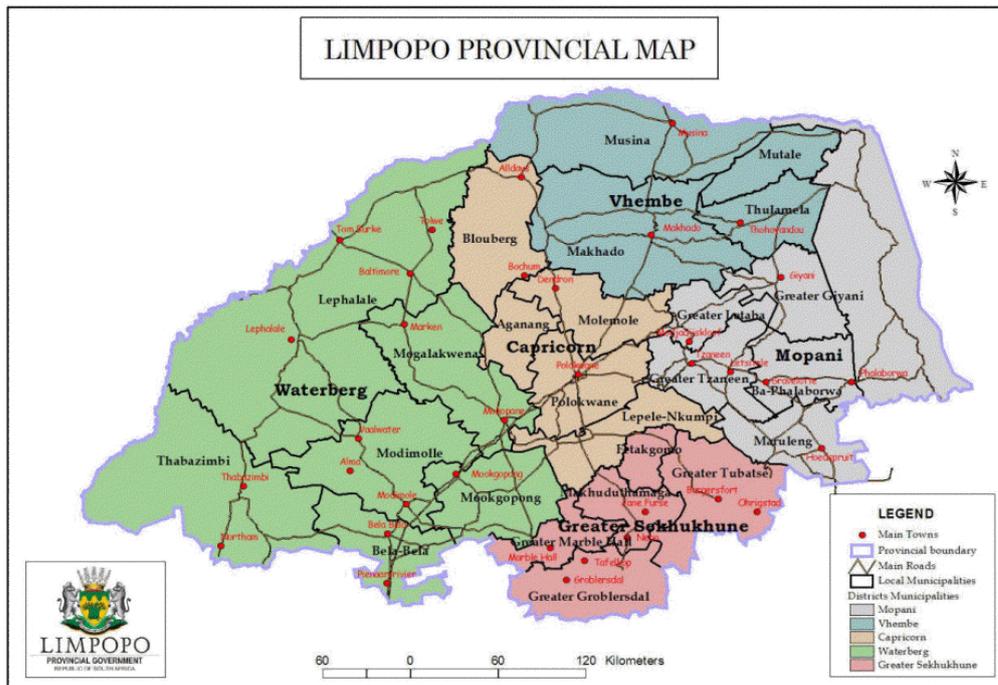


Figure 1.1: Map and districts of Limpopo province
 (Source: Limpopo Provincial Government [Sa])

1.6.3 Research methods

Research methods are the technique used by the researcher to structure a study, to gather and to analyse data relevant to the research question (Polit & Beck 2008:17). Once the aspects of the design are discussed, it is necessary to discuss in detail the research methods used by the researcher in this study. In this section, the research method entails study population, sample, sampling, data collection, data analysis, ethical consideration and trustworthiness.

1.6.3.1 Population

Population are all set of individuals who meet the sample selection criteria (Burns & Grove 2005:342). Polit and Beck (2008:338) also view population as entire aggregate of individuals in which the researcher is interested in. For the purpose this study the researcher’s population of interest were all trained forensic nurses working in Limpopo province and the accessible population was all forensic nurses trained by nursing directorate of Limpopo Department of Health and Social Development.

1.6.3.2 Sampling

Burns and Grove (2005:341) refer to sampling as a process which involves selection of people with whom to conduct a study by the researcher. In line with this definition, Polit and Beck (2005:341) also define a sample as a selected group of people or elements to be included in the study. In qualitative research the researcher relies on people who can articulate and be introspective enough to provide in-depth descriptions of their experiences (Padgett 2008:53). In this study sampling was non-probability and purposive. Berg (2009:50) explains that a non-probability sample offer the benefit of not requiring a list of all possible elements in full population.

- **Eligibility criteria**

In order for forensic nurses to participate in this study, they had to meet a specified inclusion and exclusion criteria. According to Burns and Grove (2005:342), eligibility criteria is defined as a list of characteristics that are essential for membership in the target group. In this study, the researcher formulated the following inclusion criteria of the study, see chapter 3 for a detailed eligibility criterion.

1.6.3.3 Sample

Sample size in qualitative research does not necessarily determine the importance of the study or quality of data (Holloway & Wheeler 2010:146; Polit & Beck 2008:339). Burns and Grove (2005:358) assert that in qualitative research the number of participants is adequate when the researcher has reached saturation of information in the area of study.

1.6.3.4 Data collection

Burns and Grove (2005:430) state that data collection is a process of selecting individuals and collect information from the individuals wherein the steps of information collection is specific to each study and the measurement depending on the research design and the measurement methods. In this study the researcher used, in-depth individual unstructured interviews. This method is discussed in detail in chapter 3.

1.6.3.5 Data analysis

Polit and Beck (2008:751) state that data analysis involve the systematic organising and synthesis of research data that is, the sifting, charting and sorting of data according to key issues and themes. The researcher started data analysis during data collection, i.e. the researcher simultaneously collected and analysed data (Grove, Burns & Gray 2013:280). After each interview the researcher briefly analysed and reflected on the data obtained so as to interpret the inherent meaning. These analyses influenced the next interview in terms of the probing questions asked. See chapter 3 for a full description of the data analysis approach followed in this study.

1.6.3.6 Ethical consideration

Stommel and Wills (2004:373) state that “ethics concerns the descriptive and prescriptive questions of morality, focuses on the concepts and principles of how human beings do and should think and behave”. In this study the ethical clearance was obtained from the University of South Africa’s Health Studies Research Ethics Committee (Annexure B). Permission to conduct the study was requested and obtained from the Department of Health and Social Development of Limpopo province (Annexure A and Annexure C). Informed consent was obtained from each participant guaranteeing each participant the following: privacy, anonymity, confidentiality and respect (Annexure D). See chapter 3 for full description of ethical considerations in this study.

1.6.3.7 Trustworthiness

In qualitative research every researcher wants their research findings to represent the truth (Polit & Beck 2008:195). Hill (2012:175) states that in 1981 Guba suggested that qualitative researchers should use following terms that describe operational techniques supporting rigour: credibility, dependability, conformability and transferability. These four aspects of trustworthiness are fully discussed in chapter 3.

1.7 SCOPE OF THE STUDY

The scope of the current study was limited to forensic nurses who are providing care to victims of sexual assault, who are working in Lebowakgomo, Mankweng, Kgapanne, Letaba and Seloam public hospitals in Limpopo province, South Africa.

1.8 STRUCTURE OF THE DISSERTATION

The report is organised in five chapters in the following manner:

Chapter 1 gives the general overview of the study. It gives the introduction to the study and further highlights the research problem in terms its background information. The aim is explained with reference to the purpose and objectives of the study. The significance of the study is included together with the definition of terms. The following aspects are also briefly covered, namely, the research design and methodology; scope and limitations of the study, research ethics; abbreviations; structure of the dissertation and conclusion.

Chapter 2 covers relevant literature that has been reviewed to give a background to this study.

Chapter 3 describes the research design that was used and the methodology followed in terms of sampling and sample selection; data collection including approach, development and the characteristics of the data collection tool; and data analysis. Ethical considerations pertaining to sampling and data collection are highlighted.

Chapter 4 includes analysis, presentation and description of the research findings.

Chapter 5 outlines the conclusion of the study and recommendations made from the research results.

1.9 CONCLUSION

In this chapter the background and the context of the study was described. The problem statement and significance of the study as well as objectives, purpose, research design

and method were also explained. Relevant concepts were defined and an outline of the study was provided. The next chapter will present findings of the relevant literature reviewed for the study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents findings of the literature reviewed that focused on forensic nurses' experiences when providing care to victims of sexual assault. The researcher conducted an extensive literature search on relevant concepts which include among others, forensic nursing, sexual assault, sexual assault nurse examiner (SANE) and vicarious trauma to understand the realities, expectations and the importance of forensic nursing. Both the national and international perspectives of relevant published studies were reviewed.

2.2 FORENSIC NURSING

Forensic nursing is defined as “the application of nursing science to public or legal proceedings; the application of the forensic aspects of health care combined with the bio-psycho-social education of the registered nurse in the scientific investigation and treatment of trauma and/or death of victims and perpetrators of abuse, violence, criminal activity and traumatic accidents” (Lynch 1991 cited in Lynch 2006:3). Clements and Crane (2006:43) further describe forensic nursing as the nursing speciality which incorporates the tenets of holistic medico-legal care for living and deceased victims, actual and potential offenders, their families, and the surrounding community at large.

2.2.1 Scope of forensic nursing

Despite all the developments of forensic nursing as an area of nursing speciality, in some of the countries forensic nurses are still facing some significant scepticism and opposition by other health professions and by authorities. In America forensic nurses are recognised, they examine, treat and refer victims of violence to other resources as indicated by Lambe and Gage-Lindner (2007:122), in contrast forensic nursing in South Africa are not recognised by the South African Nursing Council as one of nursing

specialities hence in the study done by Abdool and Brysiewicz (2009:19) in Durban on nurses working at the emergency department, about the description of the forensic nursing role in emergency department respondents indicated the need for post registration training of forensic nursing in South Africa.

From the report of the inaugural Forensic Nursing conference in Sydney by Anderson (2013:26), Jennifer Markowitz an editor of Forensic Health Online stated “making the role of forensic nurse better known and to expand the understanding of the forensic nurse model ...” “... it is one of the greatest challenge ...”, and further said, victims of violence often come back to the health system with different complaints resulting from maltreatment, and those kind of complaints can be costing and this could be as a results of only looking at the short term needs of victims.

Forensic nursing has two divisions, namely, clinical forensic nursing which is the application of medical and forensic science by forensic nurses to the living and forensic pathology which is the application of medical and forensic sciences to the dead (Hammer et al 2013:6).

2.2.2 The primary roles of forensic nurses

The roles of forensic nurses include, forensic examinations, collection of evidence, recording, health promotion, counselling, education and research (Rutty 2006:151). The roles of forensic nurses could be frustrated by lack of guidelines in most hospitals as indicated by Johnston (2006:185) that most hospitals do not have clear documented appropriate guidelines like policies and that leaves nurses being not ready to play their roles.

Lynch (1990) cited in Hammer et al (2013:7) did a descriptive study to identify the roles of forensic nurses in an emergency department, from the study the need for multidisciplinary team approach roles of forensic nurses to the identification of forensic trauma cases and preservation of evidence was promoted.

Providing care to victims of sexual assault is one of the core application of forensic nursing, those forensic patients includes adults, children, male and females, the living and the dead (Lynch 2011:72).

2.2.3 Forensic nurses as sexual assault nurse examiners (SANE)

The effects of sexual assault on a victim may be minimised by the provision of proper comprehensive care by SANE. Skhosana and Peu's (2009:3) findings from a study about experiences of nurses who provide care to victims of sexual assault in the emergency department in South Africa, revealed that a hand full of forensic nurses are needed to care for victims of sexual assault, as people are raped on a daily bases.

2.2.3.1 Functions of sexual assault nurse examiners (SANE)

When victims of sexual assault enter the health system with the chief complain of sexual assault, it is the role of the SANE to meet the multiple needs of the victim at the same time providing medical and nursing care while performing holistic forensic procedures along with objective documentation that may be used in the near future during giving of expert testimony in court.

The primary role of SANE addresses the comprehensive needs of the victim. The objective is to provide medical forensic examination and evaluation of evidence. As part of the roles of SANE, the forensic examination may include the following aspects as outlined by (Hammer et al 2013:351):

- Obtaining the history of sexual assault
- Providing crises intervention
- Obtaining of victim's pertinent medical history
- Performing of physical examination and assessment with focus inspection and evaluation of the forensic evidence of the body
- Evidence preservation and collection
- Treating and /or referring the clients for subsequent medical issues
- Meticulous documentation
- Interacting with clients in an objective and neutral manner that promotes informed decisions related to the available treatment options and the collection of forensic evidence
- Providing of expert testimony in court

Understanding of sexual assault or rape and the effects it has on the victim is important for SANE. In a survey done on 231 SANE programmes serving adults and adolescents in United States by Logan, Cole and Capillo (2007:28), when respondents asked on the benefits of SANE programmes for victims, 90% of respondents mentioned providing of client centered care, which includes non-judgemental and compassionate attitude, one-on-one care, specialised medical care, expertise, documentation and multidisciplinary approach services.

Martin, Young, Billings and Bross (2007:8) reviewed literature and compared two groups of sexual assault victims, one attended by SANE and the other group attended in a multidisciplinary setting, the findings was that victims who received care from SANE received high quality care, wherein high percentage of crime kits were fully completed and high percentages of consent forms were completed. This is confirmed by the findings of Skhosana and Peu (2009:130) in the study done in South Africa with nurses who provide care to victims of sexual assault, one of the participants indicated that “sexual assault cases that are attended by the medical officer do not get quality care because doctors are always in a hurry.”

Lewis-O'Connor (2008:224) evaluated the differences of the service provided by SANE and those provided by non-SANE to the victims of sexual assault in Freehold, Wichita and Boston and found out that of the 420 acute adult sexual assault cases with equal samples of SANE and non-SANE cases, with cases seen by SANE more evidence was collected, relevant documentation of injuries in 41% of SANE compared to 18% only of non-SANE and where alcohol was used SANE collected toxicology kits in 96% of cases and non-SANE was collected in only 3% of cases.

2.3 SEXUAL ASSAULT

The legal definitions of sexual assault or rape differ from country to country. A person commits sexual assault when he or she intentionally touches or penetrate the other person's body in a sexual manner without consent (Maclay 2009:137).

2.3.1 Characteristics of sexual assaults

Mostly women are the ones who become victims of sexual assault. In a study done by Morgan, Brittain and Welch (2012:2424) among 135 cases of multiple perpetrators and 139 cases of single perpetrators victims of sexual assault from Havens sexual assault referral centres, the results showed that the majority of victims were females on both groups.

People either get sexually assaulted by someone they know or by a total stranger, in most cases the assault is through vaginal-penile penetration. The study done by Ingemann-Hansen, Sabroe, Brink, Mpsych and Charles (2009:184) among 423 sexual assault victims, showed that 70 % of the victims were perpetrated by a person known to them and only 31% were sexually assaulted by strangers. Monroe, Kinney, Weist, Dafeamerkpor and Reynolds, M (2005:767) in their study found that out of 125 cases studied from 19 sexual assault centres that provide rape care in Maryland States, 42% were sexually assaulted by relatives, 16,8% by love partners, 12% by someone they know and only 8.8% was by stranger. Similar findings was reviled in the study by Murphy, Potter, Pierce-Weeks, Stapleton and Wiesen-Martin (2011:137) in New Hampshire, United states, examining SANE data about clinicians considerations based on victim-assailant relationship. Of the 741 women examined by SANE, their documents were studied and findings showed that 53% were sexually assaulted by people they knew, 18% it was by intimate partners and 11% were sexually assaulted by strangers.

