

**SPIRITUAL NEEDS OF SEXUAL
ASSAULT SURVIVORS**

**DISSERTATION SUBMITTED TO THE UNIVERSITY OF
CAPE TOWN IN PARTIAL FULFILMENT OF THE
REQUIREMENTS FOR DEGREE
M Sc NURSING**

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ABSTRACT

Sexual assault is a serious problem experienced worldwide. It is an urgent issue of concern, because it is a crime that most of the time goes unpunished. This is a qualitative study of the spiritual needs of women who have been raped, attending a health care centre in the Western Cape, for support and for follow-up management. Data collection methods for this study comprised individual face-to-face interviews with open ended, probing questions. Field notes were taken, including the use of a tape recorder, during home visits or at the health centre or at the venue of the participant's choice. Each participant was interviewed twice - initially, to determine if sexual assault survivors felt any spiritual need whilst going through the traumatic experience, their perception with regard to their spiritual need, the inclusion of spirituality in their health care management and exploring how they would have liked nurses and other health care professionals to manage them at the time.

The information was then transcribed and taken to the participants during the second interview for verification of information gathered. Data were analysed using thematic analysis as described by Cresswell, (1998:140 – 142). The descriptive statements shared were examined and findings are presented in table format with narrative description. Themes that emerged from the data were:

- Belief system
- Spiritual beings
- Spiritual comfort
- Spiritual need
- Spiritual care / intervention and
- Spiritual milieu or environment.

The findings show that sexual assault survivors have a belief system and are spiritual beings who have spiritual needs, that they draw their strength from their belief resources in order to cope, prefer

that their belief system be included in their management thus advocate for a spiritual therapeutic milieu as conducive environment that will make them comfortable to express their spiritual concerns.

These findings are in keeping with the International Code of Ethics expectations for provision of nursing care. Recommendations are made regarding the importance of *presencing* as the core for providing spiritual intervention / care inclusion of spirituality in nurse training curricula, the inclusion of spiritual leader in the referral systems and health care team members for the management of sexual assault survivors.

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Operational definitions and explanations of terms

For the purpose of this study the following terms are defined as follows:

Rape/ Sexual assault

These terms will be used interchangeably in this study. Sexual Offences Act 1957 as amended and Martin (1999:2) defined rape as the unlawful and intentional sexual intercourse with a female by a male without her consent. The above mentioned will be the working definition for this until the amendment of Sexual Offences Bill (2003) is formally introduced. Amended Sexual Offences Bill (2003) defines rape as unlawful and intentional penetration to any extent whatsoever by the genitals of the person into or beyond the anus, genitals organs of another person in any coercive circumstances, under any false pretence or fraudulent means, in respect of a person who is incapable in law of appreciating the nature of an act which causes penetration is guilty of the offence of rape.

Sexual assault survivors

Sexual assault survivors are individuals who have been sexually violated. This can be females or males, but the purpose of this study, sexual assault survivors will specifically focus on females, thereby defined as raped woman who have recovered from the initial shock of the traumatic rape experience.

Sexual violence

Is defined by WHO (2002:149) as any sexual act, attempt to obtain a sexual act, unwanted sexual commences or advances, trafficking act or any other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in my setting including but not

limited to home and work include rape, defined as physically forced or otherwise coerced penetration, even if slight, of the vulva or anus, using a penis, or body parts or an object.

Spirituality

Spirituality is defined in a number of different ways. The definitions consulted by the researcher for this study were the following:

Pesut (2002: 131) defines spirituality in three ways:

- **Relationship with a higher being** (intimate relationship) characterised in ways such as life sustaining, creator and father.
- **A reason for living:** as primary motivator of their lives bringing meaning and purpose to their lives.
- **A journey to growth:** Spiritual growth described as a "roller coaster and stairway".

Mahlungulu (2003: 34) defines spirituality as "an individual quest for establishing and maintaining a dynamic transcendent relationship with self, others and God".

Legere (1984: 378) defines spirituality as "the experience of the radical truth of things, the movement of the human spirit as it soars to only God knows height.

Burnard (1989) in Goldberg (1998:838) describes spirituality as being a search for meaning. Casaldaliga and Vigil (1994) in Goldberg (1998: 837) consider spirituality as a way in which people are spiritual, or live with the spirit. Stall (1975) in Carson (1989: 11) defines spirituality as her inner being, her inner person. It is who she is, unique and alive. It is expressed through her body, her thinking, her feeling and judgement and her creativity.

Spiritual need

Stallwood and Stall (1975:1088) in Carson (1989:15) defines spiritual need as any factor necessary to establish and maintain a person's dynamic personal relationship with God (as defined by an individual) and out of a relationship to experience forgiveness, love, hope, trust and meaning and purpose in life.

Spiritual care

Spiritual care is aspects and acts of spirituality, which is shaped by nursing presence through interventions such as touching, active listening, unspoken and spoken words. "Spiritual care is intuitive, intangible, small and often unnoticed acts rather than obvious, momentous, and/or recognized rituals" (Rankin and DeLashmutt, 2006: 285).

Abbreviations

AIDS	: Acquired Immune Deficiency Syndrome
DISCHO	: Discrimination and Harassment Office
GSH	: Groote Schuur Hospital
HIV	: Human Immunodeficiency Virus
SA	: South Africa
SAGBVHI	: South African Gender Based Violence and Health Initiative
SHS	: Student Health Services
STI	: Sexually Transmitted Infections
RVD	: Retroviral Disease
UCT	: University of Cape Town
UWC	: University of the Western Cape
WHO	: World Health Organization

CHAPTER 1

1.1 INTRODUCTION

Violence against women has been part of humanity since time immemorial. In South Africa, it was only with the emergence of the rights group initiatives in the 1970s that violation of women was recognised as a crime against persons. As a result of pressure applied by such feminist groups, men and women began to realise that it was not a man's right to force women into sexual intercourse (Martin 1999: 1).

The World Health Organisation (WHO) has declared sexual violence a serious public health problem affecting millions of people each year world wide, and the true extent of the problem is unknown (WHO 2002: 149). WHO (2002:149) further stated that sexual violence is a neglected area of research due to the following reasons:

- Available data from the police are scanty, fragmented and often incomplete;
- Many survivors /women do not report to the police because they are ashamed, fear being blamed or not being believed or otherwise mistreated;
- Data from health care centres may be biased.

In South Africa sexual assault is acknowledged as a public health issue, with severe physical and psychological health consequences (Christofides *et al.* 2003: 1). Christofides *et al.* also report that health care providers have an important role to play in the holistic management of sexual assault survivors. The UCT Department of Nursing Division Philosophy statement (1991), as amended, defines holistic to be that "the person is an integral whole of body mind and spirit". The current management in South Africa prioritises sexually transmitted infections (STIs), Human Immunodeficiency Virus (HIV) and pregnancy above urinary tract infections and mental health problems including depression, posttraumatic stress disorders, sleep

difficulties and suicide attempts. This management concentrates only on the physical aspects of health, leaving out the emotional, psychological, social and spiritual aspects of health care (WHO 2002: 149).

Lack of holistic care to sexual assault survivors is acknowledged by Zulpha Geyer of the Community Law Centre, University of the Western Cape, in an article published by the Gender Project, the Gender News (2002: 2), stating that the current state of health care services for rape survivors is by no means ideal, as women are often further traumatized by a lack of adequate holistic treatment. Geyer further states that while provision of post-exposure prophylaxis (PEP) is a monumental victory for survivors, a comprehensive system of care is lacking in many health care facilities, with the focus largely inclined towards the physical condition of the individual rather than one inclusive of her emotional and mental state at the time of treatment.

The spiritual aspect of health as part of holistic care seems to be ignored and neglected in directives for the management of sexual assault survivors. Current referral of patients is limited to counselling, and there is no mention of a spiritual leader as a referral option (Christofides *et al.* 2003: 24). Nursing as a caring profession views the individual as a biopsychosocial-spiritual being, therefore the balance of the body mind and spirit is necessary for the maintenance of the person's health (Narayanasamy and Owen 2000: 447). This is in accordance with nursing philosophy, which has its roots in spirituality and therefore highlights the importance of spiritual care in nursing in order to improve quality of life for many patients.

1.2 Background to the study

Sexual assault is a serious public health problem experienced worldwide. It is an urgent issue of concern, because it is a crime that most of the time goes unpunished. Sexual assault survivors are reluctant to report crimes due to fear of further trauma, fear of not being believed and fear of

retaliation from perpetrators (Christofides *et al.* 2003: 1). In 1995, the Human Rights Watch referred to South Africa the "rape capital of the world" (Jewkes and Abraham 2002:1231). Sexual assault in South African society is recognised to have reached levels amongst highest in the world. It occurs not only in the general society but also in schools (Human Rights Watch Report 2001:1). Sexual assault is more common in certain provinces in South Africa. The three provinces with the highest incidence of rape in 2002 were [in order] Western Cape, Mpumalanga and Gauteng (Jewkes and Abrahams 2002:1235).

In 2000, Human Rights Watch conducted a survey in three of the nine provinces of South Africa to investigate cases of alleged sexual assault at schools. The report documented twenty-three incidents of sexual assault in eight public schools in the three provinces. Sexual assault was reported to occur in school toilets, empty classrooms, hallways, hostels and dormitories with perpetrators being teachers and male students (Human Rights Watch Report 2001:2).

In 2001, the South African National Department of Health prioritised the improvement of sexual assault services at a workshop held by the South African Gender Based Violence and Health Initiative (SAGBVHI), where current status of sexual assault health services was discussed. It identified a need to initiate a survey that would systematically describe and analyse services in all provinces. This was followed by the report by Human Rights Watch initiated by the SAGBVI, which explored services in some provinces of the country (Christofides *et al.* 2003: 1). This report highlighted the poor quality of medical care received by women after sexual assaults (Christofides *et al.* 2003: 1). Findings resulted in the identification of many problems or gaps in services rendered to sexual assault survivors. One of the highlights of this report was acknowledgement of the responsibilities that health care providers have with regard to the management of sexual survivors. Gaps identified included

limited referrals for counselling and lack of referral to a spiritual/religious leader (Christofides *et al.* 2003: 24). Over zealous concern with respect to STIs, HIV and pregnancy shown by health care providers may result in other aspects of health care being ignored.

University campuses are not exempt from sexual assault, although statistics for sexual assault on higher education campuses are not easily obtainable. The Monday paper (the University of Cape Town weekly newspaper) 13 March 2003 reported that several sexual assaults had taken place on the UCT campus in recent months, and reported on an alleged sexual assault incident that occurred in December 2002, in one of the lecture buildings. In an open letter to staff members and students, the Vice Chancellor acknowledged incidents of rape on campus, and urged the UCT community to report sexual assault incidents to relevant authorities (Monday Paper 24 March 2003).

The University of Cape Town has been proactive regarding the health needs of students evidenced by a well established health care centre and resources available on campus. The Discrimination and Harassment Office (DISCHO) was initially established in 2001 to coordinate, profile and facilitate necessary services which prevent and deal with harassment and discrimination at UCT as well as to raise awareness around these and related issues. The 2005 DISCHO annual report stated that 16 female students had reported sexual harassment for the year preceding the report. Three staff members [one of whom was male] had reported harassment and four cases of sexual assault of female students were reported. The DISCHO service now has been extended to give support to staff and students relating to complaints of sexual harassment / rape/sexual assault cases (UCT, DISCHO resources 2005: 7).

1.3 Magnitude of the problem in South Africa

Unofficial estimates of sexual violence in South Africa in the early 90s indicated that at least one woman was raped every two and a half minutes, and that one in six women were regularly assaulted by their partners (Hansson (1991) cited in Stanton (1993: 1). The National Institute for the Prevention of Rehabilitation of Offenders (NICRO) report of 1990 by Vogelman cited in Stanton (1993: 3) estimated that only one in 20 rapes were reported to the police in South Africa.

Martin (1999: 2) stated that the incidence of sexual assault was escalating, as evidenced by the following figures reported to the police: -

- In 1983, 15342 cases of sexual assault were reported.
- By 1994 this had increased by 2.8%.
- In 1996 240 cases per 1000 000 women were reported.
- By 1997 there was an increase of 9 %, with 52160 reported cases.
- In 1998, South African Demographic and Health Survey reported that 11,735 women between 15 and 49 years were raped (Martin 1999: 2).
- In 2000, 52,500 cases of sexual assault and attempted sexual assault were reported to the South African Police, with the highest risk group being teenagers and young women; 21,438 (41%) of whom were minors under 18 years and 7898 (15%) under the age of 12 years (7 – 14 years). The incidence varied between provinces.
- In 2005 police reported an increase of 4%, less than one in nine cases was estimated to be reported; of those reported only 7% cases are successfully prosecuted (One in Nine Campaign 2006).

A community based survey done by Jewkes and Abrahams (2002) found that in the age group 17– 48 years, 2070 per 100 000 women were sexually assaulted per year. According to Meel (2003: 65) South Africa has the highest incidence of rape in the world (300 per 100, 000 women). Meel (2003: 66) attributed this increase to the HIV/AIDS Virgin Cure or Virgin Cleansing Myth, a belief that having sex with a virgin will cure HIV / AIDS, which is prevalent in South Africa and poses a major problem.

In a WHO report (2002: 150) the reasons for non-reporting of rape to the police are attributed to the barriers women encounter after being sexually assaulted which deter them from reporting the assault. Of those cases reported, many are thrown out of court due to scanty investigations, fragmentation of data collected by police and incomplete records. Emma Durden of UCT HIV/AIDS Unit is reported as stating that there are issues that cloud statistics in this country, an example being the narrow definition of rape under South African Law and the fact that rape is unreported (Monday Paper 18 November 2002).

1.4 Consequences of rape

Rape profoundly affects the physical, emotional, mental and social and spiritual well being of women, men and children. Genital and other bodily injuries often result from force used in rape; however there may be no visible injuries as survivors are threatened, particularly when weapons are used. The importance of spirituality in health is emphasised as the spiritual dimension is a critical aspect of the sexual assault survivor's response to crisis, stress and emotional trauma, many of whom are at risk of being killed (Carson 1989: 15; Ross 1995: 459; Narayanasamy 1999: 119; Mahlangu 2003: 34).

Narayanasamy and Andrews (2000: 58), Mahlangu (2003: 34) and Kelly (2004: 167) emphasise the person's use of spiritual resources and spirituality as sources of strength for coping with life threatening situations. According to Somlai, Heckman, Kelly, Mulry and Mulnauf (1997: 182), most religious faith communities have a tradition of commitment to providing an environment of spiritual support and compassionate care for people in times of crisis.

Stanton (1993:19) states that a strategy for protection is not to offer physical resistance. While many persons demonstrate visible signs of distress after sexual assaults, some respond to trauma with extreme composure but are, however, traumatised.

There is evidence in the literature that sexual assault survivors suffer and struggle to find meaning and purpose in life (Christofides *et al.* 2003: 1). Sexual assault survivors are at risk of long term health problems including depression, post traumatic stress, sleep difficulties, mental health problems and suicide, with stigmatisation as a profound social consequence (Stanton 1993: 19; Kim and Motsei 2002: 1245; Romito and Gerin 2002: 1817; WHO 2002: 149–63; Christofides *et al.* 2003: 1). Rape trauma syndrome is described as the long term sequelae of sexual assault characterised by physical psychological and psychosexual symptoms (Delerooy 1989: 532; Petrak and Hedge 2002: 354; Connop and Petrak, 2004:29). Kaus (1984: 2) describes rape trauma syndrome an "umbrella" concept, involving the manner in which a sexual assault survivor responds to the assault.