Consistent with the above findings, of the 741 women studied through examination of SANE data on clinical considerations based on victim-assailant relationship from 1997-2007 in new Hemisphere, United States, it was found that 53% were assaulted by non-strangers, 18% were assaulted by intimate partner and 11% were assaulted by strangers (Murphy et al 2011:139). These findings support the notion that most of the sexual assaults cases take place at home or in secure environment.

Murphy et al (2011:139) in New Hemisphere United States found out that of the 741 women studied 96% were assaulted by males and only 5% were assaulted by females. In Ingemann-Hansen et al (2009:184) the finding were from the 423 cases studied 87 % were vaginal penetration, 26% oral penetration and 12% anal penetration.

In most cases the perpetrator uses different ways to coerce the victim, such as verbal threats, physical restraints, use of drugs, and physical violence. Brecklin and Ullman (2010:1510) in their study on the roles of victims and offender's substance use in sexual assault outcomes conducted in the Midwestern City of America amongst 970 female victims found that 71.8% of the perpetrators used physical force in their victims. This is supported by Murphy et al (2011:139) who found out that in 741 cases studied weapons were used to perpetuate the sexual assault in 8% of the cases. Another study conducted in South Africa, Cape Town by Kalitchman, Simbayi, Cain, Cherry, Henda and Cloete (2007:23) examined the hostility attitudes toward women, acceptance of violence against women and masculine ideological beliefs in relation to sexual assault history amongst men, and of the 435 cases, the findings showed that 12% had used threats to force a woman to have sexual intercourse with them and 19% reported to have used force to pursue a woman to have sexual intercourse with them.

2.3.2 Effects of sexual assault on a victim

Sexual assault has both long and short term consequences. The effects can be devastating in a multitude of ways and its consequences may produce physical, medical and psychological consequences, which may include life threatening injuries, nightmares, distribution in relationships, cost for treatment and follow ups and the trauma of having to go through the entire legal journey.

Evidently, post sexual assault most of victims have many needs to be fulfilled; victims may go to many formal services that are available for them. Campbell et al (2001) cited in Campbell, Dworkin and Cabral (2009:233) indicated that 26% to 46 % of victims usually report the cases to police, 27% to 40% usually report their case health facilities seeking medical care 16 to 60% do receive mental health care services.

2.3.2.1 Physical effects

Sexual assault injuries can include injuries to the vagina, anus, and or rectum, oral cavity, penis or scrotum. People who had been sexually assaulted may also suffer non genital trauma, which may be the results of strangulation, self-defence or a physical attack by the assailant.

Morgan et al (2012:24) studied the roles of victims and offenders in substance use in sexual assault found out that 75,5% of victims had injuries in the body and anogenital, victims of multiple perpetrators had higher % of injuries than those of single perpetrators. Brecklin and Ullman (2010:15) studied the roles of victims and offenders in substance use in sexual assault in 970 female victims and found out 83% of victims were injured by their offenders. Murphy et al (2011:138) discovered that 20% of the victims suffered genital injuries and 38% suffered non genital trauma, of which there was a relationship between the assailant type and the type of injuries sustained, 48% of the non-congenital trauma it was an intimate partner, the 54% of the time the assailant was a stranger.

A retrospective study on the severity of injuries among sexual assault victims was conducted among 113 sexual assault cases files in Belgrade district court in the Republic of Serbia by Alempijevic, Savic, Pavlekic and Jecmenica (2007:267). The findings revealed that 63.4% of the victims had extra genital injuries those injuries were mostly recorded from the extremities that's 32% from the face 7% from the scalp 5.3%, from the neck 7% and general body bruising constituted 50%.

2.3.2.2 *Medical effects*

Victims of sexual assault may develop medical conditions following sexual assault due to the inability to accept what had happen to them or due to lack of support from the system.

Burger and Clements (2006:116) in a case study of an elder woman who has been raped, found out that following the sexual assault the woman was diagnosed with Alzheimer's dementia, hypertension, atherosclerotic cardiovascular disease, arthritis and repair of right hip fracture. Burger and Clements (2006:116) on their case study of a 62 old elderly widow found out that after the sexual assault she was hospitalised because of cerebral vascular accident affecting her right hand and speech.

2.3.2.3 Psychological effects

Victims of sexual assault are traumatised and when visiting the hospital usually they are experiencing a wide range of emotions, such as feelings of helplessness, powerless, shame, guilt, loss of control, embarrassment, concern about sexually transmitted infections and pregnancy, fear of telling, bitterness, and fear of testifying in court, isolation and so many feelings. Campbell et al (2009:235) found out that self-blame is common amongst American women who have been raped, which intern lower the self-esteem of victims. Blame of victims by legal and medical system do contribute to the victim's self-blame (Campbell 2005 cited in Campbell et al 2009:237), this is supported by Amar (2008:14) who investigated violence in nursing, critical reflection on victim's stories from four students, one of the students indicated that a victim in some way or form have asked to be raped, whether by the way of dressing or by the route she used when going wherever, in the same study one student indicated that victims are left alone to pick up pieces of their lives after rape and further relate the victims story of having to live the life as a survivor after having to deal with stares, roomers, doubt from authorities and friends, family that is not able to bear the pain and the fight of trying to make sure that the rapist is in jail.

Burger and Clements (2006:115) reviewed the records of 284 elderly sexual abuse and from the findings, 27 elders reported numbness, 25 reported psychological upset, 14 startle, 12 reported anger the symptoms reported being deregulation in eating and sleeping pattern.

2.4 EXPERIENCES REGARDING CHALLENGES FACED BY SANE

Forensic nursing is relatively a new field, that is yet to meet its full potential and forensic nurses still face many professional, legal, organisational and victims related challenges during the execution of their work.

2.4.1 Professional challenges

2.4.1.1 *Lack of recognition*

In South Africa there is lack of formal recognition of forensic nursing as a speciality by the South African Nursing Council, despite the study done by Abdool and Brysiewicz (2009:19) in Durban describing the critical roles played by forensic nurses working in emergency department. The study also revealed that participants strongly felt that forensic nursing should be part of post registration training in South Africa. Furthermore, they indicated that it will be helpful if a forensic nurse is allocated in the casualty department to provide care to victims of sexual assault (Abdool & Brysiewicz 2009:19). Lack of recognition also leads to lack of interest in forensic training by nurses. This is confirmed by the same study when participants were asked if they did receive forensic training and only 9% indicated to have received training while 70% did not, which they felt contributes to poor rate of conviction due to helping victims of violence without enough training (Abdool & Brysiewicz 2009:19).

SANE encounter recognition challenge from the doctors that they are working with, as evidenced by findings from a study conducted by (Maier 2012:1227) which include emotional challenges. SANE verbalised that doctors sometimes believe that SANE are overstepping boundaries when they are conducting forensic examination and they start to question nurse's credibility (Maier 2012:1227).

Further findings revealed that SANE does encounter challenge when working with law enforcement officers, who does not believe that collection of evidence is part of their work, they belief forensic nurses are overstepping boundaries, and this is confirmed by (Maier 2012:1329).

2.4.1.2 *Lack of support from organisation's management*

In a study conducted by Plichta, Clements and Houseman (2007:19) it was found that the hospital administration opposes the SANE programme. While SANE provides the best care to victims of sexual assault not all the hospitals have the SANE programmes especially the small and rural hospitals, and in hospitals where they have SANE programmes there is lack of uniformity in the implementation of SANE programmes

Plichta et al (2007:21). Organisational support only becomes available during the times where when there is government interest in the programme and where political interest is focused on the programme (Maier 2012:87).

Organisational support can be seen by SANE through the availability of policies, procedures and protocols for the care of victims of sexual assault and this leads to quality care. Literature reviewed by Martin et al (2007:6) on studies that surveyed clinicians who assess and /or care for sexual assault victims, Rosenberg, DeMunter and Liu (2005:1454) found out that 9% of the departments did not have written protocols of caring for victims of sexual assault. The same findings was produced in the study done by Eldredge (2008:160) assessing the trauma nurse's knowledge related to forensic practice on 38 trauma nurses working at trauma resuscitation and emergency departments, when asked about the existence of forensic protocols in the departments, 42% reported that they were unsure. Participants in a study conducted in South Africa indicated that one of the challenges they face is that structures in place for the management of sexual assault are not uniform across all provinces, which can have an effect when going to court to give expert testimony (Skhosana & Peu 2009:119).

2.4.2 Lack of resources

Forensic nurses faces a challenge of lack of resources, in the study done by Logan et al's (2007:25) findings revealed that, from the participants only about half had resources specific for care for victims of sexual assault and further says that only 40% had a one fulltime SANE. Lack of resources is more of a challenge with services being rendered in rural areas (Averill, Padilla & Clements 2007:44). From a literature reviewed by Martin et al (2007:5) on health care-based intervention for women who have experienced sexual assault violence, clinic managers indicated that some clinics need improvement with regard to resources they have concerning dealing with violence against women.

Funding for the programmes that provide care to victims of sexual assault has been identified as one of the challenges faced by SANE. The study conducted by Maier (2012:86) revealed that forensic nurses at the hospitals are not part of the budgeting process for the programmes and this lead to them not being aware of financial constraints the programme is facing, and those forensic nurses who are directors of the programme had perception that cutting of funding is as a results of lack of political

interest to the programme. Lack of funding has an impact on the way forensic nurses are compensated, which then lead to them not having enough time to make follow-up with victims after they left the hospitals and lack of follow-up care to victims may be problematic as they may never come back to receive follow-up care (Maier 2011:166) and further more without enough funds SANE may not be able to go for training and conferences for professional development (Maier 2012:87).

SANE are unable to conduct community awareness about rape in order to influence change on the perceptions and myth about rape due to lack of funds.

2.4.2.1 Shortage of forensic nurses

In a study done at Odi hospital South Africa by Changwa and Pather (2008:45a), it was found that due to lack of trained staff at the hospitals, victims of sexual assault tend to wait for a long time. This finding is confirmed by Maier (2012:89) who found that due to lack of SANEs, victims are not treated as high-priority in the emergency departments which leads to long waiting hours before receiving medical attention. Patel, Roston, Tilmon, Stern, Roston, Patel and Keith (2013:25) also found that of 642 hospitals that were studied to assess the extent of provision of comprehensive medical care management for female sexual assault patients in the United States hospital emergency departments, 44.2% indicated that they always have SANE programme, and of the hospitals that did not have SANE the common reasons mentioned was inadequate staffing or financial constraints.

A study conducted by Skhosana and Peu (2009:119) in Mpumalanga province at Nkangala district in South Africa, findings showed that the shortage of trained staff to provide care for victims of sexual assault was a challenge. Although the training of forensic nurses taking place is not recognised by the South African Nursing Council, half of participants indicated they would like to be trained in the management of sexual assault cases. In addition literatures reviewed by Macy, Giattina, Sangster, Crosby and Montijo (2009:370) sources specifically recommend that services provided for victims of sexual assault should be provided by professionals who have received the training of managing sexual assault.

Logan et al (2007:29) did a survey with 231 SANE programmes and found out that one of the challenges programmes encounter was the issue of staffing, which include problem with recruitment, retention and scheduling, all this being the results of lack of funding. Where this are enough funding for SANE programmes more staff could be recruited, more staff could be trained, and more and relevant equipment could be purchased. Provision of effective care to victims of sexual assault by SANE, staff should be able to cover 7 days 24 hours per day. Enough funding will be able to pay SANES and this will lead to retention of SANE in the programmes and ultimately will lead to the improvement on provision of quality comprehensive care to victim of sexual assault.

2.4.2.2 Infrastructure

Victims of sexual assault have special needs like provision of safety and privacy hence the need for special infrastructure to cater for those needs. Most of the sexual assault victims are examined in the emergency departments, the survey on 231 SANE programmes about SANE programmes characteristics, barriers, and lesson learned by Logan et al (2007:25), the findings indicated that 61% of programmes was being administered in the emergency departments of the hospitals, 96% of the examinations were done in the hospitals and only half of the programmes has specific designated area for the caring of sexual assault victims.

Skhosana and Peu (2009:120) found out that emergency departments were not proper for sexual assault victims in providing care, because of its busyness and the setting that do not cater for privacy. The findings from the study done at Odi district hospital in the North West province South Africa by Changwa and Pather (2008:45a) reported that the waiting area was not appropriate, and the rooms used for examination of sexual assault victims were not appropriate. In a study by Maier (2012:89) participants made a recommendation that dedicated units for sexual assault victims should be built in the emergency departments, the same recommendation of having a private room away from the main emergency unit was made by participants in the study done by Skhosana and Peu (2009:130) on experiences of nurses who care for victims of sexual assault in Nkangala district, Mpumalanga province of South Africa.

The findings from a study done by (Maier 2012:302) on SANE perceptions of re-victimisation of victims, SANE indicated that lack of proper system where victims has to

sit in the emergency room contribute to victim re-victimisation, and when SANE comes to attend the victim already the victim has lost trust. Literature reviewed by Havig (2008:26) from 10 articles about patient information on the experience of child sexual abuse and its impact on health and health care for patients, it was found out that victims of sexual assault feel safe to disclose their assault in an exam room with walls rather than an enclosed room enclosed room with curtains.

2.4.2.3 Equipment

Lack of better equipment to provide care to victims of sexual assault in hospitals is perceived by SANEs as a result of lack of funding (Maier 2012:89), which eventually lead to poor quality of patient care. It was revealed in a study done in South Africa on perspectives of nurse's managers on retaining professional nurses that refurbished and better equipment in the hospitals improve the quality of patient care (Mokoka, Oosthuizen & Ehlers 2010:5). The study done at Odi hospital in South Africa by Changwa and Pather (2008:45c) revealed a lack of equipment which led to experiences of frustrations among health care providers who are involved in the treatment of victims of sexual assault.

2.4.2.7 Workload

The study done by Skhosana and Peu (2009:2) participants expressed the challenge of workload when dealing with sexual assault patients due to unequal distribution of workload among the multidisciplinary team. In the literature reviewed by Chouliara et al (2009:48) on vicarious traumatisation in practitioners who work with adult survivors of sexual violence and child abuse, high workload and high exposure was correlated positively with the development of post traumatic disorder and vicarious trauma amongst SANE, contrary to this the same study found high exposure to victims of sexual violence was associated with high spiritual wellbeing of the professionals.

SANE feel like they are shouldering the burden of the program on their own, when there is a problem with coverage they feel compelled to take call or respond to victim even when they are not on cover; this was a finding in a study done by Maier (2011:65).

2.4.3 Challenges related to victims

2.4.3.1 Late reporting

Most of the care given to victims of sexual assault has time frames, for evidence to be collected from victim of sexual assault ideally it should be done within 72 hours post assault, it becomes a challenge to forensic nurses when their victims report to the hospital late. A study done by McCall-Hosenfeld, Freund and Liebschutz (2009:294) on factors associated with sexual assault and time of presentation in all sexual assault patients presenting to 24 SANE affiliated hospitals in Massachusetts showed that of 955 cases studied, 392 presented to the hospital before 72 hours. From the same study McCall-Hosenfeld et al (2009:294) late reporting was found to be influenced by the following findings, assault at home(16 h versus 12 h, p less than 0.05) and known assailant (17h versus 15 h, p=0.056).

2.4.3.2 Legal challenges

SANE makes conclusions of the cases based on the observations they made from the victims not on personal opinions. The study done in United States on 11 SANE programmes who work with law enforcement on how SANE balance patient care and law enforcement and collaboration revealed that SANE encounter challenges when law enforcement ask them to give their personal opinions on whether they think the case is worth to investigate or not (Campbell, Greeson & Patterson 2011:22). SANE believe what they see or hear it just make a piece of the whole investigations.

2.4.3.3 Ethical dilemma

Forensic nursing operates under the values and principles of nursing, being objective, non-judgemental and being advocates of the patients. One of the important roles of forensic nurse is to conduct forensic examination and collect evidence from both victims of sexual assault and perpetrators of sexual assault, this pose an ethical dilemma to them when a need for a patient advocacy comes for the forensic nurse to advocate for a perpetrator of sexual assault. Literature reviewed by Patterson, Campbell and Townsend (2006:183) on SANE programmes and patient care practices revealed that

some of the SANE programmes appeared to be having a problem of meeting both patient and medico legal needs.

While one of the aims of forensic nurses is to increase prosecution of sexual assault perpetrators through their evidence of medical forensic examinations, some courts still refuse to accept the testimony of forensic nurses this is confirmed by Townsend & Campbell (2009:101) who found that programme goals for majority of SANE were, to improve quality of forensic evidence (54%) and to improve prosecution (50%).

2.4.3.4 Testifying in court

During expert testimony SANE's experiences the emotional unnerving while testifying and some difficulties with the defence and the prosecutors about the credibility of the victim, the quality of evidence and SANE's qualifications (Campbell et al 2007:11).

Forensic nurses who have seen and examine victims of sexual assault encounter preparedness challenge when going to give expert testimony in court, in the study done by (Maier 2012:1330) forensic nurses indicated that prosecutor do not prepare them when going to testify, and this lead to nurses being stressed and scared.

Campbell et al (2007:9) studied SANE's experiences providing expert witness court testimony from 288 SANE's programmes that serves adult victims of sexual assault in the United States and found out that 94% of SANE who performed the examination went to testify in court. Campbell et al (2007:9) further indicate that 49% found the court emotionally unnerving this was brought about their words being twisted in court, 25% had difficulties with defence attorneys regarding the victim, 23% had difficulties with attorneys regarding SANE's qualifications, 23% had difficulties with defence attorneys regarding exams or evidentiary findings and 12% had difficulties with prosecutor regarding preparedness, not knowing what to do with SANE's testimony.

2.4.4 Personal challenges

2.4.4.1 Role conflict

Forensic nurses have two combined roles, that of general nursing care and forensic nursing as a specialised area of care. In the study done by Downing & Mackin (2012:55) on the perception of role conflict and its effects on care delivery it was found out that majority of participants did not find any role conflict in what they do. In the same study some of the participants indicated the role conflict in a sense that being a nurse means advocating for patients and providing comfort to patients and that can create biases, because as an expert witness forensic nurse need to be neutral. Kent-Wikinson (2008:207) explored forensic nursing knowledge as a speciality area of study and educational development and interviewed some of educators who has established forensic nursing programs in North America and found out that SANE does experience dual roles dilemma as caregivers and evidence collectors as In contrast to the findings above the study on SANE providing care to victims of sexual assault, regarding role boundaries SANE indicated that they feel they would have done a good job if they offer (2011:20).

2.4.4.2 Emotional pain

The study done by Wies and Coy (2013:27), measuring vicarious trauma among sexual assault nurses examiners found that, 381% of nurses surveyed reported symptoms of vicarious trauma related to their work of working with victims of sexual assault.

Chouliara et al (2009:49) reviewed literature about vicarious traumatisation on practitioners who work with adult survivors of sexual assault and child sexual abuse and found out that practitioners had emotional exhaustion due to the power and intimacy beliefs.

The findings by Maier (2011:165) revealed that SANE experience emotional pain related to their job of listening to victims relating their experiences of sexual assault and also witnessing victims emotional pain on a daily bases. In the same study when asked about their main worries as SANE 67% indicated emotional demands related to their job, worrying about their patients after they leave the hospitals this leads to SANE suffer

pain of not knowing if the victims are okay. Logan et al (2007) and Scalzo (2006) cited in Maier (2011:166) indicated that most SANE are not able to know about their victims as they are not allowed to make follow up with the victims after leaving the hospital as this could be may affect the integrity of their testimony in court.

In South Africa Mpumalanga province Nkangala district a qualitative study about the experiences of health care provides managing sexual assault done by Skhosana and Peu (2009:127) revealed that nurses do experience emotional trauma, anger and fear due to working with victims of sexual assault.

2.4.5 Vicarious trauma

Vicarious trauma is a danger to anti-violence workers and an occupational hazard of the profession. In a survey done by Wies and Coy (2013:27) in the United States of America, amongst 42 SANE 38.1% of the nurses reported to having symptoms of vicarious trauma which is due to the kind of their work. Maier (2011:165) studied emotional challenges faced by SANE and found out that SANE experiences challenge of vicarious trauma and emotional demand produced by everyday listening to the detailed accounts of sexual assault and seeing the pain and trauma of victims, from the 39 SANE interviewed 51% reported having vicarious trauma.

Vicarious trauma has a life-changing effect on individuals which end up affecting the ways they view the world and relationships and the way they connect to family, friends and communities. Wies and Coy (2013:28) found out that vicarious trauma does has implications in both the personal and professional life of nurses, the personal quality of life become compromised due to the fact that the person will be experiencing symptoms like nightmares, fear, anxiety which have real implications in the total wellbeing of a person. Professional the presence of vicarious trauma do has a negative impact on the quality of care the SANE provide to victims. Hammer, Moyniha and Pagliaro (2006:34) referred to vicarious trauma as empathetic strain, secondary victimisation, or compassion fatigue.

2.4.5.1 Symptoms of vicarious trauma

Suffering from vicarious trauma involves profound changes in the core aspects of the individual, resulting in a mind shift in the way an individual experiences herself or himself, others and the world (Moulden & Firestone 2007:71). Symptoms of vicarious trauma are similar to those of post-traumatic stress disorder, which may include changes in an individual's physiological, psychological, and sociological functioning (Wies & Coy 2013:25).

A study done by Maier (2011:166) on SANE who are caring for victims of sexual assault and those who reported vicarious trauma, describes some of the symptoms they experienced as crying, feeling sorry for themselves, feeling frustrated, feeling preoccupied with work, wanting to resign as SANE and having difficulty in sleeping. SANE related their experiencing of symptoms to hard cases they attended, high number of cases in a short time and high number of hours at work. The findings are consistent with Chouliara et al (2009:50) where in the literature reviewed revealed that counsellors working with victims of sexual assault reported symptoms like anger, fear and sadness.

2.4.5.2 Factors contributing to the development of vicarious trauma in SANE nurses

Working with trauma is both individual and organisational challenging Perron and Hiltz (2006:230) did a survey on forensic interviewers of abused children across United States found out that the duration a person working as a forensic interviewer is not associated with the development of secondary trauma, that is $(r(57)=16,ns)$, that a person can work for more years working with victims of sexual assault and may not develop vicarious trauma and the other person may work a short time and still suffer vicarious trauma. In contrast a literature reviewed by Chouliara et al (2009:51) on vicarious traumatization in practitioners who work with adult survivors of sexual assault and child sexual abuse high work load and high exposure to victims of sexual assault correlates with the development of vicarious trauma and symptoms of post-traumatic stress disorder. Chouliara et al (2009:52) also found out that the development of vicarious trauma was associated with the short time and lack of experience of working with victims of sexual assault.

2.4.5.3 Coping with vicarious trauma

In the study done by Tosone et al (2012:237), from the shared trauma narratives of clinicians who work with traumatised patients in New York, the clinicians who had been experiencing a long tension and uneasiness, as a way of coping has changed priorities about life, more time was devoted in leisure and social activities and travelling abroad.

Professionals sometimes develop ways for coping but they can still develop severe reactions. Hammer et al (2006:35) says the most important skill of coping with vicarious trauma is by acknowledging that it is normal to be affected by the type of work the nurse is doing. An investigation in to vicarious trauma of the impact of providing sexual abuse treatment on clinician's trust and intimacy, from 383 clinical members of the Association for the Treatment of Sexual abusers and the American Professional Society of the abuse of children by VanDeusen and Way (2006:78), high number of respondents indicated using of positive coping skills and a use of professional help as a way of coping strategies.

Understanding that the reactions have been initiated by the traumatic experience, by understanding the reason of why and what is happening to a person and having the believe that the reactions are normal and natural this encourages for going for help and accept help when needed.

Literature reviewed by Chouliara et al (2009:51) revealed that most practitioners who work with victims of sexual assault and professionals who did not have good coping mechanisms had a higher level of vicarious trauma and those who has better coping mechanisms may stay longer in the profession because they will be less affected by the work. Chouliara et al (2009:50) further found out that those professionals who had good relationship to self and others has less chance of developing vicarious trauma than those without.

In the study done by Martine (2006:110) it was found out that 76% of nurses use support from their friends and families in dealing with vicarious. This is consistent with Maier (2011:167) on emotional challenges faced by SANE which indicated that their ways of coping as talking to family members, reaching out to other SANEs for

decompressing and talking about problems they experienced after hard cases, and detaching from victims.

2.4.5.4 Support system needed in vicarious trauma

The effects of vicarious trauma can be minimised by immediate debriefing after intense, painful sessions. Organisations such as emergency medical service have strategies for helping professionals to cope with trauma through education and training and by using techniques like debriefing, monitoring, supporting personal and counselling, Moulden and Firestone's (2007:75) findings maintain that the way a person who is exposed to trauma copes can be a result of whether the person feels supported or not, Moulden and Firestone (2007:75) further indicates that clinical Supervision, training and peer consultation are critical to support and to prevent inappropriate or unsupportive responses to particular situations. Active learning environment support renewal and staff wellbeing are important aspects in coping by professionals. Martine (2006:110) in her study found out that 86% of nurses felt that better working conditions and 84% felt support by management would minimise vicarious trauma in nurses dealing with traumatised patients.

A good working environment helps in providing clear guidelines, structures, roles and policies for staff members. Perron and Hiltz (2006:230) examined factor associated with burnout and secondary trauma among forensic interviewers of abused children across the United States and found that organisational satisfaction is negatively associated with the development of secondary trauma in forensic interviewers.

2.5 CONCLUSION

This chapter discussed the literature review conducted to gain insight into the experiences of forensic nurses when providing care to victims of sexual assault. In the next chapter the methodology used to conduct the study will be discussed.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter presents the research design and methodology used by the researcher in addressing the research objectives described in chapter one of this study. In this chapter the researcher discusses in greater depth the qualitative research strategy and methods applied in an effort to address the research objectives. The chapter begins with the orientation of readers to the research design that was used in this study followed by the methods applied in the research process. Ethical considerations are also presented in this chapter.

3.2 RESEARCH DESIGN

A research design is defined as a blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings (Burns & Grove 2005:211). In line with this definition Rebar, Gersch, Macnee and Macnee (2011:175) describe the research design as “the overall plan for acquiring new knowledge”. In addition to an overall plan Holloway and Wheeler (2010:339) is of the view that a research design also deals with methods and procedures for collecting, analysing and interpreting data. In this study the researcher explores the experiences of forensic nurses in rendering care to victims of sexual assault. As a result, a qualitative inquiry that is explorative, descriptive and contextual is employed by the researcher. The characteristics of this design are detailed in sub-sections of the design below.

3.2.1 Qualitative aspect of the design

In order to understand the experiences of forensic nurses in rendering care to victims of sexual assault, one has to apply a qualitative inquiry. Qualitative research is a form of social inquiry that focuses on the way people make sense of their experiences and the world in which they live (Holloway & Wheeler 2010:3). According to Polit and Beck

(2008:17), this approach to research places heavy emphasis on understanding the human experience as it is lived, usually through the careful collection and analysis of narrative and subjective data. Burns and Grove (2005:23) further add that it is a systematic and an interactive process of inquiry that gives life experiences meaning. Speziale and Carpenter (2003:18) are of the opinion that qualitative inquiry helps the researcher discover the emic view of research participants. They further argue that in this kind of inquiry, the researcher becomes an instrument of data collection. In this study, the researcher used a qualitative research strategy to explore the experiences of forensic nurses in rendering care to victims of sexual assault. The qualitative research strategy applied by the researcher in this study was explorative, descriptive and context bound.

3.2.2 Explorative aspect of the design

The main purpose of qualitative research is to explore the phenomenon in-depth. According to Polit and Beck (2008:21), exploratory research is used to understand the full nature of the little understood phenomenon, it is used to shed light on various ways in which a phenomenon is manifested. In addition to this Burns and Grove (2005:357) exploratory studies are not intended for generalisation to large populations, but designed to increase the knowledge of the field of study. In this study the researcher used this aspect of the design to explore forensic nurse's experiences when providing care to victims of sexual assaults.

3.2.3 Descriptive aspect of the design

In qualitative studies, once a phenomenon has been explored, it is necessary to describe in detail what has been observed during fieldwork. According to Polit and Beck (2008:274), the purpose of descriptive research is to observe, describe and document aspects of a situation as it naturally occurs in the field. According to Burns and Grove (2005:26), they provide an accurate portrayal or account of characteristics of a particular individual, situation, or group. These authors further state that descriptive studies are a way of (1) discovering new meaning, (2) describing what exist, (3) categorising information. In line with the objectives of this study, the researcher used this aspect of the design for the following reasons:

- To describe the socio-demographic characteristics of forensic nurses providing care to victims of sexual assault in selected public hospitals of Limpopo province, South Africa.
- To explore and describe the experiences of forensic nurses when rendering care to victims of sexual assault in selected public hospitals of Limpopo province, South Africa; and
- To recommend relevant measures to address the work experiences reported by forensic nurses in selected public hospitals in Limpopo province, South Africa.

3.2.4 Contextual aspect of the design

Qualitative research is not value free. It takes into consideration various factors that influence or shape the experiences or perception of the world. The context is important for the participant in qualitative research. According to Holloway and Wheeler (2010:41), “the context includes the environment and the conditions in which the study takes place as well as the culture of the participants and their location.” In order to understand the experiences of forensic nurses when providing care to victims of sexual assault, the researcher had to study the phenomenon within the setting or environment in which it takes place. The interviews were conducted in the natural context of the phenomenon. The setting of the study was the hospital where participants come into contact with victims of sexual assaults. As a result this inquiry was undertaken at the casualty or trauma centres where the participants met the victims.