Schnechter, Swartz and Greenfeld (1987: 313) describe rape trauma syndrome as a two phase reaction. The initial phase is characterised by the physical symptoms and the disorganization of lifestyle and the second phase is the reorganization whereby the sexual assault survivor develops coping mechanism to deal with the trauma. The One in Nine Campaign (2006)

further describes rape trauma syndrome as powerful and distressing. Schechter *et al.* (1987:313); Delorey (1989: 535); Newton-Taylor, DeWit and Gliksman (1998:158); WHO's report on sexual violence (2002:149). Connop and Petrak (2004: 34) also detail the profound impact of sexual assault on short and long term physical and mental health, characterised by an overwhelming fear of “going mad” and puzzling behaviour.

1.5 Research setting

The research setting for this study is a unit that caters exclusively for survivors of discrimination, harassment and sexual assault who study and or work in a higher educational institution [UCT] in the Western Cape. The unit is located centrally on the main campus for ease of access, for students and staff members from all the campuses of the institution, within an area designated for rendering a comprehensive health and welfare service. This includes the Discrimination and Harassment Office [DISCHO], a Student Health Service, Psychological Service and HIV Unit, all of which form the support and development services of the health care centre.

The sensitivity of issues that are reported and managed at this unit requires strict confidentiality. Clients frequently request that the perpetrator's name not be identified due to fear of victimisation, as it may be a colleague, supervisor or a lecturer. A female clinical social worker and a male legal advocate, employed by the institution, staff the unit.

Standard procedure followed

Survivors present to the service as self-referrals, or are seen as referrals from the student health

service, psychological service, wardens of residences and campus protection service within the institution or as referrals from any health care centre outside the institution. There is no time limit for presentation, it may be immediately after the assault incident or some time after assault has occurred. The unit operates Monday to Fridays from 08h30 to 16h30 during the university term. Outside of these periods, its role is taken over by the campus control protection service, which only intervenes when an incident of sexual assault occurs and is reported. Survivors are then taken to a specialised service at the trauma unit of a nearby hospital.

The unit offers general counselling for sexual assault survivors, which includes containing them emotionally, giving them support through brief psychotherapy and/or referring them to a student health service (SHS) for prophylaxis for STIs and pregnancy. After managing a survivor, if within 72 hours of the incident, the SHS refers her for voluntary counselling and testing for HIV and HIV post exposure prophylaxis at the specialised service of the trauma unit at a nearby hospital. This includes forensic management. Legal counselling and advice is provided given by the advocate, which includes encouraging the survivors to report the assault to the police and preparing them for a subsequent court hearing.

The advocate represents them in Court. Survivors are seen at the unit as follow-up clients until they feel they no longer require it. If the counsellor in the unit feels that the survivors would need intense psychotherapy, she/he refers them for long term counselling to the psychological service within the institution. The number of clients seen at the unit varies, but numbers are large enough to keep the unit busy. The majority of the service users are students. Staff members do attend but then drop out because of uncertainty regarding confidentiality.

1.6 Problem Statement

Sexual assault is a traumatic experience, as it may be life threatening and leave life long emotional scars. Survivors struggle to find purpose and meaning in life long after the incident. The Monday paper (UCT weekly newspaper) 17 March 2003 reported that UCT had committed significant resources in an attempt to ensure safety of students and staff members, and that management believed that the number of preventative security measures adopted in recent years had improved the safety of the university community. The report also noted that UCT was facing a new challenge as crime, including sexual assault, was on the increase.

Sexual assault on campus was viewed as a serious risk and a threat to the well being and safety of female staff members and students and a violation of Constitutional Rights as enshrined by the Constitution of the Republic of South Africa Act 108 of 1996, chapter 2.

As a clinical nurse practitioner and a team member in the student health care centre from 1998 to 2004, the researcher was aware of all incidents of sexual assault reported to the service. Although all protocols were adhered to and physical and psychological support services were provided to the sexual assault survivors, the researcher was aware of the traumatic effect of the assault on survivors, and noted that it appeared as if limited spiritual support was provided.

The current sexual assault management protocols and guidelines aim to address most of the physical and legal needs; however, these guidelines do not adequately address the spiritual needs of survivors. Examples of sexual assault management protocols and guidelines available in the Western Cape include the WHO (2002) guidelines on the priority of care for health and welfare of the patient, with the medico- legal care of secondary importance; the Western Cape Provincial Department of Health (2001) standardised management guidelines for survivors of rape and sexual assaults (91/2001) and the University of Cape Town Sexual Harassment and Rape Policy (2004).

The common theme in all the above protocols or guidelines for the management of sexual assault survivors is priority of the management of physical injuries and prevention of STIs and pregnancy as well as the collection of forensic evidence. Spiritual care of sexual assault survivors is not specifically addressed and the referral of patients for counselling is limited with no mention of referral to spiritual leaders of the survivor's choice. The spiritual aspect of health is omitted in all three protocols.

If sexual assault is regarded as a life-threatening crisis, then it can be strongly argued that the spiritual needs of the survivor need to be addressed immediately after sexual assault or as a follow-up. No published research on this very important aspect of health care and management for sexual assault survivors could be found. It was therefore appropriate that a study be conducted to determine what these needs are and how they are met or should be met from the sexual assault survivor's perspective.

1.7 Purpose of the study

The purpose of the study was to explore and describe the spiritual needs of the sexual assault survivors, and how these survivors would like nurses and other health care professionals to meet their spiritual needs.

1.7.1 Objectives of the study

- 1.7.1.1** To determine and describe the needs for the spiritual care of sexual assault survivors during their initial health care management following the sexual assault
- 1.7.1.2** To explore and determine the perception of sexual assault survivors during the initial health care management of sexual assault with respect to meeting their spiritual needs.

1.7.1.3 To describe how sexual assault survivors would like their spiritual needs to be met by nurses and other health care professionals.

1.7.2 Research questions

1.7.2.1 How do sexual assault survivors experience and express the need for spiritual care during their initial health management following sexual assault?

1.7.2.2 Do sexual assault survivors feel that nurses and other health care professionals are meeting these needs, during the initial health care management following sexual assault?

1.7.2.3 Are there aspects of care that the sexual assault survivors have found helpful?

1.7.2.4 How would the sexual assault survivors like the identified needs to be met?

1.8 Conceptual framework guiding the study

The conceptual framework guiding this study is based on Watson's theory of caring.

Watson's Theory of Caring

Jean Watson's theory of human caring is unique in its focus on the spirit or soul of the human being (Watson 1985:45). Watson describes her orientation as phenomenological, existential and spiritual. According to Watson's model of human care, "human caring is concerned with spirit rather than matter, flux rather than form, inner knowledge and power rather than circumstances" (Watson 1985: 219). Watson provides the following definitions in support of her position.

Act of Nursing

For Watson, nursing is both a science and art, further defined as a "human science of persons and human ill-health – healing". The art of nursing is expressed through the activity the nurse is engaged in during human contact (Watson 1985: 47). Watson viewed the human-to-human engagement as an important aspect of intervention to render spiritual care. The goal of nursing activity is to assist the person in achieving greater harmony of the mind, body and spirit. It is expected that greater harmony of the mind, body and spirit will produce self-knowledge, self-reverence, self-healing and self care (Watson 1989: 224).

Person

Watson (1985: 45-6) defines a person as the locus of human existence and views each person as a magnificent spiritual being comprised of a mind, body and soul. Watson further states that a person's power base for healing and transcendence resides in the soul, the inner self. Through self awareness, meaning emerges that allow the person to evolve towards higher level of consciousness. The sexual assault survivor is a person, and she is the magnificent spiritual being comprised of mind, body, and soul. This study attempts to address the spiritual needs of the soul being.

Health

Watson (1989: 226) states that health is an experience of the whole person. Unity and harmony of the mind, body and soul is equivalent to health, therefore health is reflected in the harmony between self, others and nature. According to Watson, a person becomes ill when there is disharmony within spheres of mind, body and soul and, as such, illness is not necessarily disease, but is a subjective experience of inner turmoil and suffering. It is when the soul is troubled and distressed because of lack of congruence with self, others and nature that illness and disease develops (Watson 1985: 48).

Environment

Watson (1985: 56) states that the external and inner world play a role in the basic human care model and refer them as environmental consideration. The term environment is specifically used in eight Watson carative factors which are: promotive, supportive, protective, corrective, mental, physical societal and spiritual (Watson, 1985: 75). Watson (1985: 81) further describes physical environmental activities and the nurse's manipulation to support and protect the person as *external* variables, and *internal* ones being supportive, protective and corrective measure nurses take to facilitate the patient's experience of harmony.

Human care and transpersonal relationship

Watson (1985:75) defines the transpersonal caring relationship as a specific type of professional human to human contact having a goal of restoring the patient's experience of inner harmony. Inter-subjective feelings and thoughts are released, transmitted and reflected in such a way as to free energy that potentiates transcendence. Intervention or modalities used are:

- Formation of humanistic or altruistic value systems
- Faith and hope
- Sensitivity to self and others
- Creation of a helping trusting relationship
- Expressing feelings
- Creative solving problem caring process
- Promotion of supportive, protective, corrective, mental, physical societal and spiritual environment.
- Transpersonal teaching - learning
- Assistance with gratification of human needs
- Existential phenomenological spiritual forces.

Watson's theory emphasises the spirituality of humans and as such, is perceived to be an appropriate frame of reference to this study.

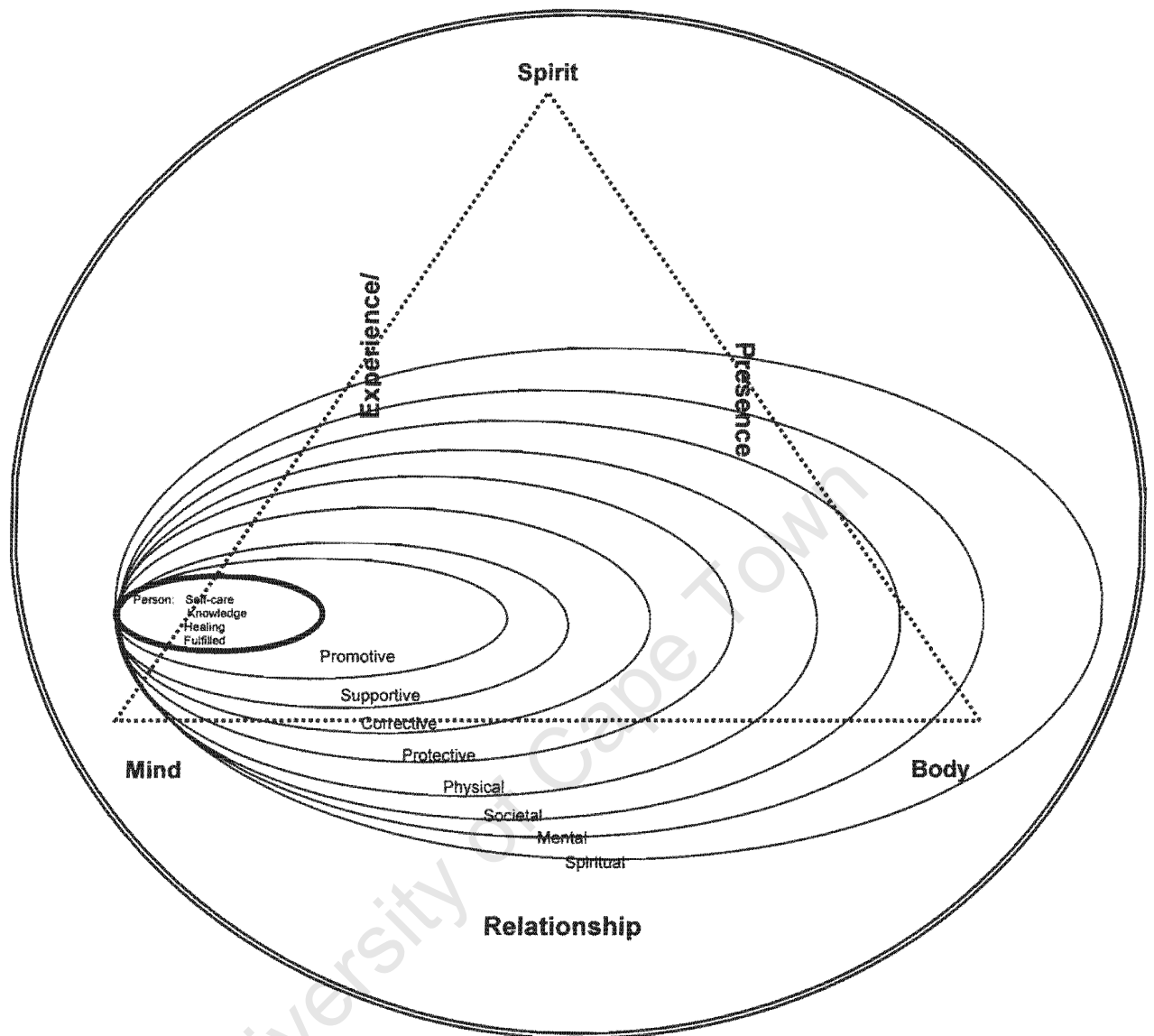


Fig 1.8 Environmental variables involved in experiencing spirituality and presencing during human caring (adapted from Watson 1985 theory of caring)

1.9 Conclusion

Sexual assault has been identified in South Africa as a major social issue and a serious public health problem, with severe physical and psychological health consequences. The South African National Health Department is committed to improve services to the sexual assault survivor, yet there appears to be no inclusion of the spiritual component of health in the current management protocols. If sexual assault survivors are to be managed in a holistic manner, the inclusion of spiritual care where required would be appropriate, thus providing the range of environment caring activities as identified by Watson.

It is also evident that nursing is viewed as a profession that has its roots in spirituality; therefore there is a need to embrace spirituality to be part of the holistic care. The crisis and traumatic experience sexual assault survivors go through may result in them being troubled and spiritually distressed, thus in need of spiritual care. Watson's Theory of Caring is used to guide the study, due to its focus on the soul (spirit) of the human being. Watson theorises that when there is disharmony between mind, body and soul, ill-health results. Though not necessarily physical, it emphasises experiences of inner turmoil or suffering (Watson 1985). The limited literature regarding spirituality in the South African context as part of the holistic care makes this study appropriate. In the following chapter the literature relating sexual assault and spirituality is reviewed.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

International and local literature highlights the impact rape has on the health of sexual assault survivors. Spirituality has been found to be an important aspect of health, thus playing an important role in the lives of people who are in crisis. Violence against women is an important cause of morbidity and mortality in South Africa and, indeed the rest of the world.

Both international and local resources were searched and the following data bases were accessed: CINAHL; Medline; Journals@ EBSCO. The key words explored dealt with aspects pertaining to rape, sexual assault and spirituality.

The literature review was initially limited, based on the principles relating to the use of literature in qualitative research (Holloway and Wheeler 1996: 24). In qualitative research, literature may be consulted at different points in a study: an initial review, a review of methodology, and a review once the findings have been analysed in order to dialogue with findings from other studies. Chinitz (1986) cited by Holloway and Wheeler (1996: 24) stated “literature search and review is an ongoing process, as it becomes another source for data in the main body of the study, where it is guided by the emerging categories”.

The literature review uses the following framework:

- Classification of violence against women.
- Forms of sexual violence.
- Rape as sexual violence: causation and contributing factors.
- The consequences of rape for the sexual assault survivors.
- The experience of sexual assault survivors.
- Management guidelines for sexual assault survivors.
- Spirituality and Nursing / health.
- Sexual assault: a crisis situation

- Forms of spiritual need.
- Patient's perception regarding spiritual needs.
- The nurse's role in meeting the spiritual needs of the client.
- Keys points in the providing spiritual care.

2.2 Classification of violence against women

Hamberg, Johansson and Lidgren (1999: 241) state that violence against women is classified according to the following categories:

- **Physical:** this includes being kicked, strangled, hair pulling, banging her head on the floor and spitting on her, and pain caused by injuries sustained e.g. broken ribs and legs.
- **Psychological:** Anxiety due to constantly being on guard. Tension, fear of the abuser and psychosomatic conditions such as shoulder pain, chronic sinusitis, headache and facial pain.
- **Sexual assault:** labelled as forced intercourse or sex and rape.