3.3 RESEARCH METHOD

Once the aspects of the design are discussed, it is necessary to discuss in detail the research methods used by the researcher in this study. The purpose of this study was the exploration of the forensic nurses’ experiences of providing care to victims of sexual assault. The methods for data collection and analysis used are detailed bellow.

3.3.1 Population

Polit and Beck (2008:337) and Rebar et al (2011:106) define population as “the entire aggregation of cases in which a researcher is interested in studying”. In line with this statement Burns and Grove (2005:342) further describe the population as “the entire set

of individuals or elements who meet the sampling criteria” and further describe accessible population as “the portion of the target population to which the researcher has reasonable access”.

In this study, the researchers’ population of interest were all trained forensic nurses working in selected public hospitals in Limpopo province and the accessible population was all forensic nurses trained by nursing directorate of Limpopo Department of Health and Social Development.

3.3.2 Eligibility criteria

In order for forensic nurses to participate in this study, they had to meet a specified inclusion and exclusion criteria. According to Burns and Grove (2005:342), eligibility criteria are defined as a list of characteristics that are essential for membership in the target group. In this study, the researcher formulated the following inclusion criteria of the study:

- Participations had to be forensic nurses working in public hospitals in Limpopo Province, South Africa.
- Participants had to either be a male or female.
- Participants had to be providing care to victims of sexual assault.
- Participants had to be willing to provide an informed consent to be interviewed in this study.
- Participants had to give permission to be tape recorded during interviews.

3.3.3 Sampling and sampling technique

Burns and Grove (2005:341) refer to sampling as a process which involves selection of people with whom to conduct a study by the researcher. In qualitative research the researcher relies on people who can articulate and be introspective enough to provide in-depth descriptions of their experiences (Padgett 2008:53). In this study sampling was non-probability and purposive. Berg (2009:50) explains that a non-probability sample offer the benefit of not requiring a list of all possible elements in full population. This sampling approach was relevant in this study for the researcher was seeking data about forensic nurses’ experiences when providing care to victims of sexual assault.

3.3.4 Sample size

Sample size in qualitative research does not necessarily determine the importance of the study or quality of data (Holloway & Wheeler 2010:146). Burns and Grove (2005:358) assert that in qualitative research the number of participants is adequate when the researcher has reached saturation of information in the area of study.

3.3.5 Data collection

Data collection is the precise, systematic gathering of information relevant to the research purpose or the specific objectives or questions of a study (Burns & Grove 2005:733). This can be done in many ways. In this research project, the researcher used two methods of data gathering, namely: (1) in-depth individual unstructured interviews and (2) observations in the form of field notes. These are discussed below.

- **In-depth individual unstructured interviews**

In-depth unstructured face-to-face interviews were used to collect data, as was done by Ruffin (2007:66) and recommended by Ploeg (1999: 37.) in similar qualitative studies. Interviews involve verbal questioning of the participants by the data collector. This can be done over the phone or face-to-face (Lobiondo-Wood & Haber 2008:356). The later was adopted in this research. Participants had an option to choose between English and Sotho languages and all of them preferred English. Face-to-face interviews are characterised by synchronous communication in time and place. This allows the interviewer to get the additional information communicated by the interviewee non-verbally through social cues like intonation and body language (Brink 2006:147; Opdenakker 2006:3). At times participants were not comfortable or willing to verbally disclose some experiences of caring for individuals who had suffered sexual assaults, hence the need to capture non-verbal communication as well. In addition, it gave the interviewer an opportunity to clarify questions and concepts to the interviewees where there was a need (Brink 2006:147).

Research participants were given an informed consent form containing information about the whole research process, including the following: its purpose and benefits; the

data collection process; risks and benefits of the study as well as the participants' rights to choose to or not to participate and/or discontinue participation at any time without any penalty or differential treatment. The consent form also requested permission for the researcher to audio-tape all the interviews. Those who agreed to participate in the research were requested to sign the consent form (see annexure D).

- **Interview process**

Although participants had an option to schedule the interview at any other time later, all of them preferred to be interviewed instantly. The interviews were conducted in a private room negotiated for this purpose at the participants' work places.

A grand tour question was asked. This involves starting by asking one broad open-ended question in order to gain a general overview of the phenomenon, on the basis of which more focused questions would be subsequently asked. The grand tour question in this study was structured as: "*What is your experience of caring for individuals who have suffered from sexual assaults?*" This helped to elicit the initial impression about their experiences. Subsequent questions enabled a deeper and wider exploration of, and probing into, participants' feelings, opinions and perspectives so as to come up with the rich data that was required to discover their experiences of caring for such patients. The duration of the interview sessions were subjective, varying from about 20 minutes to about 60 minutes, with an average of 30 minutes. This was dependant on the amount of information which each participant was able to share. Further probing questions emerged subjectively as the interviews unfolded, depending on each participant's response (Polit & Beck 2004:340, 719). The researcher used communication techniques to facilitate participants to express themselves.

- **Communication techniques applied during the interviews**

The communication techniques applied by the researcher to encourage participants to express themselves included both verbal and non-verbal techniques. The verbal communication techniques include probing, clarification, paraphrasing/reflective commending, silence, empathy, summarising and short verbal response.

- **Probing:** Polit and Beck (2004:728) defines probing as eliciting more useful or detailed information from a participant in an interview than was volunteered on the first reply. According to Salazar et al (2006:184) cited in Matshediso (2008:74), it triggers additional thoughts thereby yielding detailed information necessary for a qualitative study. Probing in this study was mainly in the form of asking more specific and focused open-ended questions based on the initial response, as directed by the research objectives.
- **Clarifying:** Clarifying means to make clear or easier to understand (Farlex 2012; *Collins English Dictionary* 2006:141). The researcher ensured that participants accurately understood questions by elaborating where participants seem to have missed the point. Paraphrasing was also used to ensure accurate capturing of the message from participant.
- **Paraphrasing/reflective commending:** According to the *Oxford Dictionaries Online* (2012, “paraphrase”), to paraphrasing is to express the meaning of (something written or spoken) using different words, especially to achieve greater clarity. It involved mirroring to the participant what he would have conveyed, which could be the specific message, implication or underlying feelings. The researcher did this each time as need for clarity arose.
- **Silence:** The *Oxford Dictionaries Online* (2012, “silence”) defines silence as the fact or state of abstaining from speech, or complete absence of sound. In a trusting and rapport relationship, silence gives time for reflection and gathering thoughts and feelings. Similarly, in this study, silence was used to give participants to recall remote memories of their past experience.
- **Empathy:** This refers to the ability to recognise and acknowledge feelings of someone without experiencing the same emotions (*Merriam-Webster Online Dictionary* 2012; Health24 2003). This skill was used where participants expressed undesirable or painful past experiences or status that would have motivated them to care for victims of sexual assaults.

- **Summarising:** According to the *Macmillan Dictionaries Online* (2012b, “summarising”), summarising refers to providing a short account of the most important facts or features of something. It involves giving an overview of a text or using your own words to shorten a piece of text so that it includes only the essential information.

In this study, the researcher used the technique of summarising at the beginning of each interview session to give the participant direction. It was also used at any time when need arise to focus or make the participant move when he gets stuck. Each session was also concluded with a summary.

- **Short verbal response:** The researcher also used short responses like “Uhm ...” to encourage the participant to continue, or “ee” to show agreement. These were often used either to trigger further elaborations or as interjection in between a participant’s continuous narration.

In addition to the verbally expressed information by participants, non-verbal cues were also observed as recommended by Groenewald (2004:5). These were captured in the form of field notes as described in the following section.

- **Observations in the form of field notes**

According to Schwandt (2007), there is no standard definition of field notes, their form, or content. The *Oxford Dictionary of Archaeology in Answers* (2012) defines them as records of observations or interpretations made during fieldwork. Similarly, Polit and Beck (2004:718) defines them as the notes taken by the researchers describing the unstructured observations they have made in the field, and their interpretations of those observations. This was the conceptual definition adopted in this study, with a specific focus on those records in the form of written notes. These notes were in the form of jottings as described in Bernard (2011:293). These are scratch notes taken during the course of data collection to serve as a trigger to recall some observations, thoughts or realisation made during the process (Polit & Beck 2004:382; Wilson 1993:222; Moule & Goodman 2009:174; Bernard 2011:293).

Field notes can be broadly categorised into two: observational (descriptive) notes and theoretical (analytical) notes (Polit & Beck 2004:382), both of which were collected in this study.

- **Observational (descriptive) notes**

These are detailed and accurate descriptions of what the inquirer sees, hear, and experiences. They include the description of the participants themselves, their behaviours and reactions as well as the physical setting and environment itself. Accounts of particular events and actions in the setting are also be given, including the involved parties. The researcher-participant relationship is also described. This kind of notes constitutes the bulk of the total field notes taken (Polit & Beck 2004:382; Wilson 1993:222).

- **Reflective notes**

These comprise comments about researcher's own feelings and what the researcher is learning while collecting the data. They build on the descriptive field notes described above and go beyond mere descriptions to include speculations, feelings, problems, ideas, hunches, impressions, prejudices, analyses, plans for future inquiry, clarifications, syntheses, connections, and other ideas about what the researcher is learning in the inquiry. This way they help to provide a contextual framework for interpreting descriptive field notes, their analysis and the conclusions of the study as whole (Polit & Beck 2004:382; Wilson 1993:222).

Since in a qualitative research, the researcher serves as the data collection instrument, reflective notes also help to provide the bases for deducing possible influences of the researcher on the study findings, reflective notes can also be further categorised as follows according to their content and the purpose which they serve (Polit & Beck 2004:382).

- **Methodological notes:** These are reflections about strategies and methods used in the data collection. It is based on a review of these notes after each interview session that the researcher manages to progressively refine the

interviewing and observation skills. Any alterations to the originally planned method are indicated (Polit & Beck 2004:382; Wilson 1993:222).

- ***Theoretical (analytical) notes:*** These are reflections of the researcher's efforts to attach meaning to observations, and serves as the starting point for data analysis (Polit & Beck 2004:383). In fact they constitute the on-going process of clarifying meaning and interpreting the information being gathered in light of the relationships being developed between the researcher and the participants, and a better understanding of the phenomena of interest is obtained, a similar understanding may also be obtained from repeated reviewing of observational and methodological notes (Bernard 2011:258).
- ***Personal notes:*** These are comments about researcher's own feelings while in the field. They include emotions resulting from, and challenges encountered during, the field work. Ethical dilemmas and possible conflicts also form part of these notes. These notes are crucial in determining the possible influence of the researcher on the study results (Polit & Beck 2004:383).

All the field notes described above together with the audio-taped interviews were integrated into the data analysis process as described below.

3.3.5 Pilot interviews

Holloway and Wheeler (2010:341) describe pilot study "as a small scale trial of research interview or observations", Holloway and Wheeler (2010:88) further state "pilot studies are not always used in qualitative inquiry as the research is developmental, but novice researchers could try interviews with their friends or acquaintances to get used to this type of data collection.

Two interviews were conducted with two forensic nurses who provide care to victims of sexual assault using questions derived from this study were conducted, and these took place at their workplaces. The researcher used a voice recorder to ensure correct usage of the tape recorder during the real interviews. This was done to identify any problems that the researcher might experience during fieldwork. The researcher also

used fieldwork to ascertain her expertise as an interviewer so as to address any gaps in her knowledge skill before data collection.

The audio taped interview was presented to two senior colloquies at work for the purpose of checking its effectiveness of being able to get information needed; corrections and input were made as indicated in Glesne (2011:110).

From the feedback the researcher got the opportunity to learn and improve her skills of, approaching participants with sensitivity and open mind, probing relevantly on participants Reponses, put aside preconceived ideas from her experience.

3.3.6 Data analysis

Corbin and Strauss (2008:1) cited in Grove et al (2013:279) define qualitative data analysis “as a process of examining and interpreting data in order to elicit meaning, gain understanding and develop empirical knowledge”.

In this study data matrix of socio-demographic characteristics was done using Microsoft word 2010 and under each participant relevant data was entered. Then the data was analysed using data interpretation table. In the table the variables, the numbers and the percentages were presented.

The researcher started with the process of data analysis during data collection that is:

- The researcher simultaneously collected and analysing data (Grove et al 2013:280). After each interview the researcher briefly analysed and reflected on the data obtained so as to interpret the inherent meaning. These analyses influenced the next interview in terms of the probing questions asked.

The researcher listened to the recoded data over and over again for deeper and better understanding. Collected audio-taped data was transcribed in English. The researcher read and read over and over the transcribed data to become familiar with the data intimately.

Transcripts were subjected to an analysis with ATLAS.TI. According to Babbie and Mouton (2001:280), ATLAS.TI is probably the best package in the world right now for analysis of qualitative data. It has a variety of excellent features that aided the researcher in data analysis process. Using ATLAS.TI the researcher was able to code data in various ways, create memos and make notes about from the data throughout while analysing.

Through ATLAS.TI free and open codes were created and where codes belong together in some way or another, they were organised into families. The meaning units were used as the basis on which to translate the qualitative assessment of the patterns of meaning units into categories and sub-categories. The sub-categories were grouped under one category and categories were grouped together under one major theme, and then interpreted with integrating into the respondents' description of their experiences in a way bringing meaning to the mass of collected data (Marshall & Rossman 1995:111).

The grouped sub-categories and categories of data under major themes were subjected to interpretation and explanation. The researcher searched for identity from the themes and describes and then showed the linkage between them (Marshall & Rossman 1995:117).

3.4 ETHICAL CONSIDERATIONS

Stommel and Wills (2004:373) state that “ethics concerns the descriptive and prescriptive questions of morality, focuses on the concepts and principles of how human beings do and should think and behave”. When the researcher abides in research ethics, the researcher earns respect and trust of the participants (Ruane 2008:16). In study ethical considerations were considered throughout the study. The researcher observed the following ethical consideration:

3.4.1 Permission to conduct the study

The researcher sent the proposed study and the consent form to University of South Africa for the ethical clearance by the Ethical Committee (Holloway & Wheeler 2010:60, 66). The Department of Health Studies, Research and Ethics Committee, University of South Africa granted the ethical clearance certificate (Annexure B). Permission to

conduct research from the Department of Health and Social Development Limpopo province was obtained (Annexure C) and when arriving to the hospital verbal permission to conduct interviews was obtained from the Chief Executive Officer of the hospitals and also verbal permission was given by the heads of emergency units.

3.4.2 Informed consent

Before commencing with the interview, the researcher gave verbal information to the participants followed by a written informed consent (Annexure D) stating the aim and objectives of the study and informing participants that they can freely decide whether to participate or not and they can discontinue their participation at any time (Stommel & Wills 2004:380; Glesne 2011:115; Padgett 2008:65). The researcher provided participants with informed consent explaining the nature of the research, assured confidentiality, privacy and the protection of participants' anonymity (Berg 2009:88; Johnson & Christensen 2012:107). As indicated by Ruane (2005:19), participants acknowledge that they understood the information received and that they were knowingly participating in the study, doing so of their own free will by signing on the consent form, including their name and surname, provided also was the signature of the researcher.

3.4.3 Respect for a person

Respect for a person was maintained. The researcher explained to the participants the purpose of the study. The researcher explained the possibility of minimal risk of recalling emotional pain by the participants during interview.

The researcher informed a participant about the plan of managing the risk of recall pain, because is common during face to face interview for the participant to become agitated, due to the sensitivity of the phenomenon under study. With the aim of not causing harm to participants, on identification of the unsettledness or agitation by the participants during the interview, the researcher had a plan in place (Berg 2009:86, Ruane 2005:18; Butler 2003 cited in Holloway & Wheeler 2010:57). The plan being, should a participant shows the sign of emotional recall pain she will be referred for a professional psychotherapy available in the hospital.

3.4.5 Anonymity

Anonymity referring to the keeping the identity of the participants by the researcher from everyone (Johnson & Christensen 2012:116), the researcher assured participants about maintaining anonymity throughout the study. During data collection the researcher made sure that all information that may link data to the participants was omitted and during data transcription all information in the audio tape which links the participants to the data collected were omitted (Ruane 2008:24). Socio-demographic data forms were assigned identifying case numbers for example participant.

3.4.6 Confidentiality

Confidentiality was first assured by the researcher verbally and in the formal informed consent. Documents that require identification for the purpose of the researcher to keep track of the interviews, case numbers were assigned to the documents, the same case numbers were used during Data reporting (Berg 2009:91; Padgett 2008:67). During the interviews the researcher made sure that voice recorder and transcripts were kept in a lockable cupboard throughout, only the researcher and the person who helped during coding of data had access. The signed consent forms were kept separate from, recordings and notes.

3.4.7 Privacy

Maintaining privacy involves the ability by the researcher to have full control on others on the access of information about participants (Ruane 2008:22). The researcher explained and requested from the participants a room, which was quiet and far from the reception or mostly used areas. In this study the interviews were conducted in private rooms, with the door and windows closed at participant's workplace (Ruane 2005:22)

Before the interview could start, the researcher forewarned the participants about the sensitivity of the phenomenon under study and assured them about the measures in place to protect their privacy (Ruane 2005:22). In maintaining privacy the informed consent signed by participants were kept under care of the researcher and was kept in a safe place by the researcher (Berg 2009:89)

3.5 MEASURES FOR ENSURING TRUSTWORTHINESS

Lincoln and Guba (1985) cited in Rebar et al (2011:153) describe trustworthiness “as the honesty of data collected from or about the participants”. Rebar et al (2011:153) define rigor “as the strict process of data collection and analysis as well as a term that reflects the overall quality of that process in qualitative research”. Lincoln and Guba (1985) cited in Padgett (2008:180) developed criteria of establishing rigor applicable in qualitative methods; those criteria together connoted trustworthiness of qualitative study.

In this study the following criteria developed by Lincoln and Guba were used to demonstrate the rigor and trustworthiness of the study, that is: credibility, transferability and applicability, conformability and dependability, (Marshall & Rossman 1995:143; Padgett 2008:181), the researcher again used reflexivity and bracketing to ensure rigour.

3.5.1 Credibility

The researcher maintained the credibility of the data by using the semi-structured open ended questions and prolonged the interview time, one to half an hour, participants got enough time to give narratives of their experiences as they provide care to victims of sexual assault and the researcher spent sufficient time with participants at their place of work to identify and verify reappearing patterns, this allowed participants to become more accustomed to the researcher and they were able to give more sensitive information about their experience.

The researcher worked as a forensic nurse for seven years, and has the experience of providing care to victims of sexual assault, to ensure the credibility of the study the researcher kept a field journal, recoding all. The researcher worked hand in hand with her University supervisor, consulted a competent Qualitative researcher and an independent data coder, and their agreement reached between them served as a peer review of the data (Holloway & Wheeler 2010:307; Padgett 2008:188). The researcher used methodological triangulation by using both interview and Observations of forensic nurses' non-verbal communication during data collection and interview and observations were analysed (Holloway & Wheeler 2010:309; Padgett 2008:187).

3.5.2 Transferability and Applicability

Transferability of the findings will be demonstrated by the applicability of the findings to another context and the ability to generalise from a sample to a larger population or from one setting to another ..." (Bailey 2007:182; Marshall & Rossman 1995:143). These can be compromised by "its focus on local conditions, specialised knowledge, in-depth of accounts, and highly contextualised understanding of setting, small and none probability samples" (Bailey 2007:182).

In this study findings, generalisation is a limitation with the fact that in this study the findings are descriptive and contextual in nature, only focusing to forensic nurses working in Limpopo province and only forensic nurses who are providing care to victims of sexual assault, from seven hospitals were selected and interviewed, furthermore those hospitals belongs to the three districts from the five districts of Limpopo province.

3.5.3 Conformability

The other aspect on ensuring rigor in qualitative data collection is conformability, wherein the researchers develops and maintain an audit trail (Rebar et al 2011:153). In this study the researcher established an audit trail by which the research could be examined in the future; this includes:

- Audio recoding
- Fields observation notes
- Original interview scripts
- Thematic categories
- Study proposal (Holloway & Wheeler 2010:303)

A voice recorder has been kept safe and it can be accessed if necessary.

3.5.4 Dependability

According to Padgett (2008:181), dependability "means that the study's procedures are documented and are traceable". In this study the supervisor of the research audited the

research project and the researcher ensured dependability by means of inquiry audit, where she kept relevant supporting documents and allowed a qualitative research expert to do an external review. The researcher left an audit trail in a form of field notes, archives and transcribed data, which can be accessed if necessary.

3.5 CONCLUSION

This chapter discussed the research design and methodology which included the approaches, population, sampling and sample, data collection, data analysis and trustworthiness used in this study. Chapter 4 will present and discuss data analysis and findings.

CHAPTER 4

DATA ANALYSIS, PRESENTATION AND DISCUSSION OF RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter presents the analysis and discussion of the research findings. The main purpose of the study was to explore the experiences of forensic nurses when providing care to victims of sexual assaults in selected public hospitals in Limpopo province of South Africa. In-depth, unstructured individual interviews and observations in the form of field notes were used to collect data. The main research question was: “What is your experience of providing care to victims of sexual assaults in the clinical setting? During data analysis four themes emerged.

4.2 DATA MANAGEMENT AND ANALYSIS

Polit and Beck (2008:751) states that data analysis involves the systematic organising and synthesis of research data that is, the sifting, charting and sorting of data according to key issues and themes. The researcher started with data analysis process during data collection that is: the researcher simultaneously collected and analysing data (Grove et al 2013:280). After each interview the researcher briefly analysed and reflected on the data obtained so as to interpret the inherent meaning.

Since data were recorded using an audio-tape recorder, the researcher listened to the recorded data over and over again for deeper and better understanding. Collected audio-taped data were transcribed in English. The researcher read and read over and over again the transcribed data to become familiar with the data intimately.

Data transcripts were analysed by means of ATLAS.ti software, which enabled the researcher to code data in various ways, create memos and to make notes from data throughout the analysis process. Through ATLAS.ti free and open codes were created and where codes belong together in some way or another, they were organised into

families. The meaning units were used as the basis on which to translate the qualitative assessment of the patterns of meaning units into themes, categories and sub-categories. The sub-categories were grouped under one category and categories were grouped together under one major theme, and then interpreted with integrating into the respondents' description of their experiences in a way bringing meaning to the mass of collected data (Marshall & Rossman 1995:111).

4.3 RESEARCH FINDINGS

4.3.1 Sample description

As shown in Table 4.1 a total of seven participants formed part of this study. All of them (100%) were female registered nurses rendering care to victims of sexual assaults in selected public hospitals in the Limpopo province. Participants' age groups were between 30-40 years 3(42.8%), 41-50 years 1(14.2%) and 51-60 years 3(42.8%). All participants received tertiary education in nursing, 3(42.8%) had a degree and 4 (57.2%) had a diploma in nursing. Majority 3(42.8%) of participants are divorced with 1(14.2%) being married, 2(28.5%) single and 1(14.2%) widowed. With regard to the number of children participants had 1(14.2%) had one child, 2(28.5%) had two, 3(42.8%) had three and 1(14.2%) had five children.

Regarding participants' years of experience in providing care to victims of sexual assaults, most of them (42.8%) had three years while equal proportions indicated two 2 (28.5%) and 2 (28.5%) four years. Less number 3(42.8%) of the participants reported to have experienced some form of abuse as an adult compared to 4 (57.2%) who did not experience any form of abuse. With regards to the number of victims of sexual assault that were provided care to during the past four years, 4 (57.1%) participants provided care to lesser than 101 victims. Two (28.6%) participants provided care to over 100 but lesser than 201 victims and only 1 (14.3%) provided care to more than 200 but lesser than 301 victims as shown in table 4.1.

Table 4.1: Socio-demographic characteristics of participants (n=7)

Variables	Frequency	Percent
Gender		
Females	7	100
Age		
30-40 years	3	42.8
41-50 years	1	14.2
51-60 years	3	42.8
Total	7	100
Marital status		
Married	1	14.2
Single	2	28.5
Divorced	3	42.8
Widow	1	14.2
Total	7	100
Number of children		
01	1	14.2
02	2	28.5
03	3	42.8
05	1	14.2
Total	7	100
Highest level of education		
Degree in nursing	3	42.8
Diploma in nursing	4	57.2
Total	7	100
Number of years providing care to victims of sexual assault		
02	2	28.5
03	3	42.8
04	2	28.5
Total	7	100
History of experiencing any form of abuse as an adult		
Yes	3	42.8
No	4	57.2
Total	7	100
Number of sexual assault victims attended to within the past four years		
1-100	4	57.1
101-200	2	28.6
201-300	1	14.3
Total	7	100

4.3.2 Themes, categories and sub-categories

In this study, four themes emerged from data analysis, namely: (1) psychological experience of nursing sexually assaulted patients; (2) experience of physical challenges in implementing forensic nursing specialty; (3) coping strategies used by forensic nurses to deal with occupational stress and (4) forensic nurses' experience of managerial support. Table 4.2 shows the categories and sub-categories that emerged from the analysis.

Table 4.2: Themes, categories and sub-categories

THEME	CATEGORIES	SUB-CATEGORIES
Psychological experience of nursing sexually assaulted patients	Psychological difficulty establishing forensic nursing specialty in a clinical setting	<ul style="list-style-type: none"> • A sense of being a "loner" • A sense of being an Initiator • A sense of being responsible for everything
	Psychological trauma associated with nursing victims of sexual assault	<ul style="list-style-type: none"> • Trauma as experienced by the nurse • Perceived trauma to the victim of sexual assault • Trauma associated with the age of assaulted victims • Trauma associated with the time and contributing factor to the assault • Trauma associated with the season the assault occurs
	Feelings associated with nursing victims	<ul style="list-style-type: none"> • Anger • Fear • Frustration • Empathy for the victims • Hopelessness
Experience of physical challenges implementing forensic nursing specialty in a clinical setting	Lack of space versus patient volume	<ul style="list-style-type: none"> • Lack of space to examine patients • Patient volume
	Staff shortage and lack of understanding of what the job entails Inappropriate shift hours Forensic patients' visiting hospital times Lack of appropriate equipment to examine patients	-

THEME	CATEGORIES	SUB-CATEGORIES
Coping strategies used by forensic nurses	Intrapersonal coping strategies	<ul style="list-style-type: none"> • Reflection
	Interpersonal coping strategies	<ul style="list-style-type: none"> • Debriefing • Sharing with the psychologist • Sharing information about the case with friends and colleagues • Telephonic follow up sessions to patients • Sharing love with the patients
	Physical coping mechanisms	<ul style="list-style-type: none"> • Excursions and taking a break from patient care • Workout at the gym • Focusing on work
	Spiritual coping mechanisms	
Forensic nurses' experience of managerial support	Perceived managerial support	<ul style="list-style-type: none"> • Attempts to resolve the problem of inappropriate shift hours • Attempts to provide adequate counselling to patients • Pay for overtime
	Perceived lack of managerial support	-

4.3.2.1 Theme: Psychological experience of nursing sexually assaulted patients

Participants reported to have experienced a sense of difficulty in providing nursing care to victims of sexual assaults. Although most of the challenges they experienced were related to the physical environment, these challenges had an impact on their psychological wellbeing.

Participants found themselves thrown into the deep ends as they realised that they were the first people to undergo forensic nursing training at their institutions. As a result, they had to start everything from scratch, for an example they had to establish policies, educate their supervisors and implement everything that was associated with forensic nursing in their hospitals. In this theme the researcher identified three categories, namely: (1) psychological difficulty establishing forensic nursing specialty in a clinical setting; (2) psychological trauma associated with nursing victims of sexual assault; and (3) feelings associated with nursing victims of sexual assaults. These are discussed in detail in categories below.

4.3.2.1.1 Category: Psychological difficulty establishing forensic nursing specialty in a clinical setting

The experience of difficulty in initiating forensic nursing to patients who experienced sexual assaults was associated with a number of psychological hurdles that forensic nurses had to endure in order to establish this clinical specialty in their respective hospitals. The psychological difficulty experienced by participants in initiating forensic nursing as a clinical specialty exposed them to various perceptions that ranged from being (1) a loner, (2) an initiator and (3) responsibility for entirety. These psychological difficulties are discussed below.

- *A sense of being a “loner”*

Being the only forensic nurse in the clinical setting created a sense of being an outsider in a hospital setting. The participants perceived themselves to be alone. As a result, they had no one to discuss day-to-day hurdles of work. A sense of being “alone” made their work feels difficult at the beginning.

“...there was no one who did forensic nursing before me...”; “...I am the only forensic nurse in the hospital patients can be managed even on my absence...”.

- *A sense of being an initiator*

The worse experience of participants was that of being an initiator, a sense of being an architect responsible for designing the forensic nursing speciality in the clinical setting of the hospital in which they were employed was seen as burden. MacCarty (2009b:39) found that forensic nurses recognise schedules and activities to ensure that all available mechanisms for providing proper care to victims of sexual assault are in place and for proper referrals and treatment of victims of sexual assault it is important to have policies and procedures in place Wadsworth and Van Order (2012:435). This is what nurses had to say about being an initiator.