In this study the focus is on rape or sexual assault which is explored further hereunder.

2.3 Forms of sexual assault

Sexual assault has been classified and categorised into different forms by different researchers in the field. Stanton (1993: 3) classified sexual violence into harassment, rape, wife battery and femicide. Martin (1999:1) reports that the working group of Women Health Conference held in South Africa in 1994 included in their categories of sexual violence sexist jokes, sexual harassment, pornography, incest, rape, wife battery and murder. Campbell (2002: 1331) defines intimate partner violence as a form of sexual violence, as there is forced sexual

intercourse while the couple are dating or when one partner in a relationship is not ready for sexual intercourse.

2.4 Rape as sexual violence: causation and contributing factors

Historically rape has been used as a weapon to terrify, humiliate, degrade and destroy the opponents during times of war. It is also committed in internal conflicts such as in Yugoslavia and Rwanda (Campanaro 2001: 2569). The WHO (2002:149) report on sexual assaults provided reasons for rape as the following: rape is used as a weapon, as a form of an attack to the enemy typifying the conquest, degradation and punishment of women for transgressing social and moral codes, such as those prohibiting adultery and drunkenness in public. Rape is also committed as part of a deliberate cleansing, for example, in certain areas of South Africa especially rural communities, virgins are raped by older or mature men to cleanse themselves of the HIV (Meel 2003: 66; Campanaro 2001: 2567). Caron and Carter (1997: 569) state that inaccurate beliefs, sexual orientation and man's attitude towards rape are contributing factors leading to the rape of a woman, as rape is viewed as being a sexual rather than a violent act, and that women ask for it. Further, there is a belief that wives cannot be raped by their husbands. Rape is viewed as masculinity and expression of the male power.

2.5 Consequences of rape for the sexual assault survivors

Rape affects profoundly the physical, emotional, mental and social well-being of women (Christofides *et al.* 2003: 1). Connop and Petrak (2004: 29) state that rape can have an enduring psychological impact on female survivors and on their intimate relationships.

- **Physical:** Christofides *et al.* (2003:1) highlights genital and other bodily injuries that often result from force used in rape. WHO report on sexual violence (2002: 149) also reported the profound impact of physical and mental health consequences of rape, which can be short or long term. Other physical

et al (1998: 158); Connop and Petrak (2004: 34) and the One in Nine campaign (2006: 3) as: shock, symptoms of numbness, chills, faintness, disorientation and trembling, dietary problems of over-eating characterised by bulimia and anorexia nervosa, lowered immune response resulting in physical illness, distortion of body image by feeling bloated and fat, sleeping disorders and irritability.

- **Psychological:** Christofides *et al.* (2003: 1) and Stanton (1993: 19) state that sexual assault survivors are at risk of long term problems which include depression, sleep difficulties, mental health problems, post traumatic stress and suicide. Post traumatic stress is also referred to as rape trauma syndrome (RTS) and is characterised by loss of self respect, shame, guilt, humiliation, anger, intrusive thoughts, flashbacks, poor concentration, high sensitivity to noise, exaggerated startle responses, self-blame, suicidal thoughts, nightmares, trauma phobia and anxiety around STIs and notably HIV/AIDS (Schechter *et al.* 1987: 313; Delorey 1989: 532; Stanton 1993: 19; Newton-Taylor *et al.* 1998: 158; Connop and Petrak, 2004:34; One in Nine Campaign 2006:3).
- **Behavioural:** Repeated bathing and showering, violent fantasies of revenge, increased alcohol consumption, fear of being alone, fear of being followed, volatility, crying, violent fantasies of revenge and a decreased interest in academic pursuit (Delorey 1989:535; Connop and Petrak, 2004: 34; One in Nine Campaign 2006: 3).
- **Social:** Drastic changes in lifestyle whereby an individual may decide hastily to relocate or move to another country, or resign from her job in the absence of another job, or with no security at all. Changing jobs, changing telephone numbers, travelling to obtain support or moving in with her parents and other family members may also

occur. The survivor may divorce her husband without a tangible reason, if sexually assaulted by an outsider without disclosing, even to her husband (Delorey 1989: 535; One in Nine Campaign 2006: 3).

- **Sexual dysfunction:** Inability to resume pre-sexual relations, anger towards partners for being blamed and perceived as "damaged goods, a sense of disgust, and reliving the sexual assault as partners "act like rapist" during their sexual act (Delorey 1989: 535, Connop and Petrak 2004: 34).
- **Other responses:** Reidinger (1990: 92) describes other responses whereby the sexual assault survivors pretend to be in control and present themselves as not needing assistance, as if there had been no crime, and there may be hesitation to name the perpetrator if he is an acquaintance or friend.

2.6 The experience of sexual assault survivors

Sexual assault survivors may experience a number of traumatic experiences:

- Insensitivity on the part of health provider: who may minimize or deny the existence of sexual assaults (Kim and Motsei 2002: 1245; Romito and Gerin 2002: 1817). Sexual assault survivors reported feeling ignored, disregarded and rejected by health professionals resulting in an atmosphere of mistrust (Hamberg, Johnson and Lindgren 1999: 243).
- Fear of the listener's perception: Hamberg *et al.* (1999: 241) state that sexual assault survivor's fear that they will be labelled neurotics and those doctors will view them as suffering from a psychiatric illness.
- Fear of abuser: Sexual survivors change may their looks and or their identity; they may sit in the dark and seldom answer the phone (Hamberg *et al.* 1999: 241).

- Physical pain (due to the assault): Facial pain as a consequence of repeated beating, headaches, broken ribs and sinusitis has been reported (Hamberg *et al.* 1999: 240).
- Difficulty in telling: Some sexual assault survivors experience difficulty in telling people about what happened and (come up with) contradictory arguments to cover up instead of disclosing sexual violence (Hamberg *et al.* 1999: 240).
- The experience of shame and stigmatisation: Sexual assault survivors have reported the experience of shame and fear of stigmatisation by being physically examined and being further traumatised by the legal system whilst going through the legal process of reporting the abuse to the police and through court hearings (Kim and Motsei 2002: 1245; Romito and Gerin 2002: 1817; WHO Report 2002: 150).
- The experience of harassment and intimidation: Harassment and intimidation are also part of the experiences sexual assault survivors go through. The New York Times (22 May 2003) reported that women cadets of the Air Force were punished, made to resign, and refrained from pressing charges against male cadets who had sexually assaulted them .

2.7 Management (care) of sexual assault survivors

2.7.1 Introduction

Guidelines outlining protocols for the management, care and support of survivors of sexual assault have been compiled by international agencies as well as national and local institutions. The management protocols examined by the researcher are: the Western Cape Provincial Department of Health (2001); WHO sexual assault guideline report (2002); South African Gender Based Violence and Health Initiative (SAGBVHI) Conference report (2003) and UCT official draft policy on rape and sexual assault guideline (2004).

2.7.2 International agency: World Health Organization (WHO)

WHO guidelines on the care of survivors of sexual violence prioritise the health and welfare of the survivor. The medico-legal services assume secondary importance to the provision of general medical services.

2.7.3 National policy:

South African Gender Based Violence and Health Initiatives (SAGBVHI) conference report (2003). This report focuses on the situational analysis of State Health Care services in South Africa. Christofides *et al.* (2003: 3) presented findings from a study undertaken by the South African Gender-Based Violence and Health Initiative, which are as follows: -

- Women often receive very poor quality medical care after sexual assault especially in certain provinces of the country. In exploring the management of sexual assault, health care providers were found to be sensitive to the risks of STIs, HIV and pregnancy, thus focused on pharmacological prophylaxis, offering STI prevention or treatment and emergency contraception occurred quite uniformly.

- Medical treatment provided to sexual assault survivors was not always correct or providers did not know the correct treatment protocols, which is of concern regarding the quality of treatment being provided at health care centres and hospitals.
- Sexual assault survivors often had to wait a long time before receiving care and their health needs beyond the initial examination were not well met. Sexual assault survivors were given little information about the medical examination. Many survivors demonstrated visible signs of distress after sexual assaults, but some responded to the trauma with extreme composure.
- The referral system was limited, and few referrals were made to social workers and none to spiritual leaders.

2.7.4 Local Guidelines:

Western Cape Provincial Department of Health (2001). Policy and standardised management guidelines for survivors of rape and sexual assaults. This policy is used by the Western Cape Provincial health services and some Non Governmental Organizations (NGOs). The policy provides guidelines as to what type of health setting should be available:

- The examination room must ensure that privacy and confidentiality are maintained at all times.
- The type of examination to be done and correct procedure, e.g. taking specimens for forensic evidence. Pharmaceutical prophylaxis for STIs and pregnancy. HIV (post exposure prophylaxis).
- Referrals to social worker, police and / or hospital for further management, should there be a need.

Official Draft: University of Cape Town (UCT) Policy on Rape and Sexual Violence (2004)

The draft provides guidelines regarding whom to contact when students find themselves in a crisis situation of rape, guidelines for health practitioners, psychologists and wardens, regarding the procedure after the sexual assault survivor has had initial treatment. This includes offering them support and comfort. Clinicians are required to administer HIV, STI and pregnancy prophylaxis procedures and medication and stabilize the woman, who is then referred to the local emergency department for collection of forensic evidence.

None of the above guidelines address the spiritual health needs of sexual assault survivors. Referrals are recommended to social workers, but not to spiritual leaders or care givers of the survivor's choice. Health care professionals are not provided with any guidelines on how to address the survivor's spiritual needs.

2.8 Spirituality and Nursing

The literature on spirituality and nursing, although increasing in recent years, is limited, particularly from a South African perspective. Mahlangu (2003, 2004) was the only published work in South African literature, all other sources being of British and American origin. Research regarding the topic of spirituality in the nursing profession is still in its infancy, and there is lack of a concrete definition (Ross 1995: 462).

Various definitions are found in the literature. Pesut (2002: 131) defines spirituality in three ways:

- **Relationship with a higher being** (intimate relationship) characterised in ways such as life sustaining, creator and father.
- **A reason for living:** as primary motivator of people lives, bringing meaning and purpose to their lives.

- **A journey to growth** in which spiritual growth described as a "roller coaster and stairway".

Mahlungulu (2003: 34) defines spirituality as "an individual quest for establishing and maintaining a dynamic transcendent relationship with self, others and God". Legere (1984: 378) defines spirituality as "the experience of the radical truth of things, the movement of the human spirit as it soars to only God knows height, as the attempt to give meaning to things, an ultimate context for humanity to understand itself, the interior quest for meaning in life, which express it self in both contemplation and action and through which the divine's presence is felt and understood".

Burnard (1989) in Goldberg (1998:838) describes spirituality as being a search for meaning. Casaldaliga and Vigil (1994) in Goldberg (1998: 837) consider spirituality as a way in which people are spiritual, or live with the spirit. Stall (1975) in Carson (1989: 11) defines spirituality as her inner being, her inner person. It is who she is, unique and alive. It is expressed through her body, her thinking, her feeling and judgement and her creativity.

Stall further explains spirituality through the following statement: "My spirituality motivates me to choose meaningful relationships with pursuit. Through my spirituality I give and receive love, I respond and appreciate God and other people, a sunset, a symphony and spring. I am driven forward sometimes because of pain. Sometimes in spite of pain, I am a person because spirituality motivated and enabled me to value, to worship and to communicate with the holy, the transcendent" (Stall 1975 in Carson 1989: 11).

Narayanasamy (1992: 277-9) describes spirituality from different traditions: -

- **Within the Christian theological perspective:**

An individual is seen and made up of body, spirit, derived from the anthropological book of Genesis. A holistic understanding of spirituality has been derived

exclusively from Christian theological tradition. The above may cause confusion and misconception regarding the fact that “spirituality” is equated with Christianity.

- **Existential influences:**

Spirituality is universal to all religions and everybody is capable of potentialising this innermost aspect of themselves, therefore illness and crisis in physical health or impending death brings the person to the innermost aspect of his/her health.

- **Biological basis:**

Spirituality is universal to all religious human beings and is evoked by his or her biological existence and survival value. All individuals may manifest the inner peace and strength derived from a perceived relationship with the Transcendent or an Ultimate Reality, or whatever the individual values as supreme.

Nursing and related health care professions usually refer to spirituality in relation to the holistic view of a person (Narayanasamy (1999: 118). Holistic notion of spirituality is viewed as an aspect of understanding of a person (Carson 1989: 11). A person as a whole cannot be separated into segments when making a diagnosis and providing care. Our being, consisting of body, mind and spirit are dynamically woven together, one part affecting and being affected by the other (Carson 1989: 3).

Nursing has its origin and roots in the religious orders where the body and spirit were cared for together. An example is Florence Nightingale (a nurse theorist) who has adopted the spirituality dimension of nursing grounded in the Judeo-Christian Ethic (Rassool 2000: 1476). Although nursing has its roots in spirituality, the link between the two elements became less obvious when modern medicine began to make its impact on health care at the turn of the 19th century. A century ago, the philosophy of care shifted from a holistic to a dualistic approach. Care of individual's spirit body and mind were gradually separated (Panrose and Barret 1992 in Ross 1995: 461). Some nurses have also incorporated the spiritual dimension in to their work,

among others Watson (1984: 46), who views a person as a magnificent spiritual being comprised of mind, body and spirit or soul Goldberg (1998: 836) states that the spiritual ethos of nursing has been eroded by secularisation, which characterises “the breaking of the lamp”. Goldberg further states that “breaking the lamp of God, is the inspiration of nursing and the historic Nightingale tradition” (p. 836). Ross (1995: 462) states that despite evidence of attempts to rediscover holism, nursing remains dominated by the medical model, which concentrates on disease processes with surgical and medical treatment. Ross further states that nursing text is devoted to incorporating spiritual care into practice but lacks guideline, due to the fact that an operational definition of spiritual care is lacking.

Spiritual health is viewed by Chapman (1996: 38), as “a missing component from health promotion, a murky area, because the majority of existing health promotion programs in the community, workplace or special population setting, do not deal with the spiritual health issue. Thus it is rare to find a program that openly labels a specific activity or intervention as orientated to enhancement of spiritual health. Collective approaches to health promotions gingerly side steps this reality”.

Carson (1989: 155); Ross (1995: 422) and Kelly (2004: 162) all state that nurses are unclear about their role in providing spiritual care, and that spirituality is viewed as an unimportant aspect of nursing care. Carson (1989:155) states that discussion and interviews held with nurses revealed that spirituality as a concept was not meaningful to the nurse’s every day routine, yet nursing care incorporates the elements identified as comprising of a body and spiritual dimension. Kelly (2004: 162) states that spirituality is returning to health care because people believe in it and seek it as part of their treatment. Narayanasamy and Owen (2000: 447) state that since the 1980s, nursing practice has returned to its traditional roots and perspective.

2.9 Sexual assault: a crisis situation

The experiences of sexual assault survivors are perceived and described as life threatening, traumatic, crisis, stressful and degrading events, which most of the time result in individuals struggling to find meaning and purpose in life (Stanton 1993: 19; Kim and Motsei 2002: 1245; Romito and Gerin 2002: 1817; WHO 2002:149 and Christofides *et al.* 2003: 1). Many people do not seriously search for meaning and purpose in life, but live as if life will go on forever. It is not until the crisis, illness or suffering occurs that the illusion (of security) is shattered. Therefore illness, suffering and, ultimately death by their very nature, become spiritual encounters as well as physical and emotional experiences (Ross 1995: 461).

In crisis a person may become spiritually distressed, leading to the inability to invest in life with meaning, resulting in the need to be spiritually fulfilled. The spirituality may come into focus in illness or when the sufferer faces emotional and physical stress, including death (Burnard 1989 cited in Ross 1995: 461; Carson 1989: 15; Murray and Zetner 1989 in Narayanasamy & Andrews 2000: 58; Narayanasamy 1999: 119 and Mahlangu 2003: 34).