“...initially it was like difficult...”; “...my role was like... I had to start afresh from the beginning...”; “...initially it was like a little bit difficult but with the help of other

forensic nurses who had been there before me I managed to start the service and things were moving...”.

- *A sense of being responsible for everything*

In addition to a feeling of being an initiator, participants verbalised a sense of being responsible for the whole “shebang” that has to do with forensic nursing in their hospital setting. They verbalised that they had to establish forensic nursing in the hospital by making sure that policies, guidelines, and management was aware (knowledgeable) of what forensic nursing entails. Campbell, Patterson, Adams, Diegel and Coates’ (2008:25) finding was that when forensic nurses provide resource referrals and follow-up information the results will be that victims will know where to go for help and information or for further services. Their claims are substantiated with the following direct verbatim quotes:

“...implement everything from the start including policies place...”; “...to examine patients even to brief the management my supervisor...”; “...I had to develop some service standards on my own...”; “...I have to develop some guidelines so that when I am not around...”.

4.3.2.1.2 Category: Psychological trauma associated with nursing victims of sexual assault

During the process of data collection and analysis, it became clear that participants experienced what we called “doubled psychological trauma”. The researcher coined the concept of this traumatic experience as doubled because the participants were traumatised and their patients were more traumatised than themselves. This category is divided into two traumatic events, namely: (1) forensic nurse trauma and (2) perceived victim trauma.

- *Trauma as experienced by the nurse*

Forensic nurses verbalised that they were traumatised by being in contact with victims of sexual assaults. Some of them even verbalised inability to cope with the experience. They were also unable to sleep at night and at times they verbalised that they ended

crying when they thought about the victims. The finding is consistent with the study done by Maier (2011:165) who found that 67% of SANE expressed emotional demands associated with working with victims of sexual assault and further indicate that handling this emotional aspect of the job can be challenging for them. This is what participants said about trauma:

“...you get traumatised...”, “...what I have seen ... affected me a lot but I think I am doing well now...”, “...initially I was not coping...”, “...out of that I was crying during the night...”, “...I will wake up I will find out that yes I was crying because I was thinking of what happened to that client...”, “...they affect me psychological a lot...”, “...i was crying with them...”.

- *Perceived trauma to the victim of sexual assault*

As indicated earlier, these participants were traumatised by seeing victims of sexual assaults, and based on their stories of trauma; they indicated that there was a lot of trauma in their patients. This correlate with the findings by Outcalt (2008:65) where participants felt sorry for victims of sexual assault and express fear that of what the victims must be feeling. Participants' trauma was associated with the perceived age of the victims some who were children when they were sexually assaulted. The questions asked by children after being sexually assaulted indicated that they were not experienced about sex and some of them might have even lost their virginity during sexual assaults. Some victims did not even know semen and they kept on talking to their nurses about water that was there when they were raped. This is what participants had to say about trauma of victims they nursed.

“...The female children are affected...”, “...out that their first experience with sex is through rape some they do not even know what the semen is they will call it water, like after he did this there was water, there was a lot of water where does it come from where does it come from you know a child of 17 years who has never slept with a man you know when she sees things like that she will be asking you things like that and then you will be asking yourself that he batho...”, “...that is a trauma is a trauma she is really traumatised...”, “...it affects us it does affect us psychologically me it affects me you know it affect me it affect me very much...”, “...psychologically I am so much affected...”, “...Initially I had a problem because where I am staying I am staying with a nanny...”, “...my side is

very difficult...”, “...I am having stress because you can say not home it affects you...it stresses me even when I see those victims of rape...”, “...you are always traumatised...”.

- *Trauma associated with the age of assaulted victims*

The most traumatic experience of forensic nurses was associated with the realisation of the age of girls that were sexually assaulted. The majority of girls were still very young at the time of the assault and they were ignorant of sexual intercourse. As a result they were traumatised in conjunction with those nurses who were rendering care to them. This finding concurs with Marchetti, Fantasia and Molchan (2014:42) who found that SANE find it hard for them to get over sexual assault of children. This how nurses expressed themselves regarding the age of their patients:

“...sexual assaults of age group ehhhhh 13 to 19 years...”, “...children between the age of 13 up to 23...”, “...other thing you turn to love them to give them more love to give them support...”, “...Most of patients we see are the youth...”, “...old grannies...”, “you know a child of 17 years who has never slept with a man...”.

- *Trauma associated with the time and contributing factor to the assault*

Forensic nurses also indicated that majority of sexually assaulted patients were actually raped on Fridays late in the afternoon when they were returning from taverns or liquor places. In a study done by Changwa and Pather (2008:45) found that 25.4% of sexual assault happen over the weekend and 30% of the sexual assaults happen between 20:00 and midnight and then 19% happen between 16:00 and 20:00. They also revealed that liquor was a contributing factor to some sexual assaults suffered by their patients. This is what forensic nurses had to say about the time and contributing factors of sexual assaults:

“...sexually assaulted when they are coming back from the tavern...”, “...happen most after hours Friday from 19 hour to 3 am...”.

“...also liquor is related to most of the incidence because they happen when they say they were just going to release stress at the tavern...”.

- *Trauma associated with the season the assault occurs*

Seal assaults were associated with summer by some forensic nurses as opposed to winter due to the fact that majority of people are indoors during this season as opposed to summer where all people are always outside. This is what was said by nurses regarding the season variations for sexual assaults:

“...in summer mostly there are lot of victims because people are always outside...”, “...then winter most of the rapes are in doors...”.

4.3.2.1.3 Category: Feelings associated with nursing victims

Being in contact with victims of rape precipitated many feelings among nurses. They found themselves exhibiting a number of these feelings ranging from fear to hopelessness. In the literature reviewed by Chouliara et al (2009:49) professionals working with victims of sexual assault reported negative feelings such as anger, sadness, horror and rescue fantasies. Some of these feelings were a sign of depression, but because nurses were not assessed for depression by a member of the psychiatric multidisciplinary team, it became difficult to rule depression or anxiety among the nurses who nurse victims of rape on a daily basis.

- *Anger*

The entire process of having to nurse a victim of sexual assault evokes anger in forensic nurses. They became angry with what they observed in their victims. They mentioned several times that it was bad and they wished they could see the perpetrator. The literature reviewed by Chouliara et al (2009:52) when summarising and evaluating evidence regarding vicarious traumatisation in practitioners working with adult survivors of sexual violence and/or child sexual abuse revealed that that emotional effects on professionals of working with traumatised patients include negative feelings like anger and. This is what forensic nurses had to say about their anger:

“...I felt like if I can meet this guy I will definitely kill him...”, “...you feel very bad for them you feel very sorry for them...”, “...I feel like crying just feel very bad very sorry...”, “...really just feel very bad...”, “...you do feel sorry for them more

especially those who are being raped virgins when they tell you their plans you feel very very bad...”, “...I started to be worried about this patients...”, “...I just felt as if I could get hold of this perpetrator...”, “...I feel aggressive sometimes...”.

- *Fear*

Some participants verbalised feelings of fear associated with their constant exposure to victims of sexual assaults. As a result of being continuously exposed to sexually assaulted victims, participants feared for themselves and their children. They became preoccupied with thoughts of fear of rape in their families. This finding are consistent with those in a study done by Chouliara et al (2009:52), who found that practitioners who work with sexual assault survivors seemed to encompass the notion that the world is not safe. This is what they had to say about this issue:

“...Initially I had a problem because where I am staying I am staying with a nanny...”, “...I could not wake up during the night and go to the bathroom, I will take my kids lock ourselves in one bedroom...”, “...toilet I was scared that maybe somebody will use the roof to go inside and get me and my kids...”.

- *Frustration*

During fieldwork the researcher persistently heard concerns about poor response of management in addressing various issues that were influencing the implementation of forensic nursing as a clinical specialty within the practice setting. The finding is in consistent with the study done by Cole et al (2007:29) found that participants mention that most problems encountered was due to lack of organisational support like staffing, issues of lack of funding for updated equipments. The researcher also drew inferences from the data collected which indicated lack of space for forensic nursing since 2009. Some of the participants verbalised lack of space since they came back from forensic nursing training. From data obtained and analysed by the researcher there was evidence of frustration among participants with regards to space and privacy aspects essential for conducting examinations of victims of sexual violence.

“...No there is no space even now since from 2009 December...”; “...since I have come back I have been asking for a space to see the victims...”; “...I can say

from long time ago patients where seen or victims were seen in casualty department were examining them in small theatre...” “...small theatre is no space to see patients...”.

Another participant mentioned how the process of obtaining space for forensic nursing was a frustration her in the hospital setting:

“...I have tried to talk to the nursing service manager and I even tried to present the problem in their EXCO meeting”; “...even now I am still trying to fighting to get the space I am not succeeding...”; “...I have tried to talk to the nursing service manager...”, “...I even tried to present the problem in their EXCO meeting...”

- *Empathy for the victims*

Participants were empathetic at victims. They put themselves at the shoes of people who had suffered sexual assaults. They speculated and had imaginations of how they would have reacted if it was their own children that had been sexually assaulted. The most painful feeling was the age of victims, some of them were as young as thirteen (13), which evoked more pain for the research participants. The findings are consistent with Marchett et al (2014:42), who found out that SANE expressed the pain of caring for assaulted children and having small children at home makes it harder for them to care for sexual assaulted children. This is what they had to say about this issue:

“...empathetic because at times same of the victims you feel most especially when it comes to kids you feel what if it was my...”, “...the victim is your child like one child I have seen a13 years old girl her mother send her to a shop, unfortunately he meet this rapist who took her and rape her at gun point he even shot on the floor...”, “...I was thinking that this child at the age of 13 how can that man rape her at gun point she couldn't fight she couldn't do anything but he even shot to scare her, even the injuries that she sustain it was too much I felt bad...”, “...These people need our help and I talk to them most of the time...”, “... Sometimes I do come even if I am not working or not on call...”, “...yes I do sacrifice a lot...”

- *Feelings of hopelessness*

In addition to feelings empathy for the victims, the forensic nurses also experienced hopelessness. They were concerned that they would not do anything even if they were to come across the perpetrator. This is what one participant had to say about the feeling of hopelessness:

“...unfortunately even if they can say this is the man who raped her there is nothing I can do...”.

4.3.2.2 Theme: Experience of physical challenges implementing forensic nursing specialty in a clinical setting

Apart from the experience of the difficulty in establishing forensic nursing in the clinical setting, participants also came across many challenges in implementing their forensic nursing plans in the clinical settings of various health services where they were employed. This theme addresses various challenges ranging from: lack of space to examine patients and the increasing rate of patients reporting to hospitals, in need of care after sexual assault.

4.3.2.2.1 Category: Lack of space versus patient volume

- *Lack of space to examine patients*

Participants verbalised the issue of lack of space for them to render care to victims of sexual assaults. Due to lack of space for forensic nursing, participants verbalised that it was impossible for them to have privacy for their patients because the space was either shared with patients who had come for emergency procedures or patients with physical conditions. It was thus impossible to provide privacy for patients who are supposed to be seen by forensic nurses. Participants in a study by Marchett et al (2014:42) also showed concerns about lack of proper infrastructure with SANE programme to can allow them provide good care to victims of sexual assault. Ullman and Townsend (2007:424) found out that due to lack of space and privacy it is difficult for them to provide proper counselling to victims sexual assault. This is what participants had to say about lack of space:

“...at times you find out that there are procedures that there are supposed to be performed and here is a victim also who also want to be examined so is a very big challenge...”, “...the issue of privacy even examining them...”, “...We do not have a centre I work in casualty where there is a designated room for sexual assault...”, “...With the facilities we do not have enough facilities...”, “...I have been allocated to work in OPD Casualty then after that the patient comes at 03:00 clock when you are tired and about to knock off and you are not going to knock off you won't go...”.

Contrary to the above negative findings that indicated lack of space dedicated to forensic nursing within the clinical setting, only one participant revealed that there was a space in the area where she works that was for forensic nursing. This is what she had to say about this issue:

“...There is a room that has been given responsible for forensic patients...”.

- *Patient volume*

The volume of patients examined on a daily basis is yet another challenge experienced by participants in the clinical setting. It became clear from the interviews that lack of space for forensic nursing was coupled with high number of patients seen on a daily basis. The participants reported an average of approximately 12-15 patients per month in December and an average of 8 during other months of the year. This is what they had to say about the volume of patients seen in a month:

“...I saw six but during December you see 12 or 15 per patients month the highest I see per month is 15 but average per month is 8 cases...”, “...I remember the other day I saw eight clients...”.

4.3.2.2 Category: Staff shortage and lack of understanding of what the job entails

In addition to a high number of patients seen by forensic nurses in the clinical setting, the other shocking observation made by the researcher in this study was gross staff shortage. Staff shortage threatens the quality of patient care (Sanford 2013:43). Research participants verbalised that their other challenge was staff shortage that was

coupled with lack of understanding of what forensic nursing meant. This is what participants had to say about staff shortage:

“...the only challenge that we have at times is a staff...”, “...some people don’t understand the type of service...”.

4.3.2.2.3 *Category: Inappropriate shift hours*

As a result of staff shortage that was reported by the research participants, they had to work inappropriate hours. Research participants reported awkward working hours. They mentioned that due to the nature of forensic nursing specialty, they had to report to work for their duties regularly including weekends. Other nurses due to lack of understanding forensic nursing work were a source of frustration to participants since they refused to work night shifts if forensic nurses did not work such shifts. As a result, in some departments, forensic nurses had to work similar shifts as other registered nurses to help reduce conflicts. The findings are consistent with the study done by Mokoka et al (2010:5) participants reported feeling frustrated and feeling strained due to inflexible and long hours of working. This is what participants had to say about irregular shifts:

“... working 07:00 to16:00 hours shift although...”, “...my colloquies were complaining that they are not going to work night shift if I am not working nightshift such things...”; “...sohhhhh initially it was fine but along the way something went wrong but for now is normal again I work a16 hours shift...”, “...I work 24/7 by 24/7 I mean that I work nearly every day meaning that weekend I take calls when there are clients for sexual assault I go there and examine them and do everything for them...”, “...when you are working in casualty when a patient arrives they will call you and say there is your costume and then you leave everything...”.

Contrary to the above information regarding irregular shift work, some only one research participant reported to be working regular shifts. This is what this participant had to say about normal shift:

“...I work 8 hours because I came on duty at 7 and knock off at 4...”.

4.3.2.2.4 Category: Forensic patients' visiting hospital times

Apart from the inappropriate shift hours of forensic nurses, were the awkward times at which their patients visited the hospital. They claim that majority of their patients visits happened from 09h00 in the morning till 22h00 in the evening. SANE provide nursing care to victims 24 hours per week (Wadsworth & Van Order 2012:434). This complicated their work within the hospital setting. This is what they said about the times at which patients visited the hospital.

“...most of the cases they come during the night immediately...”, “...they kept on coming you can imagine from 09 in the morning until 10 in the night...”.

4.3.2.2.5 Category: Lack of appropriate equipment to examine patients

Participants also verbalised the lack of appropriate equipment to examine victims of sexual assaults. They revealed to the researcher that they did not have appropriate beds to conduct vaginal examinations to rape cases. They had to examine patients in normal beds that could not promote lithotomy positioning of such patients. They also verbalised use of inappropriate light devices that do not promote proper examination of sexually assaulted patients. In a study done by Changwa and Pather (2008:45c) in Odi hospital South Africa, revealed that Doctors and nurses were frustrated by the lack of proper equipment used when examining victims. This is what participants had to say about lack of appropriate equipment:

“...for example the bed that we are using for examining the patients is just an ordinary couch it does not provide for the different positions that we are supposed to have...”, “...the lights that we use they are not of good quality because we are used to the lights that we put on the forehead but we are using the ordinary light...”, “...we find that we don't have toiletry to let the patient bath after examination...”.

4.3.2.3 Theme: Coping strategies used by forensic nurses

This category addresses the ability of forensic nurses to cope with the trauma and stress of nursing victims of sexual assaults in the clinical setting. Based on inferential

reasoning, it is clear that forensic nurses were in a process of developing into reflective practitioners. In this category, forensic nurses were seen to be continuously trying to learn effectively from their experiences of nursing victims of sexual assaults. Such learning is critical in developing and maintaining competence across a practice lifetime (Mann, Gordon & MacLeod 2009:596). According to these authors such learning helps to develop one's professional identity. As such, forensic nurses are in a process of developing integrated knowledge bases, which lead to their ability to link existing knowledge with newly acquired knowledge. As a result, Mann et al (2009:596) are of the opinion that such capabilities may underlie the development of a professional who is self-aware and able to engage in self-monitoring and self-regulation. In this category the development of reflective practice is divided into two processes that are linked to one another, namely: (1) intrapersonal and interpersonal coping strategies.

4.3.2.3.1 *Category: Intrapersonal coping strategies*

Regarding intrapersonal strategies cited by nurses to help them cope with the trauma of nursing victims of sexual assaults, only reflection was identified as the sole strategy and it is discussed in detail below.

- *Reflection*

Learning from personal failures and successes is referred to as systematic reflection (Ellis, Carette, Anseel & Lievens 2014:67). In this study forensic nurses used reflection as a strategy as they conducted introspection regarding some feelings they held regarding the care of patients who had experienced sexual trauma. This is what they had to say:

“...but now I do not even blame myself I just tell myself that ok it has happened but is a mistake they did not do anything wrong...”.

According to Ellis et al (2014:67), systematic reflection is based on two factors i.e. the situation (experience of nursing patients who suffered sexual assaults and conscientiousness (person based factors).

4.3.2.3.2 *Category: Interpersonal coping strategies*

Apart from those strategies that were within the internal environment of forensic nurses like reflection, the researcher also identified interpersonal coping strategies. These coping strategies are what Ellis et al (2014:67) refers to as conscience efforts used by forensic nurses to address failures and successes in nursing victims of sexual assaults. Within the interpersonal environment of forensic nurses, the researcher identified the following strategies used for coping, namely: (1) debriefing, and (2) sharing with certain individual who are within the external environment of the forensic nurse.

- *Debriefing*

Debriefing is a process that helps enable participants to reflect on what happened, examine the impact, and to evaluate whether or not the goals and objectives of a community organisation were addressed as a result of the way in which the service experience was implemented (Henry 2004:2). In this study research participants revealed that they were engaged in debriefing sessions where participants are confronted with the experience of nursing victims of sexual assaults. The participants indicated the following:

“...We also go out for debriefing...”, “...they send us to debriefing so they helped us a lot they thought us a lot of things to take care about yourself before you can think about the next person...”, “...and even the department has arranged something for us the debriefing session. The psychologist belongs to the hospital everything is free you do not have to pay...”.

The above direct verbatim quotes are consistent with formal debriefing. According Henry (2004:2), during formal debriefing sessions, a leader or facilitator encourages, and in some cases directs, cooperative inquiry into the participants' feelings about and their understanding of the service experience as well as the greater social issues being addressed.

- *Sharing with the psychologist*

The researcher identified that forensic nurses also shared their feeling associated with nursing the victims of sexual assault with a clinical psychologist. In sharing with a clinical psychologist this is what they had to say:

“...I just go straight to the psychologist, just to go there and share my feelings there and they counsel me...”, “...IT helps me to cope very well...”, “...I have attended a psychologist I have attended two seasons...”.

- *Sharing information about the case with friends and colleagues*

In addition to sharing their cases with clinical psychologists, forensic nurses also revealed that they shared their case with friends and colleagues. They indicated that such talks with their colleagues e.g. other nurses and doctors helped them cope with the situations they came across. This is what they had to say about sharing with friends and colleagues:

“...I do talk to a friend and they do support a lot...”, “...I used to share this cases with the doctors or social workers sharing used to help buy telling...”, “... also sharing with colleagues not necessarily sharing everything just to brief...”.

- *Telephonic follow-up sessions to patients*

Apart from sharing their cases with friends and colleagues, forensic nurses revealed that they also had telephonic conversations with patients. Such telephonic sessions helped the forensic nurses to know how their patients were coping. The findings are consistent with Logan et al (2007:29) who found that 40% of SANE programmes coordinators indicated that they make follow-up with the victims by telephone. This is what forensic nurses had to say about telephone sessions with their patients.

“...so much follow-ups, always i used to phone them the victims and they use to phone me each and every victim I attended if there is a problem they use to call me so and tell me on how is she coping...”.

- *Sharing love with the patients*

Coupled with telephone sessions to patients, forensic nurses also mentioned that they shared love with victims of sexual assaults. They mentioned that it helped them cope with the trauma and stress when they saw their patients coming back to hospital for sessions happy. This is what they had to say about sharing love with patients:

“...love that I am trying by all means to give to the patients I feel very good...”,
“...her when you see them coming laughing again sharing with you, phoning the hospital just looking for you telling you what happened, I turn to cope well after that...”.

4.3.2.3.3 *Category: Physical coping mechanisms*

In addition to interpersonal strategies, forensic nurses also used physical mechanisms as a coping strategy. Stoica and Buicu (2010:9) associate the experiences of forensic nurses with occupational stress. They mention anti-stress leisure time activities as important. They mention that relaxation by means of pleasant outdoor activities should not be neglected. In their list of important activities sleep and healthy meals, exercise and hobbies are identified as essential. They also stated that a technique frequently mentioned as an effective stress reduction technique is saying "No". In this study the following occupational stress reduction activities were identified by forensic nurses as important in their day-to-day ways of coping with the demands of their work.

- *Excursions and taking a break from patient care*

In this study one of the of the physical coping strategies mentioned by forensic nurses to help them deal with the occupational stress of nursing victims of sexual assaults was taking a break and divorce one's self from the psychological trauma of observing and listening to stories patients' stories. According to Stoica and Buicu (2010:9), taking a break may be associated with the stress reduction technique is saying "No". This is what forensic nurses had to say about this aspect:

“...I just go outside and tell the patient that I am going to attend to something I am coming not telling the patient why I am going outside and I spend some two minutes or so outside and come back...”.

In addition to taking a break, forensic nurses also mentioned that they are taken out of their hospitals on excursions for a break from their stressful work. This is what they had to say about excursions:

“...is once per year where we go out like warm bath, organised by the province and then with the district one is just that they will just call the psychologist from...”.

- *Workout at the gym*

Apart from taking a break, forensic nurses also mentioned physical workouts at a gym as necessary for dealing with their occupational stress. In support of physical activity in dealing with stress, Stoica and Buicu (2010:9) mention the development of a healthy lifestyle like maintaining a normal weight, practice of healthy eating behaviours, regular exercise and practicing relaxation, giving up smoking and alcohol consumption as important. This is what participants had to say about working out at the gym:

“...Most of the time I go to gym, I just go to gym and come back and bath and eat and sleep...”; “...I do walk I prefer to walk I just go outside and walk go around the location and walk it helps a lot and i also talk to friends and relatives...”.

In addition, to support Stoica and Buicu (2010:9) indicate that the company of people with whom the individual is in close relationship reduce stress. The Anxiety and Depression Association of America (ADAA) (2012:1) argues that benefits of physical exercise which include improving physical condition and fighting disease have long been established, and physicians are always encourage staying physically active. Exercise is also considered vital for maintaining mental fitness, and it can reduce stress and it is very effective at reducing fatigue, improving alertness and concentration, and at enhancing overall cognitive function (ADAA 2012:1). This can be especially helpful when stress has depleted one’s energy or ability to concentrate. Gupta and Guptha (2010:6) also argue that longitudinal intervention studies have been appropriate for assessing the effects of physical activity. Gupta and Guptha (2010:6) further mentioned

that in a meta-analysis of randomised controlled trials it was reported that aerobic exercise was associated with a significant reduction in mean systolic (-3.84 mm Hg) as well as diastolic BP (-2.58 mm Hg), this reduction was observed in hypertensive as well as normotensive individuals and in normal weight as well as overweight participants.

- *Focusing on work*

In this study forensic nurses also identified focusing on work and not its consequences as another psychological relaxation technique. They also mentioned that focusing on work helped them a lot in achieving relaxation from stress. A psychological method for achieving relaxation according to Van den Bossche and Houtman (2003:2), includes three cognitive processes, which are namely: focusing, passivity and receptivity. According Van den Bossche and Houtman (2003:2) focusing is the ability to identify, differentiate, maintain attention on and return attention to simple stimuli for an extended period of time.

“...doctors they taught us to focus on your work so it really helped a lot...”, “...doctors they taught us to focus on your work so it really helped a lot...”.

4.3.2.3.4 Category: Spiritual coping mechanisms

The spiritual coping mechanism was the least mentioned strategy by the participants. It was only revealed by only one participant who verbalised that she would go to church in order to mitigate the effect of stress associated with nursing victims of sexual assaults. This is what she said about spiritual support:

“...like to go to church attending church prayers during the week...”.

4.3.2.4 Theme: Forensic nurses' experience of managerial support

In addition to the coping strategies that participants used to deal with occupational stress of rendering care to victims of sexual assaults, they also mentioned that they sought support from their nursing managers in the hospital. In this theme two categories emerged, namely perceived support and perceived lack of support. These categories are further discussed below.

4.3.2.4.1 *Category: Perceived managerial support*

In this category participants verbalised that they received support from their managers in hospital. Support mentioned by forensic nurses was associated with the willingness of nursing managers in approving necessary materials required for rendering care to victims of sexual assaults. They mentioned that they managers were willing to support motivations for pace and material resources required for care victims. This is what forensic nurses had to say about the availability of managerial support.

“...the nursing service manager she is giving me all the support that I need...”, “...I have been looking for space and the issue of comfort packs at some stage I wrote the letter to request the hospital to buy she did approve but unfortunately they did not buy but we have been making follow ups together...”, “...but she is really willing to help...”, “...I have a very very good support from my managers...”, “...I think if all managers turn to have that heart to love the community they can do give the support to the nurse who is working with the sexual assault victims. And also allow going out for debriefing...”, “...they are supporting me in all the way...”, “...the support that I am getting from my managers is very good they also allow me to go outside to attend courses for update concerning the work that I am doing...”, “...The management really support me...”, “...only few like my area manager in casualty that one support me...”, “...attended debriefing session last year and is needed in forensic...”.

- *Attempts to resolve the problem of inappropriate shift hours*

In an attempt to resolve the problem of inappropriate shift hours and awkward visiting times of forensic patients to the hospital, forensic nurses tried to work with management to work at least an eight (8) hour shift with overtime work being paid, which was satisfying to those who tried this method. This is what was said in support of attempts to resolve inappropriate work shift hours:

“...I wrote a letter to nursing service manager requesting to work 07 hour 16 shift so that I can be on call in case there are cases during the night...”, “...The issues of working hours most especially if you are the only forensic nurse is good if they

can make you to off 08 hours a day shift so that you can be on call and they can pay you for that overtime that you are doing...”, "...I will do shift hours until...".

- *Attempts to provide adequate counselling to patients*

Participants also mentioned that through support from their management they have are able to refer their patients for proper counselling in cases where they are unable to provide such a service to their patients. This is what they had to say about patient referral for counselling:

"...We have trauma counsellors because we have been taught that if you cannot counsel the person do not do it if you cannot do it do not do it refer to the person, or people who have been trained to do it we have the psychologist and trauma cancellers they are here in the hospital I refer or take them...", "...I take them if she can go immediately I take them or some of them will tell you that I will go later not know, and all the children I refer them to the social worker all of them because even in court they require the report from the social worker so I refer them under 18 all of them...".

- *Pay for overtime*

With the support of the management, some forensic nurses were able to secure approximately 30% of their overtime claims. They mentioned that as nurses they could not claim more money as compared to other health care professionals. This is what was said by those who were claiming their overtime work: In a study done by Ullman and Townsend (2007:434) on barriers to working with sexual assault survivors at Rape crises centres of Midwestern metropolitan area, participants indicated the lack of fund as a challenge because due to lack of funds the service they give to victims of sexual assault is limited.

"... I claim 30 per cent of my salary always...", "...claim overtime they claim 100 %...", "...in nursing you only claim 30 % of your salary but the rest you forefeet...".

4.3.2.4.2 *Category: Perceived lack of managerial support*

As opposed to the availability of support, other participants revealed that they did not receive support from their nursing managers. These participants were of the opinion that such nursing managers were not in favour of the forensic nursing specialty. This is what participants who did not receive support had to say about this category:

“...section the support from the nursing section is not so good...”, “...: They do not take forensic nursing into consideration and they do not take it as a course that a person can infect they do not take it as if is not a unit...”, “...but nursing service manager and the deputy manager there is no support at all totally...”.

4.4 CONCLUSION

This study was conducted among registered nurses who are practicing as forensic nurses in selected public hospitals in Limpopo Province of South Africa. The purpose of the study was to explore forensic nurses' experience of rendering care to victims of sexual assaults. The study revealed four themes associated with the experiences of rendering care to such victims. It was evident from the findings that forensic nurses had a number of huddles in trying to render their services to the sexually assaulted patients because they realised that they were the first ones to implement such a specialty in their hospitals. Majority of participants realised on arrival in their hospitals that there had not been forensic nurses in that setting before.