Ryan (1984: 55) reflects on a statement made by a patient in a crisis situation being "what we need and want at such a time when we feel helpless, victimised, hopeless and perhaps distrustful, first and foremost we want to be given the means and service that will meet our needs". Meaning can be gleaned by drawing from the person's spiritual resources and the person's spirituality can be a source of strength for coping with life threatening situations (Mahlangu 2003: 34; Kelly 2004: 165). Kelly (2004:165) believes that spiritual coping strategies may help the individual to transcend beyond self to reach a higher power, resulting in self empowerment and the ability to cope with the stressful situation.

Bradshaw (1994) cited in Rassool (2000: 1479) states that there is a host of critical analyses on the concept of spirituality in the nursing literature, and that spirituality plays a major, if ill-defined, role in delivering spiritual care to patients. Spiritual care is important for all people, not only for those who express religious belief, as spirituality is a fundamental need that goes

beyond religious affiliation (Rassool 2000: 1481). Spirituality is universal, it is a dimension within everybody (person), religious, atheist or humanistic (Carson 1989: 7; Narayanasamy 1999: 278).

2.10 .Forms of spiritual need

Individuals may express spiritual needs, in the sense of a need for meaning and purpose, including identity (Narayanasamy 1999: 25). Spirituality may be expressed in a variety of forms and some individuals may find that their spiritual beliefs and practice can be a source of comfort in alleviating their spiritual distress (Narayanasamy and Andrews 2000: 58). Carson (1989:13) believes that spirituality is complex and multidimensional and is uniquely experienced and interpreted by each person. Each person alone can provide another with a unique perception of his or her spirituality. Carson (1989: 11) further states that spirituality is frequently equated with religion and that the two may be used synonymously but are not synonymous. Religious practices are vehicles for expression of the person's spirituality. Rassool (2000:1479) stated that "in the Islamic context, there is no spirituality without religious practices and religion provides a spiritual pathway for salvation and a way of life". Thus there is no distinction between the two concepts as religion is embedded in the umbrella of spirituality.

Muslims embrace the acceptance of the divine and seek meaning, purpose and happiness in the worldly life and hereafter. Muslim spirituality believes in the resurrection of the physical body as well as the spirit (Rassool 2000: 1480). This leads to a holistic view of medical care. Several researchers state that spirituality has the following characteristics: hope, faith, connecting, transcending, giving life and exercising option of trust and courage. They use spiritual dimensions synonymously with spiritual beliefs (Ryan 1984: 55–57; Carson 1989: 194; Pesut 2002: 128; Mahlungulu 2003:4). Legere (1984:380) states that joy is the fruit of spirituality.

2.11 Patients' perceptions of spiritual needs

Hay (1987) cited by Narayanasamy (1999: 125) stated that people often experience an intensity of spiritual awareness when they undergo stress related to emotional or physical illness or other forms of crisis. The experience often remains a personal secret because of fear that if people find out, they might become the subject of ridicule, or be considered stupid or even mad. This personal spirituality may further be constricted because patients are unable to utilise its positive or healing aspect through fearfulness, or the inability of nurses to integrate aspects of spirituality into total care. It is unlikely that patients may trivialise or suppress this experience or remain insensitive to their spiritual need. Spiritual needs are sometimes shown in behaviours that people might display, thereby expressing unfulfilled spiritual needs (Carson 1989: 115). Carson says that a lack of opportunity to carry out one's usual religious practices whilst in hospital may cause the patient to feel a spiritual need. Piles (1990: 39) also claims that spiritual needs manifest through psychosocial behaviours.

In the Oakley study (1986) cited by Goldberg (1998: 830) a patient gave an account of her experience in which the presence of a nurse made her feel content as she lay in bed, coming to terms with having cancer. As soon as she felt recognised as a whole person rather than being defined by illness, the recognition brought relief and healing. This statement of a spiritual presence in Oakley's study (1986) in Goldberg (1998: 830) further explained the phenomenon of "giving hope" as a need often experienced by patients, and how nurses gave hope by communicating their understanding of medical notes and interpreting them to patients who were distressed due to lack of understanding.

Goldberg (1998: 838) stated that patients require nurse to actively listen active in order to allow them to express their feelings of anger or anxiety. When someone listens, the patient begins to experience a renewed sense of security and peace. According to Piles (1990: 40) patients feel comfortable to express their anger to nurses as opposed to voicing their concerns and anxiety to

the clergy, because clergy represent holiness to many patients who may not be feeling holy, especially if they are wrestling with guilt.

Harrison (1993) in Goldberg (1998: 839) regards prayers, rituals and worship as a means by which spiritual needs might be met. McGilloway and Myco (1985) in Goldberg (1998: 839) state that familiar practices of religion bring about a sense of peace and well-being. Ross (1995: 462) recommends that spiritual care be part of patient's total care. Ross (1995: 463) cites an example of a patient's behaviour in her study on spirituality. The Bible was on the patient's bedside locker and Ross enquired if the patient would like to have a passage read from the Bible, to which the patient agreed. The patient expressed how meaningful it was for her, and died later, peacefully, with a smile. The patient had a spiritual need which was met, "through a religious practice" as stated by Piles (1990: 37). Piles further state that patients report that these practices bring comfort.

Ross (1995: 462) reports on the findings of a number of studies undertaken relating to patients' perspectives on spiritual need and care, and notes that for many patients, illness and hospitalisation can become spiritual encounters. During those experiences, patients reported having spiritual needs, such as a need to seek for meaning and belief in God, often expressed through formal religious practices. Relief from fear, doubt, loneliness, relatedness to other (God) were all considered important to them.

Stallwood-Hess (1969) in Ross (1995: 462) reported that the majority of patients felt that their spiritual needs were not met in full; some patients would have liked nurses to help them with their spiritual needs by listening, being there for them and referring them to the clergy where appropriate. Many felt that nurses were too busy to help them with spiritual needs. The reports in these studies imply that patients' needs were not met.

Piles (1990: 37) reported on a study in which a paraplegic person related his story about how he searched for God and meaning in his life after an accident. The patient felt that nurses should have at least recognised his needs and referred him for help if, indeed, they were incapable of

helping him. In the same study one patient reported that health professionals were caught up in offering medication or mechanical relief. Piles concluded that spiritual needs were not assessed, recognised or appropriately dealt with by nurses. Piles (1990: 39) further related her own experience of witnessing health professionals pounding a patient's chest, during which the patient became anxious, asking if he was going to die. No one acknowledged his anxiety and fear. Instead he was told to breathe, until he felt and verbalised his anxiety and asked a direct question, enquiring if he was going to die. Health professionals gave no comfort, no explanation and no support.

2.12 The nurse's role in meeting spiritual needs

Carson (1989: 155) and Ross (1995: 461) state that it is difficult to determine the exact role of a nurse in ancient times with regards to spiritual intervention. However, most nurse historians have presented nursing as a holistic but intuitive response to the health needs of communities. Carson (1989: 155). Carson (1989: 156) further states that despite the reasons for avoiding spirituality, meeting spiritual needs is, and always has been part of a nurse's role. Spiritual care is different from emotional support, even though spiritual distress is often manifested in emotional ways (Piles 1990: 40).

2.12.1 Key points for providing spiritual care

Building a good interpersonal nurse / patient relationship has been mentioned by researchers Carson (1989: 164), Goldberg (1998: 837) and Narayanasamy and Owen (2000: 453), as the key for providing spiritual care, with interventions such as nurse presencing, caring, engaging, active listening (emphasised), companionship, giving hope, empathy and compassion. The above-mentioned researchers report that a nurse who gives spiritual care should have the traits of kindness, passion, being real, transparent, honest and trustworthy.

Goldberg (1998: 837) compared spiritual care to ethical principles such as respect for the person telling the truth. This type of care encourages patients to express their feelings of anger or anxiety. Ryan (1984: 55) recommends that demonstrating respect, empathy and honesty are necessary in the development of a human relationship. Carson (1998: 156) emphasised the importance of ensuring that patients were able to connect with those of similar beliefs. Goldberg (1998: 839) states that the procedural approach of allowing religious acts such as praying, touching and healing are roles nurses should be performing, as part of interventions, and noted that healing is both physical and emotional in nature.

2.13 Conclusion

The literature reviewed provides evidence of spirituality in nursing which needs to be explored and further researched. There is limited literature related to the spiritual need of sexual assault survivors and there is a particular need for a South African perspective.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This qualitative study aimed to explore whether sexual assault survivors who are managed in the student health service of one of the tertiary institutions of the Western Cape, have spiritual needs and to determine if those needs, are being met by nurses and health care professionals. Sexual assault survivors were asked how they would like health professionals to have responded to their perceived needs.

3.2 Research design: Qualitative Research

Burns and Grove (2005: 36) describe qualitative research as a naturalistic method, applied to increase our understanding of people, their uniqueness and holism, and a method used to generate knowledge concerned with meaning and discovery. A qualitative design was chosen for this study because of its focus on the subjective experiences of the participants.

Having chosen Watson's (1985) theory of caring as a frame work guiding the study, with her approach being phenomenological and existential, a phenomenological qualitative study was appropriate. Phenomenology is explained differently by different authors / researchers.

Watson (1985: 55) describes phenomenology as the study of the totality of human experience, of one's frame of reference that can only be known by others indirectly through empathetic understanding phenomenology as the starting point of the researcher's experience of the phenomenon and travelling through other people's experience of it, the researcher eventually arriving at a general understanding of a phenomenon in its unique and essential manifestation.

Creswell (1998: 51-55) on the other hand state that phenomenology describes meaning of living experiences for several individuals about a phenomenon, whereby specific statements and themes are analysed to search for all meaning. It is the study whereby the researcher relies in the intuition, imagination and universal structures to obtain a picture of experience.

The common focus in the definition of phenomenology by different authors is about human experience shared by subjects and the researcher analysing statements and themes in order to understand the meaning of it. Exploring and describing the spiritual needs of sexual assault survivors, one needs the sexual assault survivors to share and relate their experience, which is why phenomenological approach was chosen. The researcher was the instrument of data collection to gather information, analyse this inductively and describe the expressed needs of the participants.

3.3 Study population

The study population comprised all students who were sexual assault survivors and were willing to participate in the study, attending the health care centre of a tertiary educational institution in the Western Cape on a follow-up basis in 2005.

3.4 Sampling

A purposive sampling technique was used in this study. Purposive sampling is a type of non-probability sampling based on the judgement of the researcher to hand-pick subjects or objects that are typical or representative and knowledgeable of the phenomenon being studied (Brink 1996: 144). Katzenellenbogen, Joubert and Abdool Karim (1997: 179) describe purposive sampling as a method in which the researcher deliberately chooses respondents or settings in order to ensure that the sample covers the full range of possible

characteristics. Creswell (1998: 14) refers to purposive sampling as a technique used to identify subjects who are rich in information.

Information rich participants in this study are women who have been sexually assaulted and are currently attending the health care centre for support and counselling on an individual basis. These women have experience of the phenomenon of interest. The sample size selected comprised six (6) participants who were willing and agreed to participate in the study. Polit and Hungler (1997: 223) state that qualitative research is not concerned with number of people sampled, but rather with in-depth, holistic understanding of the phenomenon of interest.

Interviewing of participants continued until data was saturated. Data saturation occurs when no new information is generated and participants are echoing each other and redundancy is achieved (Brink 1996:141; Katzenellenbogen *et al.* 1977: 79, Polit and Hungler 1999:299). In addition experience and feelings cannot be quantified. The participants are between ages 21 and 40 years, and fluent in English, as interviews are conducted in English.

3.5 Research process

3.5.1 Inclusion Criteria

Students who are survivors of sexual assault attending a health care centre and studying at this tertiary educational institution in the Western Cape on a follow-up basis; who were committed to their program of care for continuous counselling sessions and who consented to participate in the study were invited to participate.

3.5.2 Exclusion criteria

Participants who had missed an interview session more than once, sexual assault survivors who were receiving physical treatment due to the nature of the injuries sustained during the assault

and those survivors diagnosed by a psychiatrist as mentally ill or unfit to participate were excluded from the study.

3.5.3 Participant recruitment

Recruitment began after approval from the Research Ethics Committee of the Faculty of Health Sciences was obtained, (appendix 5) and permission was given by the director of the Health Care Centre to access participants, (appendix 4). Recruitment commenced in September 2005. A list of names of potential participants was obtained from the Director of the Health Care Centre who had obtained “consent to be contacted” from sexual assault survivors during their managed sessions. Due to the sensitivity of the study they were informed of the study and requested to contact the researcher if interested in participating, to ensure that those recruited were prepared to share their experiences.

After consent to be contacted was obtained, the researcher organised meetings to meet participants individually at their homes or any other place of their choice. Potential participants were given information about the study (appendix 1) and if they agreed, signed the consent form [Appendix 2] to participate in the study. Six participants were enrolled for the study.

3.5.4 Data collection

Data collection was done by means of individual semi-structured interviews with open ended probing questions, each lasting approximately 90 minutes. Beer (1997: 133) states that interviewing facilitates exploration of one’s personal world and helps the interviewers to discover that their constructions and formulations of the world differ from those of their respondents. Data was collected by the researcher at the participant’s homes, or at any other location of the participant’s choice. Interviews were face to face, audio -taped and then transcribed verbatim. Writing of field notes during the interview was also done to capture main

phrases and sentences, for verification if needed at a later stage, as suggested by Creswell (1998: 140). Each participant was interviewed twice within an interval of approximately a month to enable the researcher to complete preliminary data analysis.

The semi-structured interview schedule comprised the following questions: -

Question 1: If I asked you to think about things like God, ancestors, spiritual and traditional healers, would you say that you believe in either of them or any other higher purpose in life not necessarily connected to a specific religion?

Question 2: Do you remember the day you were managed at the health care centre following the assault you experienced. How you tried to make sense of the incident and how you reacted emotionally to that?

Question 3: Did your belief comfort you?

Question 4: Was your belief system included in your care?

Question 5: What would have helped?

See Appendix 3

3.6 The Scientific Rigor of the study

3.6.1 Trustworthiness

In a qualitative study, rigor is addressed by the use of alternative terms recommended by Lincoln and Guba (1985: 300). Credibility, transferability, dependability and confirmability are measures for achieving trustworthiness. Lincoln and Guba (1985: 300) further state that the above terms are appropriate for the naturalistic setting of qualitative research and their focus accurately depicts experiences and perceptions of the participants.

3.6.1.1 Credibility

This refers to confidence in the selection of the appropriate method of data collection and how well process of data analysis addresses the intended focus. The amount of data is also important in establishing credibility (Graneheim and Lundman 2004: 109 – 110). Credibility in this study was established by making sure that the tool for data collection was the appropriate one. Individual interviews were viewed appropriate due to the sensitivity of the topic, and this approach is encouraged in qualitative studies (Beer 1997: 133).

3.6.1.2 Dependability

Dependability means taking into account the degree to which data changes over, time and changes made in the researcher's decisions during the data analysis (Lincoln and Guba 1985: 299). The researcher achieved dependability by scheduling data collection within a monthly interval, and only collected relevant data by utilizing semi-structured interviews that guided participants as to what the researcher wanted to know.

3.6.1.3 Confirmability

This is described by Graneheim and Lundman (2004:110) as a process whereby participants recognise the findings. This the researcher achieved through verification of data during follow-up sessions with participants. After transcribing the data the researcher returned to the participants to ascertain the meaning of their statements and whether their experiences were accurately reflected in the transcripts. This was done within a month of the initial interview.

3.6.1.4 Transferability

Polit and Hungler (1999: 717) describe transferability as an extent to which the findings can be transferred to another setting or group. The findings of this study with respect to the traumatic effects of sexual assault agreed with findings of other studies conducted previously (Christofides *et al.* 2003:1; Kim and Motsei 2002: 1245; Romito and Gerin 2002: 1817; Staton 1993:19 and WHO 2002:149).

3.6.2 Reflexivity

Graneheim and Lundman (2004:11) state that interpretation of text always involves multiple meanings and the researcher's interpretation is influenced by his/her personal history. Qualitative content analysis involves a balancing act - to "let the text talk" and not to impute meaning that is not true. The researcher in this study made sure that she bracketed her biases, by not bringing her perspective of what she thought the needs of sexual assault survivors were. The researcher had worked at the SHS as a clinical nurse practitioner where one of her key responsibilities was managing sexual assault survivors, and was thus one of the health care professionals with whom sexual assault survivors had first contact. This experience could have impacted the interviewing techniques and analysis of the transcripts. It was therefore important that the researcher "bracket" out any personal bias, and consult with her supervisor on a regular basis to ensure that her own preferences did not influence the integrity of the study.

3.6.3 Engagement with participants

Lincoln and Guba (1985: 302) state that some degree of time must be spent with participants to facilitate the building of the rapport and trust. Two sessions of one and half hours each were spent with the participants, which enabled the researcher to create a safe space in which participants felt comfortable enough to share their experiences.

3.6.4 Peer debriefing

Peer debriefing involves talking through experiences with colleagues (Krefting 1991: 217). The researcher discussed the research process, problems in particular verbalised being traumatised by listening to participants traumatic experiences and findings of the study with the supervisor who has experience in qualitative methods.

3.7 Ethical considerations

Ethical approval from Research Ethics Committee of the Health Science Faculty at UCT (Appendix 5) was obtained. Permission was obtained from the director of the health care centre to conduct the study with persons who attend the unit.

3.7.1 Written informed consent was obtained from participants (Appendix 2). Participants were informed of their right to withdraw from the study at any time and that their management care at the university health centre would not be affected in any way. The consent form included details about the purpose of the study, the benefits to future sexual assault survivors, the procedure involved, expected duration of the study, risks and discomfort that might be countered. The above was explained verbally to potential participants prior to them signing the consent. The consent form was in English, with Afrikaans and Xhosa versions available to those participants might require it.

3.7.2 Anonymity and confidentiality is of major importance in a study dealing with sexual assault survivors who may be traumatised and stigmatised. To protect participants' identities, pseudonyms were used in the presentation of data. Audio-tapes of interviews, as well as documentation of their interactions with the researcher were kept in a secure place. The researcher was the only person with access to them. Tapes will be destroyed after data analysis

has been done and the study completed. Anonymity was ensured, in that no information was released to the unit, and participants were not seen in the unit.

3.7.3 The principle of beneficence and non-maleficence was respected. The participants were entitled to enjoy basic human rights, while not feeling obligated to participate in the study. There was no pressure from the researcher and no false promises of benefit made. A potential beneficial aspect of the study is that sexual assault survivors were given a platform to voice their needs regarding their health care management.

3.7.4 Dealing with sensitive issues Possible harm, which cannot be anticipated, is the emotional harm of remembering and revisiting the incident. Participants would benefit by being referred to relevant services should the need arise. Services such as psychological services (if not already accessed) were available should this have been required and arrangements for contact with a spiritual carer (minister) was possible.

3.7.5 The justice principle was adhered to, in that the findings of the study will be made available to the student health service, which may benefit future management of survivors of sexual assault.

3.8 Data Analysis

Data analysis was an ongoing process while gathering data during transcription and returning it to participants to confirm information gathered previously. Huberman and Miles (1994) state that data analysis is not off the shelf, but is rather custom built, revised and “choreographed”. In this study, data analysis was based on general data analysis strategies advocated by Creswell (1998: 140 – 142).

3.8.1 Aim of Data Analysis

The aim was to describe the participants’ perspectives and perceptions regarding their experiences of management of sexual assault. Their individual views were respected and

viewed as unique. Miles and Huberman (1994:51) view this type of analysis as subjective and socially constructed through individual interaction and interpretation.

3.8.2 The process of Data Analysis

Three main steps of data analysis were followed and described hereunder: -

3.8.2.1 Summarising field notes

This step was the beginning stage of data analysis. Notes and points of interested captured main phrases, sentences and ideas as suggested by Creswell (1998:140), in order to draft main points as a summary, not verbatim. Summarising field notes was done immediately after each interview whilst important aspects of the interview could still be remembered. Miles and Huberman (1994:51) state that marginal notes add clarity and meaning to notes, which were useful during the summary process. Each participant was allocated a pseudonym, for example, Kerry, Lebo, Linda etc.

3.8.2.2 Transcription of data

The audio tape of each participant interview was initially listened to several times by the researcher. Whilst listening, notes were made. The audiotapes were then transcribed verbatim, including the "uhs", "ers" and even incomplete sentences. Field notes jotted down the during data collection were also used in conjunction with the audiotapes to get clarity. The transcribed interviews were then formatted so as to easy to follow for the purpose of data analysis. A summary of the responses to each of the questions was compiled.

3.8.2.3 Data Reduction

Creswell (1998:141) suggests that all the data be read through in order to obtain a sense of the overall context prior to the reduction. The researcher prefers the term "condensing" described by Graneheim and Lundman (2004:106) as a process of shortening while preserving the core,

as opposed to reduction, which refers to decreasing in size which indicates nothing about the quality that remains. The researcher looked closely at words used by the participants and all summaries of the interviews, including field notes, were grouped into specific themes that included similarities and differences to answer the interview research questions. The condensed text was then grouped together, a process called abstracting as described and advocated by Graneheim and Lundman (2004:106), since it emphasises descriptions and interpretation on a higher logical level. Abstracting in this study resulted in content areas which covered the five research questions of the study. of content identified with little interpretation, as stated by Graneheim and Lundman (2004:106).

3.8.2.4 Content Analysis

Graneheim and Lundman (2004:107) described concepts related to qualitative content analysis. The unit analysis is the one used in this study, as it is relevant. It is the text interviews, related to the experiences of sexual assault survivors with regard to their needs whilst they were going through a crisis.

The interviews were read through several times to obtain a sense of the whole picture. The content areas were then condensed. The condensed text was then coded by words and phrased into meaning, then condensed with a code, based on the interpretation and making sense of meaning by participants. This was derived from a formulated understanding and conclusion reached by the researcher from what was mentioned. Data was analysed by content, since it shed light on a specific area as stated by Graneheim and Lundman, (2004:107). Graneheim and Lundman, (2004:107) further described a code as a label of meaning unit, which allow a condensed content area to be understood in relation to the context. Once each participant unit analysis and content areas were condensed, descriptions were then combined. Table 1 is an example of a content area, condensed content and a code.

Table 1

Content Area: Belief system	Condensed Content	Code
<p>Kerry's belief</p> <p>"I believe in god, in Christianity and Jesus"</p> <p>"I am kind twisted to a higher power of the earth"</p> <p>"I do believe in the higher power"</p>	<p>Kerry is a Christian who believes in God, Jesus and the higher power of the earth.</p>	<p>Believer in</p> <ul style="list-style-type: none"> - God - Jesus - Higher power
<p>Lebo's belief</p> <p>"I do believe that there is a higher power stuff like that"</p> <p>"There is definitely something out there trying make some stop at us, certainly to connect to what happened to our soul"</p> <p>"There is something out there that has been guiding me"</p> <p>" I want to believe that there is a personal atoma that there is there beyond me, it is beyond a human being that makes me believe that there is something spiritual resulting from whatever happened there"</p> <p>" There must be a higher power, but God is in Control"</p>	<p>Lebo believes that there is a higher power and connected to that higher power , that something beyond human being's control has been guiding her and that higher power is God who is out there somewhere</p>	<p>Believer in</p> <ul style="list-style-type: none"> - Higher power - God.
<p>Linda's belief</p> <p>"I am an atheist"</p> <p>"I do most rituals of the ancestors in the spiritual way"</p> <p>"I take pride in my ancestors"</p>	<p>Linda is an atheist who takes pride and believes in her ancestors and does rituals in the spiritual way.</p>	<p>Believer in</p> <ul style="list-style-type: none"> - Ancestors - Rituals - Atheist

Table 1. An example of a content area and codes.

- Once data was consolidated into content areas, it was possible to recognise categories that emerged from the text. Graham and Lundman (2004:106) describe a category as a group of content sharing a commonality, this is a core feature of qualitative content analysis.

These categories were given headings such as “belief system, emotional reaction, and comfort aspect of the belief and participant's recommendation”. However owing to the complex nature of human experiences, it is not always possible to create mutually exclusive categories when text deals with experiences, which was the case in this study. Themes that emerged were difficult to separate and there was a lot of overlap and repetition of themes evolving due to connectedness of the nature of their experiences and needs.

After analysis each content area was presented descriptively in table format. In the final stage of analysis, themes emerged which were viewed within the context of the study, aimed at describing the needs for spiritual care of the sexual assault survivors during their initial management following the sexual assault.

Themes that emerged were that sexual assault survivors are spiritual people who have a belief system, and experienced a need for spiritual care as they tried to make sense of what happened to them, and that their belief system comforted them. Themes are presented in the following chapter

3.8.2.5 Data Display

Miles and Huberman (1994:101) state that data may be displayed in structured summaries, synopses, network-like diagrams, vignettes and matrices with text rather than numbers. In this study the researcher put together data on the basis of meaning derived, which is presented in a narrative document in chapter 4.

3.9 Conclusion

Data collected from participants gave detailed information on the sexual assault survivors' experiences and their understanding of what happened to them. The themes which emerged from the analysis of the transcribed interviews will be presented in the following chapter

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PRESENTATION OF FINDINGS

4.1 Introduction

In this chapter, the findings from the analysed transcripts are presented. The responses to each question were analysed by content, descriptions grouped into commonality from each participant, to form categories that emerged. Five categories emerged and were given headings. Themes that emerged were that sexual assault survivors are spiritual being, experienced need for care, tried to make sense of what happened to them, their belief comforted them, they would have liked that their belief be included in their care and make recommendation to their preferred care. Each theme was dealt with separately, however due to connected nature of themes that emerged, they are interlinked and there is a considerable overlap. Themes that emerged are presented as follows:

4.2 Presentation of themes

4.2.1 Belief system

All participants in this study have a belief system which has meaning for them, and included beliefs relating to God, higher beings and ancestors. During the experience of assault, each drew their strength from that belief system and this enabled them to cope with their assault. The participants view themselves as spiritual beings.

The participants' belief system played a major role in their lives. It is more than just a belief that they all have and value, but also a way of life. The belief systems signified and dictated who they are where they came from, how they must live, their upbringing, their backgrounds, their future and these belief systems carried them through their ordeals.

Kerry "believes in God, Christianity, Jesus and the higher beings", however she expressed disappointment in her belief evidenced by the statement "I am kind of twisted to a higher power of the earth". When questioned about the statement, her response was that she is partly felt let down by her belief, yet hopeful that her faith in the higher power would protect her in future, as it did whilst going through her sexual assault crisis. She verbalised that she has lost faith in Christianity but still values God.

Lerato and Lebo "believe in God" and have no doubt that they managed to cope because of their belief which carried them through their ordeals. Keketso "values Christ as her higher being" and Bridget believes that "there is definitely a higher being" but is unable to explain what this means.

Bridget explained that although she is not a "staunch" Christian, things that happened to her in the past and her experience of sexual assault made her realise that there is certainly something that guided her, looked out for her, carried her through and enabled her to cope. She however could not put it in words, yet felt that God was in control.

Linda is an atheist who values her ancestors and takes pride in them. Linda gave a clear picture of how her ancestors contributed to who she is, by dictating to her parents how they should live, bring up their children and practice their rituals. She felt a responsibility to continue with her ancestors' way of life. She believed that it is the spiritual way of living for her which would guide and support her future life.

All participants practice rituals which show connectedness and commitment to their belief systems. Kerry, Lebo, Lerato and Bridget pray, worship and go to church. Lerato complements prayer with traditional practices. Linda performs ancestral rituals such as slaughtering the cow in her home for the blood to be used for cleansing and brewing African beer for celebrations. Inviting family members, friends and neighbours for big feast and celebrations form part of ancestral rituals that are performed yearly or when things go wrong to

request pardon from the ancestors. The participants' belief systems and values are summarised in Table 4.1.

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Table 4.1
Belief system concepts

Kerry	Lerato	Linda	Bridget	Lebo	Koketso
<p>"I believe in God, in Christianity and Jesus"</p> <p>"I am kind of twisted to the higher power"</p> <p>"I do belief in the higher power"</p>	<p>"I am Black and I am aware of ancestors, I believe in them but I also believe in God.</p> <p>"I practice traditional rituals"</p> <p>"I also pray and worship"</p>	<p>"I am an atheist"</p> <p>"But I do most of my rituals of the ancestors in the spiritual way"</p> <p>"I take pride in my ancestors"</p>	<p>"I am not a staunch Christian but I do believe in God"</p>	<p>"I do believe that there is a higher power and stuff like that"</p> <p>"There is definitely something out there trying to make some stop to us certainly to connect to what is happening to our soul"</p> <p>"There is something that has been guiding me"</p> <p>"I believe that there is a God somewhere out there"</p> <p>"I want to believe that there is a personal atoma that is beyond me, it is beyond a human being that this makes me believe that this is something spiritual resulting from whatever happened there"</p>	<p>"I am aware of ancestors and traditional healers"</p> <p>"I am a Black person"</p> <p>"I practice traditional rituals"</p> <p>"I also pray and worship"</p> <p>"I do go to church"</p> <p>"I am a born again Christian"</p> <p>"I do value my Christ as a higher being"</p>

4.2.2 Making sense of the experience: sexual assault

A range of emotions, although expressed individually, were common to all participants. There was a sense of confusion and uncertainty which pervaded their beings at the time of assault. The confusion resulted from being unsure of whether their communication to their partners was clear, specifically with regard to the "no" part. The uncertainty was due to the fact that they were unsure as to the right way of acting when in a relationship. They were questioning whether they would repeat the same mistake, or communicating the "no" to the "yes" part, meaning "I am ready to move or take our relationship to a higher level of sexual intercourse, yet I am shy to admit or mention it, as was the case with Bridget.

Bridget, Kerry, Koketso and Lerato were raped by their boyfriends. They were not ready to be sexually active with their partners, but were forced, and even physically assaulted and overpowered, in particular Bridget. Lebo was sexually assaulted by her father's friend who was her custodian at the time and the "only relative" in the country when her parents went abroad. Lebo was confused by the fact that the perpetrator was acting 'in loco parentis', yet he raped her. The participants' confusion and uncertainty was evident in comments such as "I was not sure initially how to react"; I was in a confused state of mind"; I could not think straight"; I was numb and confused"; It was like I was mad".

There was a sense of blame. All participants felt that they may have been to blame for the assault, and for allowing the rape to happen. Bridget, Lerato, Koketso and Lebo rationalized this by stating that maybe they might have led their boyfriends on, as they were in a relationship and were comfortable with their partners whilst kissing. Lebo blamed herself for allowing her mom to persuade her to keep the rape and the identity

of the rapist a secret, as she was a respected member of the community and that divulging the secret would spoil the family relationship.

Linda blamed herself for allowing the act to happen. She tolerated what she hated, namely the sexual intercourse with her supervisor for the sake of completing her thesis. All the participants blamed themselves for allowing the sexual act to continue. "I thought I might have contributed". "I had a feeling that I have done something wrong". Fear was a common experience, and expressed in relation to different factors. The fear of boyfriends repeating the assault was predominant in the participants who had not been raped by their boyfriends, as they had key access to the girls' places of accommodation. "I was scared". "I was afraid". "I felt nervous".

Anger was an emotion running deep throughout the participants' responses to the assault.. Anger was directed to the rapists for hurting them emotionally, at God, at parents. Lebo was angry at her mom for forcing her to keep the rape a secret and prohibiting her from talking openly about the rape. Kerry was angry at God and felt that her Christian faith had no meaning, as God had protected her from her perpetrator. This was aggravated by the knowledge that her boyfriend professed to be a Christian.