They found themselves convincing hospital management on the needs of their specialty. This affected them psychologically since they found themselves thrown in the deep end. They also experienced double trauma, as their patients were as traumatised as themselves. Being the only forensic nurse in the setting brought its own challenges like putting strategies and guidelines in place all alone without any support and lacking a number of material resources needed to care for the patients. Lack of understanding of forensic nursing by other nurses posed yet another major problem because they did not want to cooperate with forensic nurses in terms of scheduling off duties. They always wanted to give a forensic nurse working hours which were similar to themselves. As a result forensic nurses had to develop coping strategies to deal with occupational stress. In other hospitals the support of nursing managers is seen in the improvement of

shifts and payments of overtimes done by forensic nurses. In the next chapter, findings will be summarised, limitations of the study will be highlighted, conclusions and recommendations will also be described.

CHAPTER 5

SUMMARY, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

5.1 INTRODUCTION

This chapter presents the summary of the research findings, conclusions drawn from the findings and contributions of this study. The study limitations are described as well as the recommendations which emanated from the findings of the current study.

5.2 SUMMARY

The purpose of this study was to explore and describe the experiences of forensic nurses who provide care to victims of sexual assault in selected public hospitals of Limpopo province in South Africa. Using a qualitative, exploratory, descriptive approach, the study was conducted in three districts in Limpopo province. The research population comprised of all trained forensic nurses working in selected public hospitals in Limpopo province. The researcher employed purposive sampling technique to select the appropriate research participants following pre-determined inclusion criteria. In-depth unstructured interviews and observations in the form of field notes were used to collect data from participants. The research question asked to all participants was: *“What is your experience of providing care to victims of sexual assaults?”*

During data collection a voice recorder was used to capture discussions held with participants during the interviews. The recorded data was later transcribed verbatim by the researcher. The process of data collection and analysis occurred simultaneously with the aim of increasing authenticity of research findings. During data analysis four themes emerged, namely: (1) Psychological experience of nursing sexually assaulted patients; (2) Experience of physical challenges implementing forensic nursing specialty in a clinical setting; (3) Coping strategies used by forensic nurses; (4) Forensic nurses' experience of managerial support. The qualitative research strategy was important for the researcher in this study as it enabled the researcher to gain a deeper insight into forensic nurses' experiences of rendering care to victims of sexual assault. Thus, the

findings are important to enhance the quality of work life of nurses in the discipline of forensic nursing in South Africa.

The researcher also applied measures for ensuring trustworthiness in the entire process of conducting the study. That was done to enhance the quality and authenticity of qualitative research findings for the current study. Undoubtedly, it is envisaged that the findings will improve the understanding of the experiences of forensic nurses in a rural province like Limpopo.

5.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

5.3.1 Participants' socio-demographic characteristics

The sample consisted of seven participants who were all females and most were within the age group of 30–40 years. Most of them had a degree in nursing as their highest educational qualification. Regarding participants' years of experience in providing care to victims of sexual assaults, most of them had three years of working experience in forensic nursing. Over half of the participants reported to have experienced some form of abuse during their adulthood. A higher proportion of the participants reported to have provided care to lesser than 100 victims of sexual assault in the past four years, compared to only one participant who provided care to more than 200 but lesser than 300 victims during the past four years.

5.3.2 Psychological experiences of nursing sexually assaulted patients

The findings revealed that forensic nurses experienced several psychological difficulties while providing care to victims of sexual assault. For an example, they are faced with the difficulty in establishing forensic nursing as an independent speciality in the clinical setting. This was demonstrated through a sense of being a loner; an initiator and through a sense of being responsible for everything.

In addition participants reported to experience psychological trauma associated with providing care to victims of sexual assault. Findings revealed that the causality of this trauma is associated with perceived trauma of the victims of sexual assault, the age of

victims and the time of sexual assault as well as the contributing factors to the sexual assaults.

Furthermore, forensic nurses do 'experience negative feelings associated with providing care to victims of sexual assault. Such feelings include anger towards perpetrators due to what they had observed in their patients, fear for their families that what has happened to their patients may happen to their families, frustration as a result of lack of organisational support and empathy. Participants also reported to have experienced feelings of hopelessness in a sense that they felt they would not do anything even if they were to come across the perpetrators.

5.3.3 Experience of physical challenges in implementing forensic nursing speciality in a clinical setting

Findings also revealed that participants experienced physical challenges when implementing forensic nursing speciality in their clinical settings. This was evidenced by concerns about the lack of proper infrastructure to enable them to provide good quality care to victims of sexual assault. They reported challenges of maintaining privacy to victims of sexual assault under their care due to lack of adequate space. Consequently, they find themselves having to share space with personnel caring for patients who had come for emergency procedures or with physical ailments. Significantly, the lack of space is coupled with a high number of patients seen on a daily basis.

In addition, staff shortages coupled with lack of understanding of what the job entails is another physical challenge reported by participants in this study. This resulted in forensic nurses having to work inappropriate hours. They had to report to work regularly and also they had to come to work over the weekends due to nature of forensic nursing speciality, contrary to the findings above some of forensic nurses only reported to work on regular shifts. Apart from inappropriate shift hours, were the awkward times at which their patients visited the hospitals.

The lack of appropriate equipment required to examine victims of sexual assault was reported as another challenge experienced by participants in this study. Consequently, participants reported to have resorted to the use inappropriate light devices that prohibit proper examination of victims of sexual assault.

5.3.4 Participants' coping strategies to deal with experiences of providing care to victims of sexual assault

Participants reported to have used coping strategies to deal with their experiences of providing care to victims of sexual assault. Findings also showed that participants use intrapersonal coping strategies such as reflection as they conduct introspection regarding some feelings they held regarding the care of patients who had experience. These coping strategies are what Ellis et al (2014:67) refers to as conscience efforts used by forensic nurses to address failures and successes in nursing victims of sexual assaults.

Furthermore, findings revealed that participants use interpersonal coping strategies through counselling interventions such as debriefing, sharing with friends and sharing love with patients under their care. They also use engaging in physical activity strategies like workout at the gym as coping mechanisms. Finally participants also use spiritual coping mechanisms such as going to church in order to deal with the negative experiences inherent in rendering care to victims of sexual assault.

5.3.5 Participants' experiences of managerial support

Findings indicated that participants were receiving support from their managers. For an example this is seen by the willingness of their nursing managers to assist in resolving participants' challenges of working hours. Contrary to the above, some of the participants reported that they did not receive any support from their nursing managers. And reasons cited included perceptions that their nursing managers were not in favour of forensic nursing specialisation in their respective institutions.

5.4 CONCLUSIONS

Findings of the current study revealed negative psychological and physical experiences among participants from providing care to victims of sexual assault in their respective public hospitals. Participants found themselves being the first ones to implement forensic nursing speciality in their hospitals as they were the first ones to be trained. They also experience double trauma, as they were traumatised as well as their patients. They further experience challenges of putting strategies and guidelines in place all

alone without the support from their nursing managers, although fewer participants got support from their manager which is seen in the improvements of shift and payments of their overtime done by participants. Be that as it may, participants have developed coping strategies aimed at continued and sustained provision of services.

5.5 RECOMMENDATIONS

The following recommendations are made based on the findings of the current study:

5.5.1 Practice recommendations

In terms of practice the following measures are essential:

- Development of a reflective support model in order to assist forensic nurses to deal with the psychological effects of providing care to victims of sexual assault.
- Provision of regular debriefing sessions for forensic nurses who are involved in the provision of care to victims of sexual assault under the leadership of a professional psychologist.
- Establishment of clinical forensic units in all public hospitals. The units should be fully equipped with all the necessary resources needed for the care of victims of sexual assault. To help in good placement and good utilisation of forensic nurses in the institutions.

5.5.2 Educational recommendations

In terms of educational requirements related to forensic nursing speciality the researcher formulated the following recommendations:

- Training of more forensic nurses in the Limpopo province, enough to cater for the large number of sexual assault cases reporting to hospital in need of nursing and medical care.
- A clear educational support program which addresses the issues around providing support to those who experience the negative effects of caring for victims exposed to traumatic events.

5.6 FURTHER RESEARCH

The researcher recommends a need of exploring the experiences of forensic nurses countrywide and also exploring the impact of such trauma at work and socially so that National guidelines could be developed that will promote the quality of work life forensic nurses.

5.7 CONTRIBUTION OF THE STUDY

The current findings which generally revealed negative psychological and physical experiences by forensic nurses when providing care to victims of sexual assault; will serve as an insight to managers of the public hospitals studied regarding the extent of support needed by forensic nurses.

Though the research findings were locally based in a particular province and selected public hospitals of Limpopo, they can be utilised as a reference point for further research in other locally based settings or a national research setting.

Findings of the current study could also be used by other relevant stakeholders such as, Department of Health, non-governmental organisation who can use the findings and recommendations to initiate relevant promotional programmes to enhance the quality of work life of forensic nurses.

5.8 LIMITATIONS OF THE STUDY

The following were the limitations of the current study:

- Generalisability of the findings is limited as the study was limited in one province. Thus the views and experiences obtained reflect the views of encounters of a small number of respondents in relation to the country.
- The findings of this study are based on self-reported responses of the participants and might be subjected to recall bias.

5.9 CONCLUDING REMARKS

The study set to explore the experiences of forensic nurses when providing care to victims of sexual assault in selected public hospitals in Limpopo province. The psychological and the physical negative experiences reported by participants in this study call for the hospital managers to seriously consider the introduction of relevant interventions to provide adequate support to forensic nurses in South Africa.

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ANNEXURE A

Request to conduct research to Department of
Health and Social Development (DHSD):

Limpopo province

ANNEXURE A: Request letter to conduct research to DHSD

Mrs G.T Ravhura

P O BOX 2154

MAKONDE

0984

15 March 2011

Department of Health and Social Development

PRIVATE BAG X9302

POLOKWANE

0700

Dear Madam/Sir

RE: APPLICATION FOR REQUEST TO CONDUCT RESEARCH

I am a professional (Forensic trained) nurse working at Polokwane/Mankweng Hospital complex emergency department.

I am currently studying with the University of South Africa doing Master's Degree in Health Studies, and would like to request the permission from the department to conduct research in the hospitals and health centres where in trained forensic nurses are managing victims of sexual violence.

Please find attachments of

1. Research Proposal
2. University Ethical clearance certificate
3. A sample of consent form

I would appreciate if my request is considered favourably.

Thank you

ANNEXURE B

Ethical Clearance Certificate, Department of Health
Studies, Research and Ethics Committee,
University of South Africa

ANNEXURE B: Ethical clearance certificate



UNIVERSITY OF SOUTH AFRICA

Health Studies Research & Ethics Committee (HSREC)

Faculty of Human Sciences

CLEARANCE CERTIFICATE

Date of meeting: 9 November 2010

Project No: 3409-241-2

Project Title: Experience of forensic nurses in managing victims of sexual violence in Limpopo Province

Researcher: Grace Tshilidzi Ravhura

Supervisor/Promoter: Prof LI Zungu

Joint Supervisor/Joint Promoter: N/A

Department: Health Studies

Degree: Masters of Arts, Health Studies

DECISION OF COMMITTEE

Approved

Conditionally Approved

A handwritten signature in black ink, appearing to read "TR Mavundla".

Prof TR Mavundla

RESEARCH COORDINATOR

A handwritten signature in black ink, appearing to read "MC Bezuidenhout".

Prof MC Bezuidenhout

ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE C

Letter of approval: Department of Health and Social
Development (DHSD):
Limpopo Province



LIMPOPO

PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH & SOCIAL DEVELOPMENT

Enquiries: Selamolela Donald

Ref: 4/2/2

04 May 2011
Ravhura G.T
University of South Africa
Pretoria
0001

Dear Madam

Re: Permission to conduct the study titled: Experience of forensic nurses in managing victims of sexual violence in Limpopo Province

1. The above matter refers.
2. The permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that-
 - Further arrangement should be made with the targeted institutions.
 - In the course of your study there should not be any action that will disrupt the services
 - After completion of the study, a copy should be submitted to the Department to serve as a resource
 - The researcher should be prepared to assist in the interpretation and implementation of study recommendation where possible

Your cooperation will be highly appreciated

Acting Head of Department

Department of Health

Limpopo Province

Private Bag x 9302 Polokwane.

18 College Str. Polokwane 0700. Tel.: (015) 293 6000 Fax: (015) 293 6211 Website: <http://www.limpopo.gov.za>

The heartland of Southern Africa - development is about people!

ANNEXURE D

Informed consent letter to participants

ANNEXURE D: Participant's consent form.



Informed Consent Form for Dissertation Research project Participation: trained Forensic Nurses providing care to victims of sexual violence in Limpopo province

Title of study: Experiences of trained Forensic nurses when providing care to victims of sexual violence in Limpopo province.

Principal investigator: Mrs. Grace Tshilidzi Ravhura

Institute: Department of Health Studies, University of South Africa

Introduction:

I am a postgraduate student in Health Studies at University of South Africa. I would like to invite you to participate in a research project; I am interested in exploring on experiences of trained Forensic Nurses when providing care to victims of sexual violence.

Moreover, the focus of my study will be to explore the psychological and emotional experiences of trained forensic nurses when providing care to victims of sexual violence .In the process, their coping mechanism will also be explored.

Your participation will include being interview for forty minutes to an hour and a half at your work place or at an arranged place.

Background information:

Forensic nurses provide care to victims of sexual violence of all ages and background and those people are traumatized by what has happed to them, the sharing and the listening of that trauma may result in vicarious trauma of forensic nurses and there is no clear structures in place to support them in dealing with vicarious trauma.

Procedures

In this study the researcher will interview participants using an interview guide asking open ended questions which will be supplemented by probing questions?

- How does working with traumatised patients impact on you personally, emotionally and psychologically?
- How do you cope with the psychological and emotional impact of working with traumatised victims of sexual violence?

During the interview a voice recorder will be used and the interview will be conducted in a secure environment to be decided during making of appointment.

The interview will take approximately forty minutes to one and half hour.

Possible risks or benefits

There may be a minimal risk of recall distress involved in this study due to recalling of painful past events and your valuable time. There is no direct benefit to you also. However, the results of the study may help us to make recommendations to the department so that they put support system for trained forensic nurses providing care to victims of sexual violence and to formulate guidelines for dealing with the emotional and psychological impact of providing care to victims of sexual violence.

Right of refusal to participate and withdrawal

You are free to choose to participate in the study. You may also withdraw at any time from the study without any adverse effect on you or your profession. You may also refuse to answer some or all the questions if you don't feel comfortable with those questions.

Confidentiality

The information provided by you will remain confidential. Nobody except principal investigator will have an access to it. Your name and identity will also not be disclosed at any time. However the study be shared with Dissertation committee, department of Health in Limpopo province, may be published in journal and elsewhere without giving your name or disclosing your identity.

Available Sources of Information

I appreciate you're your giving time to this study.

Please feel free to call me at Mrs. G. T. Ravhura at cell 084 607 6224 Home 015 223 0493 work 015 287 5031.

1. AUTHORIZATION

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

Participant's Name (Printed or Typed):

.....

Participant's Signature: Date:

Researcher's Signature: Date.....