Lebo "was angry at the nurses" that attended to her during her first encounter with them after the assault. She stated that they were unsupportive and unprofessional, as they discussed her assault in front of her, and how it happened as if they were present at the scene of the crime, as if she was non-existent. She verbalised that she remembered the incident at the health care centre as if it happened yesterday. Lebo was also angry at the disrespectful manner in which the police enquiry was conducted and felt that their main concern was the collection of forensic evidence. "I felt very angry".

Denial was linked to disbelief that the rape had really happened to them – it was as if such a thing could not happen to them. It was also impossible to believe that the people

they loved, trusted and respected could inflict that kind of pain to them, hurt them, and betray their trust. Kerry "did not want to believe that it really happened" and "made up stuff in my head" as she tried to pretend that her boyfriend did not rape her and that the whole thing was just a dream – that she would wake up in the morning and things would be back to the way they were before.

Shock was an overriding emotion, experienced as something which was difficult to handle and associated with a feeling of numbness "I was numb".

Sadness and unhappiness preoccupied all the participants, and was an ongoing emotion evoked by the discussion of the event or of a similar experience by others. Lebo stated that "although it happened eighteen years ago", she still experiences moments of sadness whenever she hears people talking about rape. Expressions of sadness were presented as "I was unhappy"; "I was tearful"; "I felt unhappy and I was upset".

A sense of loss was also experienced. Linda experienced the loss of her family values, which required her to wait until she was married to be sexually active. Loss of virginity was viewed as a major loss by Bridget, Koketso, Lerato, Kerry and Linda. Linda felt disrespected by the rapist, because her family norms and values were undermined and her family was disgraced.

For those participants whose boyfriends were the perpetrators, there was insecurity regarding their future relationships. They said they did not know how to behave in the future relationships and "felt like a fool". They did not feel in control of their lives, they felt helpless and "felt that I had run out of options" as there was no one to help at the time of the rape, and they had to cope with the inevitability of sexual assault. This was verbalised by statements, "I felt alone". "I did not know what to do".

The sense of vulnerability emerged as they realised and verbalised that being in the relationship resulted in them being sexually used by their partners. They did not know how to react to the situation, and this rendered them vulnerable, expressed by statements "I felt vulnerable".

Paranoia was experienced as an overwhelming feeling of fear that everybody knew that they had been sexually assaulted and resulted in acute feelings of embarrassment. When they consulted the health care centre, they felt as if nurses judged them for wanting HIV post exposure prophylaxis for unprotected sex, whereas they were requesting this as a result of the assault. This was due to the fact that there were no visible bruises or marks to show that there was resistance, especially in the case of Bridget and Kerry. Participants also felt as if nobody would believe them if they reported rape, due to the fact that people knew that they were dating. A feeling of pain was constant and verbalised with statements such as "I felt traumatised"; "I was hurting"; "I was broken in spirit"; "I felt painful inside".

4.2.2.1 Individual Reactions: How participants made sense of their traumatic experience

Kerry experienced denial, anger, distrust, and helplessness, loss of control and loss of purpose in life. Lebo felt trapped because even if she was hurting, she could not talk about what had happened, which made her distressed. This resulted in a sense of loss and a sense of helplessness but she managed to cope and survive by drawing on her inner strength (coping skill). Lerato expressed emotions of denial and uncertainty, being violated, personally attacked and betrayed, which resulted in a lack of trust, sense of loss,

low self esteem and loss of hope. She also drew her inner strength and used coping skills to manage.

Koketso felt helpless, experienced a loss of connectedness and was struggling to find meaning. She practised rituals such as praying which led to a feeling of connectedness to her Lord. Her connectedness to the Lord gave her purpose in life she then became a child of Christ. Bridget experienced a sense of loss of control, as she feared her own reactions. She was being overwhelmed by anger. She also felt very paranoid towards the health professional and felt as if everybody knew that she had been sexually assaulted. Linda expressed denial, anger vulnerability, helplessness and a sense of loss due to her and her family to being disgraced, which led to her feeling violated.

4.2.3 The ability of participants' belief system to act as comfort

For those participants who drew strength from their belief systems, the belief systems acted as a source for comfort. Those who were angry at God being their belief system and those participants, who failed to draw strength from their belief system, whether due to ignorance or lack of insight, were not comforted. Three participants felt that their belief system helped them to cope.

Praying was an instrument of hope for Koketso and she had faith that that Jesus would heal the wounds. The trust, hope and faith she had in her belief gave her strength to cope with the crisis situation. Bridget was comforted by "something" which was more than just praying, "something looking out for her" that signified that God is in control.

Lerato, who complemented her belief in God with believing in her ancestors benefited from having two belief systems, as one of the belief systems gave her support and comfort. She was angry at God and felt let down. She had not engaged with her

ancestral beliefs, but was grateful that she did not, as she would have been angry at them as well. This would have been wrong, as she believes that they are the reason she coped with the crisis. She claimed that her ancestors are the only thing that looked after her and kept her going, comforted her.

For Kerry, her Christian faith did not meet her needs. Although impractical, she was nevertheless angry at God, and resorted to having faith in the higher being "I am kind of twisted to the higher power of the earth will protect me in future". Kerry belief system did not give her comfort. Linda felt a sense of loss and failure for engaging her ancestors when she needed them the most. Her family are very supportive to her but she had not made them aware of her emotional need for support during the crisis. She pretended to be in control although in pain, emotionally and spiritually. She had not requested ceremonial cleansing or indicated to them a need for that, instead she verbalised her intention in future to request help and not play the "superwoman". Thus her belief system did not comfort her.

4.2.4 Inclusion of the participants' belief systems and practices into their care (Participant's perception)

None of the participants had experienced the inclusion of their beliefs in their management, yet appreciated the care they had received from the health care professionals. The participants felt cared for, listened to, respected, acknowledged and supported. They reported on how the counsellors' presence allayed their fears, gave them hope and courage to go on as they felt safe to express their concerns and anxiety.

Kerry was thankful about the fact that her belief system was not included, as she claimed that it would have been "unearthly". She explained "unearthly" as being angry at God and

is not practical for her as she still view him as her higher being whom she values. She felt it is immoral to even think that a person can be angry at God. Worshipping God has been her way of life and God has been looking out for her, and reaching out to God at this time would have been inappropriate. Another reason she gave was that God's name should not be associated with things that are not Holy, as rape is a dirty act and would devalue the name of God. Lerato said that her belief system was not included as part of her management.

Lebo, who had had been previously sexually assaulted at the age seven (7) years, by her father's friend, stated that it had not been included in her care at the institution she attended with her previous sexual assault. Nurses at the health care centre she attended at that time had been unprofessional, and then treated her with no respect, and their lack of support towards her had been very disturbing. The staff had failed to give her information about the procedures which were being done, and she now realised this was her right. The presence of the counsellor, who was a good listener, supportive, respectful and accepting, enabled her to cope.

Koketso said that although spirituality was not an open topic, the health professionals' non-judgemental attitude, kindness, respect and support towards her was amazing. She was happy that spirituality was not brought up openly as it would have been done incorrectly. She stated that she found fulfilment in the experience she went through as she found her purpose in life after going through the ordeal, which helped her find her Christ. The counsellor's supportive approach helped Bridget a great deal, even though her belief system was not specifically included in her management. Again the presence of a counsellor was viewed as an act of spiritual care. Linda was happy with the management as she stated that psychotherapy and the support she received from the health care centre had been very helpful.

4.2.5 Aspects of care that would have been preferred

Overall participants were happy with management the health professionals offered, despite that lack of specific spiritual care. They appreciated the manner in which they were treated in respect of spiritual intervention. The participants felt that the interventions that they had received were appropriate and should be the preferred mode of treatment.

Kerry said that she would have further preferred that the health care centre developed a program to encourage more in-depth legal options. Lebo stated that it would have helped if people were more sensitive towards what happened and that there should be someone at the health centre whose job is to attend to particular processes of setting up follow-ups appointments, talking to clients about what happens at the health care centre.

Lerato was content with the management that the health care centre had offered and with the treatment she received. Koketso and Bridget were satisfied with the care that they had received and felt that it was appropriate for their needs. For Bridget, psychotherapy had been valuable and she would recommend that this be included. Linda stated that although her belief system was not included, she felt supported and satisfied with the management and recommended psychotherapy.

4.2.6 Conclusion

Individual and general presentation of data provides a description of the participants' perceptions regarding their experiences, their expectations and the recommendations they made regarding the management of sexual assault survivors. Although spiritual care was not specifically included in the management of the sexual assault survivor, for the participants in this study the care that they received was experienced as spiritual – as they had felt acknowledged, respected and cared for at the health centre. These findings will be

discussed within Watson's framework of caring, compared with other studies on spiritual needs and care in the following chapter.

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CHAPTER 5

DISCUSSION

5.1 Introduction

In this chapter, the findings are discussed with reference to relevant literature. Limitations of the study are noted and the recommendations for future research made. The conceptual framework, Watson's theory of caring is used to understand the findings of the study.

Health practitioners, policy makers and recipients of health care increasingly recognise the influence of spirituality on health and the importance of considering the spiritual dimension in the provision of health care services (Chiu, Emblem, Van Hofwegan, Sawatzky and Meyerhoff, 2004: 405). There is also evidence that recipients of health care have expectations of spiritual care from health professionals (McEwen 2005: 166).

5.2 Belief systems

All participants in this study have a belief system, and thus view themselves as spiritual beings. They value the higher being, and from whom they draw strength during their crisis experience, and this enables them to have hope and cope. Their trust and faith in their belief system was an important source of strength. The rituals practised by the participants show connectedness and commitment to their belief, similar to the spiritual coping strategies discussed by Baldacchino and Draper (2001: 835), who state that effective spiritual coping strategies may help the individual to find meaning and purpose in illness and suffering, resulting in self empowerment to cope with current stresses until adaptation takes place. The most frequent coping strategies used are: hoping that things will get better, praying and trusting in God, maintaining control over the situation, worrying and

accepting the problem. The participants in this study utilised coping strategies as described by Baldacchino and Draper (2001: 835).

Delgado (2005: 157) states that a belief system or acceptance of a belief and faith is one of the four characteristics necessary for spirituality. The remaining three are a search for purpose, connectedness and self transcendence, but that none is sufficient on its own. Delgado (2005:159) further explained that spirituality requires faith or acceptance of a belief system that involves personal search for purpose and meaning, that encompasses an awareness of connection or relatedness to others and self-transcendent. According to Delgado (2005: 159) a belief is never self made, it originates from a process within the culture in which a person is embedded. All people have a belief system regarding the nature of the world they live in and hold to be true. The participants' acceptance of the belief system they all reported to have made them spiritual beings.

Despite their varied backgrounds, culture and heritage, the participants had firm spiritual beliefs and values. Different expressions of spirituality have been reported by other researchers in earlier studies, among others, (Carson 1989: 7) and Narayamasamy (1989: 275) who state that spirituality is universal and multidimensional, whether atheist or humanistic.

Delgado (2005: 157) also states that spirituality goes beyond religious or cultural boundaries and that spirituality is characterised by faith, which was evident in all participants in this study. Malinski (2002: 283) noted that men and women might express spirituality differently. Participants in this study presented as Christian or atheist with a belief in ancestors. McSherry and Ross (2002: 481) state that cultural and religious diversity may account for a variety of ways in which spirituality has been viewed, and that for some people the term spirituality may take a more humanistic, existential meaning, and that the word spiritually is void of any religious connotation. Chiu *et al.* (2004: 406)

however, state that spirituality is often embedded in culture and cannot be separated into individual entities for a study.

In this study the sexual assault survivors were spiritual beings who have a belief system from which they draw their strength and courage to continue with life after their experience. When they realised that the situation was beyond their power to control, they reached out to the higher power, utilizing spiritual coping strategies, which helped them to adapt and cope with their situation. The findings are in accordance with Watson (1985: 45-6) who views each person as a magnificent spiritual being comprising mind, body and soul.

Because participants are spiritual beings, their powerbase for healing and transcendence resides in their inner souls. In response to their sense of troubled inner soul they acknowledged their spiritual needs. They then reached out to their higher power utilizing spiritual coping strategies to cope. Coping and adapting were the healing power, which according to Watson (1985: 45-6) resided in their inner souls. A sense of spiritual healing facilitated their sense of purpose in life and the ability to go on with their lives. The participants' perceptions regarding spirituality can be understood in the light of Watson's (1985) theory of caring as they expressed trust, faith, and hope and the valuing of their beliefs. Watson (1985: 75) describes how the human to human contact restore the patient's experience of inner harmony where inter subjective feelings are released and transmitted through transpersonal caring relationship. The provision of a spiritual environment gives hopes, and faith of sensitive to one another, valuing one another which individuals enjoy within the eight carative factors that form a conducive environment as depicted in fig. 1 [chapter1].

5.3 Emotional reaction to sexual assault

Participants reacted individually to their crisis, demonstrating a range of emotions. The reactions to emotional trauma were presented verbally, and expressed as anger, fear, anxiety, hurting, upset, feeling nervous and crying. There was a sense of loss of connectedness and control, feeling challenged and diminished inner strength. Carson and Soeker (1987: 605) state that individuals react differently in times of crisis, and may experience disharmony of body, mind and spirit, which can turn them either towards or away from the growth process. The reactions of the women in this study confirm Carson and Soeker's (1987) study. The crisis they went through made them value life even more. One of the participants reflected that the experience had made her a better person, as she learned to forgive. This response is highlighted by Delgado (2005: 160) "a spiritual person is solemnly conscious of tragic realities of human existence". The participants made the best out of their compromising situation. Experiences such as a sense of connectedness, meaning-making and existential reality, findings emerging in this study, are similar to the findings of Chiu *et al.* (2004: 409), in a study which described spiritual need in response to the spiritual distress individuals experience. During the crisis period sexual assault survivors were trying to establish reasons relating to their disbelief that they had been raped. Why them? Why didn't God or their higher being protect them? This led to their deep anger, which they had to work through by utilizing coping mechanisms to come to terms with the experience. Creating meaning out of the chaos of their lives after the assault was seen as a bridge between hopelessness and meaningfulness. Searching for meaning gave them hope to overcome their feelings of worthlessness, by drawing inner strength from their resources, and by becoming spiritually fulfilled through connectedness with their belief.

The findings with respect to participants' initial reactions after their sexual assault show that there is questioning of beliefs which were previously considered to be strengths, as they attempted to find answers as to what might help them. Watson (1985:55) theory of caring described a phenomenal field which stated that "the subjective experience of the person and one's frame of reference can only be known by others through empathetic understanding". Participants shared their perception regarding their sexual assault and described what it meant to them.

5.4 Spiritual comfort

Three participants reported that their belief system helped and comforted them. They were able to cope because they reached out to their higher power in a search for meaning. Mahlangu (2003: 34) and Kelly (2004: 165) state that meaning can be gleaned by drawing from the person's spiritual resources and the person's spirituality can be a source of strength and a method of coping with life-threatening situations, and also may help to transcend beyond self to reach a higher power resulting in self empowerment and the ability to cope. Tanyi (2002:503) describes self transcendence as reaching beyond boundaries and attaining a wider perspective, which facilitates finding meaning in life experiences. Tanyi further states that transcendence, connectedness, belief, inner strength meaning and purpose in life add to the meaning of spirituality. When the survivors reached out they were self transcending. When they were transcending, they had inner strength and peace that came from having faith in their higher power, and a belief system. Tanyi (2002: 504) states that inner strength comes from having faith and belief.

In the present study participants were able to cope because they had faith in their belief that things would work out and an awareness of connection or relatedness to others, as suggested by Delgado (2005: 160), who states that extension beyond self is possible,

which is self-transcendence. Delgado further states that the consequence of spiritual connectedness is an experience of inner peace which provides hope for the better, and that inner peace, tranquillity or comfort may indicate success in coping.

Naranayasamy and Andrews (2000: 58) state that spirituality may be expressed in a variety of forms, and some individuals may find that their spiritual belief and practices can be a source of comfort in alleviating their spiritual distress. Characteristics of spirituality :- hope, faith, a belief connecting, transcending, giving life and exercising options of trust and courage, have been described by a number of researchers, Carson (1989: 194), Pesut (2002: 128), Tanyi (2002: 504), Mahlunqulu (2003: 34), Delgado (2005: 159). These characteristics act as vehicles and bridges to attain comfort when used together with spiritual coping mechanisms. The spiritual coping strategies utilized were appropriate rituals practised in a specific structure. Those who were of the Christian faith prayed and worshipped and those believing in ancestor's practised ancestral rituals. Participants experienced connectedness on two levels: a vertical connectedness to their higher power and horizontal connectedness centred on a strong belief in significant relationships, self chosen values and goals, which became the driving force in their lives as outlined by Tanyi (2002: 502).

In this study Linda (atheist), said that her family are her driving force and gave her comfort and support. The participants who reported being comforted by their belief gave a clear indication that they felt spiritually fulfilled and were ready to move on with their lives. For the participants who reported that their belief did not comfort them, the inability or unwillingness to draw on their spiritual resources maybe due to ignorance or anger.

For the person with a deep sense of spirituality, a time of crisis may drive them to draw strength from the spiritual belief, thereby gaining some comfort. Spirituality affects healing and health. According to Gray (2006: 58) and Tanyi (2002: 507) states that

spirituality awareness and transformation can occur in given circumstances in life and that the spiritual perspective that transcends devastating life experiences may lead to peaceful resolution. The sexual assault survivors presented themselves for care at the health care centre, not physically sick, but spiritually distressed, having spiritual needs that required fulfilment. They lacked harmony after being troubled. In Watson's (1989: 224) theory of caring, spirituality is described as a possession of human being, enabling self awareness, heightened consciousness and providing the strength to transcend the usual self. It is evident that participants in this study are spiritual beings who were aware and conscious that they had a spiritual need as their spirits were troubled, they had to reach out (transcending), and could cope by using spiritual coping skills, were connected to their higher power and found inner strength because of their faith in their belief. They had to hope to overcome the crisis and found peace and were able to forgive. They were spiritually empowered to accept the hardships of their crisis and went on with their lives. This is an aspect not highlighted in other studies pertaining to sexual assault, therefore an area which may need further study.

5.5 Spiritual care / Intervention

This study found that there had been minimal attention given to the spiritual needs of the sexual assault survivors during their management by the health professionals. Despite this, however, the participants were appreciative of the counsellors' and nurses' attitudes towards them. They had felt cared for, listened to and supported, respected and had their wishes acknowledged. The presence of the counsellors allayed their fears, gave them hope and courage, and helped them to develop inner strength.

They felt comfortable to express their concerns and anxieties, and found that the health care services provided the survivor participants with a therapeutic environment that made

them feel safe. Because participants felt comfortable to be themselves, they could then draw inner strength from their belief system which was the only familiar thing to them, whilst struggling to overcome their trauma and find purpose and meaning in life, through the utilization of the coping strategies. These strategies enabled participants to reach out to their higher power, and the support given to them helped them to persevere. The characteristics, behaviour and attitude of counsellors and nurses are described by researchers as key factors for providing spiritual care (Carson 1989: 155; Taylor 1995: 223; Goldberg 1998: 838; Narayanasamy and Owen 2000: 451; Smit 2002: 303; Tanyi, 2002: 507; Villagomez 2005:228). Interventions such as presencing, caring, active listening, companionship, giving hope, empathy and compassion are keys for providing spiritual care. Watson (1985:76) states that the nurse uses self to engage in a caring relationship, avail herself to assist, to create an environment full of trust by offering their empathetic listening. Participants in this study experienced interventions above mentioned. Participants were in need of a spiritual intervention as an integral part of a holistic care (Gray 2006: 62).

Malinski (2002: 283) cites Walton's (1990) study that viewed presencing as the core of spiritual care for patients with acute myocardial infarction, by stating that nurses are present with people during experiences of healing, illness, suffering, dying and near death experiences. Walton's study reported that the contributions to spiritual healing were provided by the divine presence from friends, family, communities and health care providers. The experiences of spirituality for patients in Walton's study which evolved during their recovery included a desire to give and nurture, as they felt that the spirituality helped them to develop strength and gave them hope and courage. Spirituality provided comfort, peace and a sense of wholeness and wellness. Other recurring practices in

arranging clergy visits (Stranahan 2001: 91).

Smith (2002: 303) states that true presence is one of the principles of spiritual care, and is defined as a special way in which the nurse is attentive-to-moment to moment changes in meaning as she/he bears witness to the person's own living and value priorities. Smith (2002: 304) further states that when nurses are with sexual assault survivors in true presence during frightening times, fears are faced and scrutinised. There is also a struggle with hopefulness, powerlessness, powerfulness, perseverance and beyond. Moving beyond hopes and dreams through creating new ways of viewing what is familiar.

Denying inclusion of spirituality may be due to lack of understanding of the terminology. McSherry and Ross (2004: 935) are of the opinion that users of health care might not know or understand the terminology used in spirituality. Draper and McSherry (2002:122) explain further that there are significant numbers of people who do not know what is meant by spirituality, but believe in something that transcends the physical world, describe events or relationships that invest their lives with meaning or that inform or shape their values and behaviours and have a belief that they value. They were not aware that spirituality was part of their care, yet the care they received enabled them to have inner peace and be comforted. Johnson, Tilghman, Davis-Dick and Hamilton- Faison (2006:59) state that spirituality is a word of comfort suggesting inner peace and ability to go outside everyday familiar, which is one of the findings of the present study. Sexual assault survivors in this study were comforted by aspects of spirituality and they could go on with their lives.

Smith (2002: 304) states that sexual assault survivors are normally reluctant to reveal themselves to a stranger, even if the stranger is a nurse. Findings in this study, however, show that the sexual assault survivor participants trusted the health care professionals and

felt comfortable enough to express their concerns, which confirms findings in Piles' (1990: 40) study, in which it was reported that patients felt comfortable to express their anger to nurses as opposed to voicing this out to their priests. Participants in the present study were able to open up to counsellors and nurses. The health care team represented the approachable health professionals who have their clients' interests at heart. None of the participants complained of not being listened to, or that "the health professionals were too busy with other things such as giving out medicine and doing procedures", as in the study of Stallwood and Hess (1969) cited in Ross (1995:462).

One point noted in this study is that the core concept of spiritual care was practised and rendered by health professionals whilst managing sexual assault survivors, yet neither participants nor professionals were overtly aware of it. The findings confirm those of studies by Carson (1989: 155), Ross (1995: 422) and Kelly (2004: 162), namely that nurses are not aware or are unclear of their role in spirituality and spiritual care. Spirituality is a largely ignored aspect of nursing care. In this study health professionals did not specifically deal with spiritual management of the participants but nevertheless demonstrated the core principles of spirituality.

Providing spiritual care is and will always be a key function of the nurse. As Johnson *et al.*, (2006:60) state, spirituality always has been present in the nursing profession, whether nurses acknowledge it or not, there is no way of avoiding it. The expectations originate from the "drivers" of the nursing profession, nursing theory and theorists. The International Council of Nursing (ICN) (2000: 2) states that in providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual belief of the individual, family and community are respected. The Student Health Services are following and practising within the expectations of the ICN namely: nurse practitioners

should provide care that respects human rights and is sensitive to the values, customs and belief of the clients.

Spiritual health care rendered to sexual assault survivors in this study is viewed as counselling and psychotherapy and not as spiritual care as such. This may be due to an awareness of challenges of the labelling specific interventions. Chapman (1996: 38) states that "it is rare to find a program that openly labels a specific activity or intervention, as orientated to enhancement of spiritual health". The other reason for not labelling the programme as spiritual health care might be, as is pointed by most research findings in this field, that nurses do not feel comfortable or are inadequately prepared to address spiritual concerns, and that they will be creating expectations from the client that they are competent, knowledgeable and skilled regarding spirituality which may not be entirely true (Carson, 1989: 155; Ross, 1995: 422; Malinski, 2002: 281; McSherry and Ross, 2002: 486). Spirituality or meeting spiritual needs has not been formally included in nursing curricula, or made a pre-requisite for registration and competency achieved prior to professional registration (McSherry, Cash and Ross 2004: 935 ; McEwin 2005: 163).

Baldacchino and Draper (2001: 836) state that various awful stresses may render individuals powerless, resulting in an individual resorting to going beyond themselves to reach a higher power to gain control over their life, irrespective of any religious affiliation. The findings of the present study show that all the participants, irrespective of their belief systems drew their strength from those belief systems and utilised spiritual coping strategies to help them cope.

5.6 Provision of a spiritual environment

McSherry and Ross (2002: 433) state that it should not be assumed that everyone's spiritual needs require attention at the time of health encounter, and that the type of spiritual need depends on the individual's definition of spirituality. Furthermore it should not be assumed that clients will require help from the health care professional with their spiritual need, as they may be self sufficient or may have called on friends and family for help with spiritual concerns. The findings in this study are consistent with those of McSherry and Ross (2002: 433).

Linda had been practising ancestral rituals and always turned to her family for support, although she did not utilise these during and after the act of the assault, accessing support and counselling only when she needed this and was unable to draw on her own inner resources which is acknowledged by McSherry and Ross (2004: 433). Kerry had expectations of spiritual care which she felt were not met and had unfulfilled needs which were not identified. Kerry would have preferred her care to be focused on in-depth legal counselling, legal information and options open to her. The focus of management appeared to be viewed differently by Kerry and the counsellor, resulting in different expectations from both. Kerry was, however, eventually content with the management offered and was able to manage. Goldberg (1998: 839) suggested that respect for the person and truth telling are ethical aspects and considers them to be spiritual care which may encourage individuals to express their feelings of anger and anxiety. Thus the in-depth legal advice Kerry expected and which she felt was inadequately given, emerged as expressed and preferred care.

Provision of a spiritual environment and spiritual / preferred care

The relevance of Watson's (1985) theory of caring is the appropriate framework for the study. Watson's (1985: 56) carative factors formed part of the preferred care sexual assault survivors which was provided in this study by health care professionals. These are also recommended interventions by the participants. It was evident that although management rendered to the survivors was not intended to be spiritual care, there was an underlying, although unnamed spiritual element to the care provided. The environmental considerations of caring as described by Watson (1985:56) were present. The participants were supported, respected and provided with a conducive environment that facilitated and helped them to attain inner peace and enhance their healing.

The interpersonal relationship identified and presented in the findings between health care professionals is similar to the concepts of transpersonal relations, including the interventions practised as described in Watson's (1985) theory of caring.

5.7 In summary

The findings show that regardless of their personal belief systems, the sexual assault survivor participants are spiritual beings, because they have a belief relevant to their world. They practised rituals which were their spiritual coping strategies at a time of crisis. Their belief system and their familiarity with this enabled them to respond to their crisis. Their coping strategies engendered a sense of hope. A sense of spirituality and spiritual awareness played a significant role in the healing process for the sexual assault survivors. Spiritual interventions [although not specifically named as such] and support enabled them to accept their experience and continue with their lives. They managed to cope with the

support of health professionals who provided the spiritual care to heal the emotional wounds inflicted by the sexual assault.

Watson's (1989: 226) theory of what constitutes health states that unity of mind, body and soul are equivalent to health, and harmony of mind, body and soul is equivalent to health. If a person becomes ill, when there is disharmony with spheres of mind, body and soul, illness is not a necessary disease, but a subjective experience of inner turmoil and suffering. The sexual assault survivors might have presented themselves at student health services at a time when their bodies did not require healing, but were mentally and spiritually distressed and traumatised, which Watson argues is part of what needs to be addressed in order to regain holistic health.

The health care professionals at the health care centre provided Watson's (1985) *carative* factors, by being supportive, non-judgemental, protective, maintaining confidentiality, respecting the sexual assault survivor's views and providing a therapeutic environment. The sexual assault survivors were able to trust them, work through their pain, engage with their higher powers/belief systems and were able to work through the experience and find meaning.

The present study addressed spirituality from the health management perspective, which appeared to have been overlooked, as noted in literature reviewed. Delgado (2005: 161) states that spirituality and its relationship to health needs to be better understood, as it is a way of perceiving reality in its entirety, holding and realizing certain values and goals, experiencing positive and satisfying behaviour and emotions in life.

5.8 Recommendations

Spirituality and the care of the patient's spiritual needs play an important role in health care provision, and is an integral part of holistic care. Based on the findings of the present study, recommendations are made for practice and further research.

5.8.1 Principle of spiritual care

Spiritual care is valued and is the integral component of quality, holistic care (McEwin 2005: 161). Spirituality has been viewed as the backbone of nursing presence and without it the premise for nursing care is lost (Rankin and DeLashmutt 2006: 285). Sexual assault survivors need someone to be in true presence with them, to be with them, to truly listen, encourage them to realize their dreams, hopes and expectations to support them to use spiritual coping strategies as suggested by Smit (2002:34).

McEwin (2005: 162) reported that patients indicated that they wanted health care professionals to attend to their spiritual needs in similar way to meeting the physical and psychological needs. Nurses should provide interventions to render spiritual care in order to bring greater harmony of mind, body and spirit to produce self -knowledge, self reverence, self healing and self care (Watson 1989: 224). Spiritual care can also be given "even when in happiness" (Taylor 1995: 37).

5.8.2 Nursing Curricula

It is recommended the nursing curricula include spirituality and spiritual care modules for both undergraduate and post graduate courses in South African nursing colleges and universities. This will help to develop awareness of spirituality (Baldacchino and Draper 2001: 839). Including spirituality in the nursing curriculum will enhance holistic

professional nursing practice (Rankin and De Lashmutt 2006: 283), and will also enable South African nurses to be on par with other countries such as UK and America where spirituality modules have been made a pre-requisite for registration and a required competency for professional registration. This has made a difference in nurses' care, as these nurses now acknowledge and understand spirituality better, and are able to render congruent spiritual care (McSherry, Cash and Ross 2004: 935; McEwin 2005: 163).

5.8.3 In-depth research

The topic of spirituality in health care provision needs to be further explored and researched in the context of health and management, with the focus on developing a reliable assessment tool for spirituality to enhance identification of spiritual need. One example of assessment of spirituality is the need indicator based model of spiritual assessment designed by McSherry and Ross (2004: 484). The tool identifies defining characteristics that may indicate underlying spiritual distress of client through non-verbal cues such as crying or seeking explanations. There is limited documented South African literature on the topic of spirituality and nursing (Mahlungulu 2003: 34; 2004: 15).

5.8.4 Team Approach

A further recommendation is that everyone within the health team, including faith based and traditional healers be involved in spiritual care and spiritual assessment of clients in their care. McSherry and Ross (2002: 483) state that it is in their experience that ministers and traditional healers often feel neglected and not made to feel part of the health care team, yet have a crucial and valuable contribution to make in assessment and provision of

spiritual care. They should form an integral part of the health care team, as spirituality seems to be located firmly in the nursing profession (McSherry, Cash and Ross 2004: 935).

5.8.5 Referral to spiritual healers

In view of the findings of this study, which identified different belief systems and diverse cultural groups to which clients belong, it is recommended that referral for spiritual care be made to a relevant spiritual leader who understands and has knowledge of his/her client's belief and background, to facilitate understanding and enhance trust building for efficient management.

It is hoped that the recommendations will encourage other researchers to further explore this important aspect of care and contribute to further understanding of spirituality in nursing care.

5.9 Limitations of the study

The topic of sexual assault is very sensitive, as sexual assault survivors are reluctant to reveal themselves to strangers, even if those strangers are nurses. Survivors may provide the carer with some information themselves but not all, and the findings may therefore not be a complete reflection of their experiences (Smith 2002: 304). Exploring their experiences further may traumatize survivors as they relive the traumatic experience, therefore caution must be taken whilst interviewing them to avoid creating further trauma and consequently important issues might have been omitted. With regard to spirituality and nursing perspectives, South Africa literature is limited, thus it is difficult to compare international and local trends pertaining to the topic of spirituality.

The study found that a lack of conceptual clarity was a major obstacle in exploring spirituality due to its multidimensional, ambiguous and complex definition, bound by a common set of defining characteristics, and surrounded by misconception and subjectivity (McSherry and Ross 2002: 481; Tanyi 2002: 500; McEwen, 2005: 162).

The interviewer's own limitations in respect of interviewing technique and the structured nature of the questionnaire may have contributed to information not being obtained. An in-depth interview approach may have facilitated further exploration of sensitive issues.

The sample of survivors was limited to a specific setting and context, in which specific protocols were followed with respect to the management of sexual assault survivors, and is therefore not generalisable to other higher education institutions.

5.10 Implications for Nursing

There is a recognized connection between spirituality and health, and nurse leaders have acknowledged the importance spirituality in providing optimal care (Delgado 2005:157). Nursing has its origin in spirituality, and it needs to go back to its roots and incorporate spirituality in nursing care (Carson 1989: 3; Rassool 2000: 1476). Henery (2003: 55) states that spirituality is considered an important focus of nursing theory and practice and also a part of, or property of the patient, and that by addressing spirituality, nurses can help patients to cope with death, suffering and loss.

Baldacchino and Draper (2001: 839) state that by developing insight into the meanings of spiritual coping methods, nurses will facilitate patients' spiritual coping strategies. Identification and provision of spiritual care is the responsibility of the nurse (ICN 2002: 2). Watson (1989: 224) states that in providing care, the nurse promotes an environment in which human rights values, customs and spiritual beliefs of the individual, family,

community are respected, and that provision of spiritual care is expected to bring greater harmony of mind, body and spirit. Nurse practitioners need to make sure that they develop in themselves the skills needed in order to be competent in assessing and providing spiritual care, so as not compromise the client's health by failing to identify needs. Managers and administrators should revise policies in order to incorporate aspects of spirituality and appropriate spiritual care.

5.11 Conclusion

This study aimed to explore the needs of sexual assault survivors in a specific tertiary educational setting in the Western Cape. Through the voice of the participants, the findings have shown that, although not specifically identified, there was acknowledgement of the spiritual needs of the sexual assault survivors and that the care that they received in part met their often unexpressed spiritual needs, and that such the care was acceptable. It has identified a need for spiritual leaders within the health care team, in order that they may be accessible when required by the survivor. It further recommends that nurses are exposed to theoretical and practical aspects of spiritual care for all faith communities, in order to facilitate holistic care of the survivor.

It is hoped that this study may provide information which enables policymakers and managers to improve management protocols of sexual assault survivors with respect to spiritual care. Health care professionals are a critical resource in the care of the sexual assault survivors, including spirituality in health care protocols will facilitate holistic management.

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University of Cape Town

APPENDIX 1

PARTICIPANT INFORMATION SHEET

NB This information will be translated into Xhosa and Afrikaans.

I am Hermina Dyeshana, a Masters in Nursing student researcher at the University of Cape Town, School of Health and Rehabilitation Sciences. I am investigating and exploring the specific spiritual needs of sexual assault survivors, to determine whether nurses and other health care professionals have met those needs and how survivors would have liked to have being treated, managed and cared for.

Why am I doing this research?

Studies reviewed showed that sexual assault survivors experience a great deal of trauma resulting in adverse health effects. There are countries that have done well in prioritising sexual assault management by putting together services aimed at improving the service rendered to these women. Further studies reviewed also showed that internationally, different approaches are used with a view to provide holistic comprehensive health care delivery. Thus benefited the survivors of sexual assault. However, there is no documented research done in this country highlighting the approach in question.

The information that you will share with us, might not directly benefit you as individual participants in this study, but might be helpful to others who will be sexually assaulted in the future. This study offers you some voice to inform professionals, policy makers, educators and health care providers what your needs are, especially those that are currently not being met whilst going through the traumatic experience. You can indicate how you would have preferred health professionals to act in order to help them through their ordeal.

What is expected from your participation in the study?

I would like to interview you twice. I will need to tape the interview to help me remember accurately. I will not write your name on these or any of the data I get from our conversation. You will be expected to answer open ended and probing questions. The interviews will be scheduled as follows: twice at monthly intervals. Each interview will last for approximately one and half hours.

Are there any risks involved?

There are emotional risks involved, as the interviews will necessitate revisiting the traumatic experience. However, arrangements will be made for you to be referred for counselling should such a need arise.

Confidentiality?

After you have consented to participate in the study, you will be interviewed in a private area of your choice, which could be at your home or any other place where your privacy will be respected. Confidentiality will be maintained at all times. Your real name is not required. I would like you to choose a name I can use instead (pseudonyms). Notes, tapes and transcribe material will be kept in a locked premises, accessible to the researcher only, and then be destroyed once the research is completed and findings presented and published. The only other person, who might have access to them, will be the researcher's assistant who will not know your real identity, as she will be helping only with the transcribing of the tapes and data management.

What will happen if you withdraw from the study or refuse to give consent?

The study is completely voluntary. It is your right to give consent or refuse or to withdraw from the study at any time. Withdrawal or refusal will by no means affect the management you are receiving at the health care centre; no one at the centre will know that you are participating.

How long will the study last?

The study will last until the researcher has interviewed six persons who meet the selection criteria, attending the health care centre, and each participant has been interviewed twice at monthly intervals. The study will last approximately five months.

What will happen with the information obtained?

After analysing all data, documents will still be kept secured and accessible only to the researcher and her assistant, until these findings are presented as a thesis, which will be published in health journal, after which they will be destroyed. No identifying information about you will be put into the thesis. If you would like to read the thesis or journal article prior to publication, I would be happy to make it available for you.

Who to contact for more information or in the case of a query

Contact number, name and telephone numbers of the researcher and e-mail address are as follows: - E-Mail: mdyeshana@pgwc.gov.za Tel: [021] 940 7138 during office hours. Alternatively you can contact the research supervisor Mrs P Mayers, E-mail address: pmayers@uctgsh1.uct.ac.za Tel: [021] 406 6464 office hours.

If there are any other questions besides those already mentioned, please feel free to ask the researcher. If you are happy with the above information and wish to participate in this study, please read and sign the attached consent.

Thank you

Sincerely

Hermina Dyeshana

APPENDIX 2 – INFORMED CONSENT

UNIVERSITY OF CAPE TOWN: SCHOOL OF HEALTH AND REHABILITATION SCIENCES. CONSENT TO PARTICIPATE IN THE RESEARCH STUDY

Spiritual needs of sexual assault survivors. Rec Ref: 407 / 2004

Accepted and Approved by: Research Ethics Committee – E52 Room 24 Old Main Building GSH. Tel [021] 406 6338 Fax: [021] 406 6411

Why is this study done?

I have read the information sheet and I understand why this study is being done and why my participation is required and requested. I am being requested to participate in the study because I am in the position to share my experiences with the researcher, with regard to my specific needs during the management phase and how I would have preferred to have being managed, treated and cared for.

My role in the study?

If I agree to participate in the study:

- I will have two sessions with the researcher, one for the research interview and the second one for verification of data at monthly interval.
- I will choose a name by which I will be known in the research.
- All interview sessions will be recorded then transcribed at the later stage. Notes will also be taken. Information obtained will be destroyed once the research is completed, and the findings have been published or presented.
- During each session, I will share my experiences regarding my emotional reaction to the incident, how my belief system helped me deal with the trauma and also to inform the researcher as to how I would have preferred to be treated / managed in the care I received.
- I will inform the researcher if I feel uncomfortable answering some of the questions, and will not be obliged to answer them.
- I am free to withdraw from the study at any time if I so wish.

Follow-up sessions

The venue and date of our next session will be confirmed and my contact details will be made available to the researcher. Any changes in my contact details will be communicated to the researcher.

Risks and Discomforts

I realise that I might experience flash back memories, which might affect my emotional stability resulting in further psychological trauma. I might also feel embarrassed sharing my belief system and answering some questions. Counselling will be offered to me, which I am free to accept or not.

Confidentiality

The researcher will keep information about me confidential at all times. My name will not be used in any reports or publications resulting from this study, only pseudonyms will be used.

Benefits

I understand that there is no benefit to me for participating in the study.

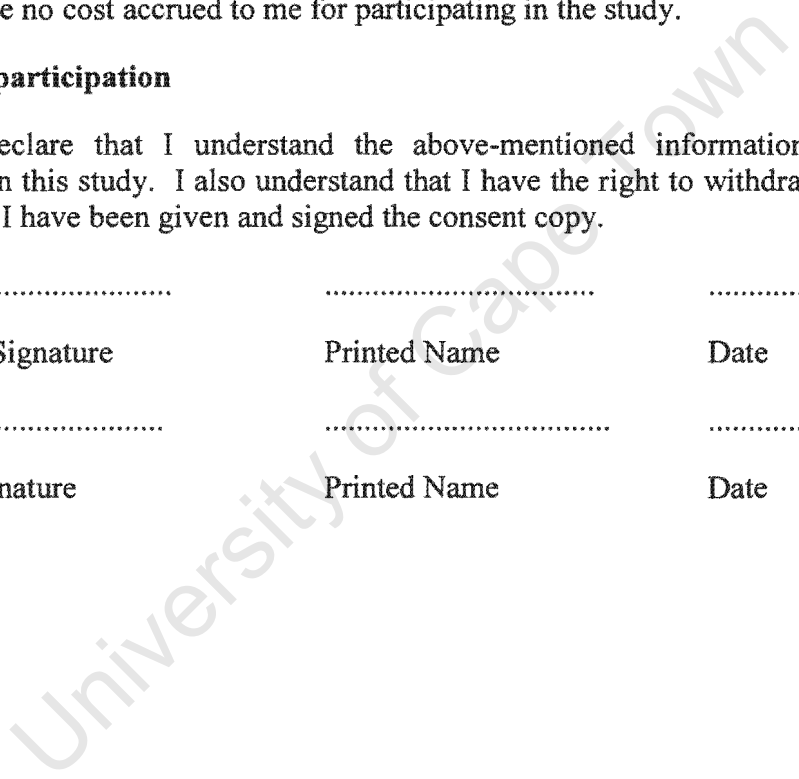
Costs

There will be no cost accrued to me for participating in the study.

Voluntary participation

I hereby declare that I understand the above-mentioned information and willing to participate in this study. I also understand that I have the right to withdraw from this study at anytime. I have been given and signed the consent copy.

.....
Participant Signature	Printed Name	Date
.....
Witness Signature	Printed Name	Date



APPENDIX 3

INTERVIEW SCHEDULE

Initial interview

Data collection approximately one and half hours session

1. Obtaining a written consent.
2. Clarification of the purpose and the process of research, which includes verification that there will be at least two sessions.
3. Explanation of the use of tape recorder and notes taking.
4. Allowing participants to ask questions regarding information given and any other concerns they may have.

Data Collection Process

Question 1: If I asked you to think about things like God, ancestors, spiritual and traditional healers, would you say you believe in any of them or that there is that there is a higher purpose not necessarily connected to a specific religion?

Question 2: Do you remember on the day you were managed at the health centre following the assault you experienced, how did you try to make sense of the incident and how did you react emotionally to that?

Question 3: Did your belief comfort you?

Question 4: Was your belief structure included in your care?

Question 5: What would have helped?

Probing questions for clarity regarding statements made by the participant will follow this.

Setting up of the next session.

APPENDIX 4
REQUEST FOR PERMISSION TO ACCESS PARTICIPANTS

No 12 Idaliya Street
Bongweni
ELONWABENI
7784

Tel: [021] 387 5557
Cell: 083 7642 826

E-mail: mdyeshana@pgwc.gov.za

2005-09-01

The Director
Discrimination and Harassment Office
Cottage 8 Protea, Lower Campus
University of Cape Town
Private Bag
RONDEBOSCH

Dear Sir

**REQUEST TO ACCESS PARTICIPANTS: RESEARCH STUDY, SPIRITUAL NEEDS OF
SEXUAL ASSAULT SURVIVORS, REC REF: 407/2004**

Study approved by: Research Ethics Committee: E 52 Room 24 Old Main Building GSH.
Telephone [021] 406 6338 fax [021] 406 6411.

I am Hermina Dyeshana, a Masters in Nursing student researcher at the University of Cape Town, School of Health and Rehabilitation Sciences. I am investigating and exploring the specific spiritual needs of sexual assault survivors, to determine whether nurses and other health care professionals have met those needs and how survivors would have liked to have being treated, managed and cared for.

I am requesting permission to access participants. My study population is those students seen at your department for care and management following a sexual assault.

I am attaching an information sheet that explain reasons for doing the study, what is expected from participants, confidentiality, consent form and benefits.

I am conducting a purposive sampling, thus request you to please identify participants suitable for the study and also obtain consent to be contacted from potential participants on my behalf. A summary of findings of the study will be made available to you and to the participants. There will be no risk of enclosure regarding identity of participants.

Your support will be highly appreciated.

Yours sincerely

.....

HERMINA DYESHANA

University of Cape Town

REQUEST FOR PERMISSION TO ACCESS PARTICIPANTS

UNIVERSITY OF CAPE TOWN



Research Ethics Committee
 E52 Room 24, Old Main Building Groote
 Schuur Hospital, Observatory, 7925
 Queries : Lamees Emjedi
 Tel : (021) 406-6338 Fax: 406-6411
 E-mail : lemjedi@curie.uct.ac.za

11 July 2005

REC REF: 407/2004

Mrs HM Dyeshana
 Nursing Administration
 Red Cross Children's Hospital
 Klipfontein Road
 Rondebosch
 7700

Dear Mrs Dyeshana

SPIRITUAL NEEDS OF SEXUAL ASSAULT SURVIVORS

Thank you for your letter to the Research Ethics Committee dated 14/06/2005. The revision of the protocol, information sheet and consent forms have now been received.

Due to the problematic nature of the content and process of the study it is enquired as to whether the supervisors have been involved in the revision.

It is stressed that the responsibility for the conduct of the study and its sensitivity remains that of both the investigator and the supervisor in this situation.

The consent form must as is standard practise include contact details of the Ethics Committee for the subject's information (please revise) should problems be experienced.

The study and the reported participation of the Director of the Health Care Centre (pg3) is approved on condition that above information is submitted and a letter of acknowledgement of the issues receiving attention is provided from the supervisor.

Please quote the REC. REF in all your correspondence.

Yours sincerely

PROF T. ZABOW
CHAIRPERSON

APPENDIX 6

PERMISSION LETTER FROM DISCRIMINATION AND HARASSMENT OFFICE TO
ACCESS PARTICIPANTS

University of Cape Town



Discrimination & Harassment Office
Director: Francois Botha

Cottage #8, Protem
Lower Campus
University of Cape Town
Private Bag Rondebosch 7701
Tel: (021) 650 3530
Fax: (021) 650 5176
e-mail: Fbotha@protem.uct.ac.za

5 September 2005

Ms Hermina Dyeshana
Student Health
Protem
Lower Campus
University of Cape Town

Proposed study on sexual harassment/violence survivors

Dear Hermiena

Your request to interview complainants within the context of The Discrimination Office, and sexual harassment/violence cases, has reference.

Permission is hereby given to access the complainants whose names will be forwarded to shortly. Such permission is however given only for the agreed purpose, and my understanding is that the information that you will obtain will be for the 'investigating and exploring the specific spiritual needs of sexual assault survivors, to determine whether nurses and other health care professionals have met those needs and how survivors would have liked to have being treated, managed and cared for'.

My best wishes, and good luck with the project.

A handwritten signature in black ink, appearing to read 'F. Botha', with a large, stylized flourish at the end.

Francois Botha