ASSESSMENT OF VICARIOUS POST-TRAUMATIC STRESS IN NURSES CARING FOR VICTIMS OF SEXUAL ABUSE IN THUTHUZELA CARE CENTRES IN KWAZULU NATAL

BY

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DECLARATION

I, Nonhlanhla H. Hlomuka (Mweli), hereby declare that the study title “Assessment of vicarious post-traumatic stress in nurses caring for victims of sexual abuse in Thuthuzela Care Centres in KwaZulu Natal” is my work. All sources that I have utilised or quoted from are indicated and acknowledged by means of a complete reference record, furthermore this work has not been submitted before, for any other degree or at any institution.

_____ 19 March 2024

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DEDICATION

This dissertation is dedicated to my families, the Hlomuka's, and Mweli's, as well as my daughter Sibusisiwe Snegugu Mweli. My dedication also goes to both my late grandmothers. MaMtshali Hlomuka, ma Zungu Thwala and my dad Mr J.R. Hlomuka my late mother

Mrs N.A. Hlomuka

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ABSTRACT

The aim of this study was to determine whether nurses working in Thuthuzela Care Centres experience vicarious post-traumatic stress. Thuthuzela is a Xhosa word which means comfort. The word comfort awakens feelings of warmth, freedom from emotional and physical concerns, safety, security, being pampered and above all reinforcing dignity, hope and positive expectations for the victims

Thuthuzela Care Centres are one stop facilities that have been introduced as a critical part of South Africa's anti –rape strategy. There have been a number of studies exploring vicarious post-traumatic stress for health care workers other than nurses caring for victims' sexual abuse but little is known about the risk for nurses. A non-experimental descriptive survey design was used to assess vicarious post-traumatic stress of nurses caring for victims of sexual abuse who report to the Thuthuzela Care Centres in KwaZulu Natal. 6.Data was collected in this quantitative study through the administration of a questionnaire.

The professional quality of life (ProQol) questionnaire was used to answer the research questions. In this study a convenience method of sampling was used. A convenience sampling is referred to as availability sampling and it involves the choice of readily available respondents for the study. The sample included all nurses working in Thuthuzela Care Centres irrespective of their category following repeated exposure and listening to different scenarios while executing their duty of caring for victims of sexual abuse in KwaZulu Natal. 10. The sample size was 31 nurses working in Thuthuzela Care Centres.

The data collection instrument of this study measured all the aspects included in vicarious post-traumatic stress, secondary traumatic stress, compassion satisfaction and burnout. All of these being in line with the objectives of the study. Factor analysis with Promax rotation was applied to the 30 items measuring the three constructs (compassion satisfaction, burnout and secondary traumatic stress) in order to elicit the latent structure that applies to the current study. The KMO (Kaiser-Meyer-Olkin) measure of sampling adequacy yielded a relatively low value of .521 which was likely due to the limited sample size. It is, however, considered by some to be adequate and indicates adequacy of the data. Bartlett's test of sphericity was significant thus indicating that the variables are related and therefore suitable for factor analysis. Rotation converged in 5 iterations. The reliability of compassion satisfaction and secondary traumatic stress are shown to be adequate. Cronbach's alpha of .567 for burnout indicates that results need to be interpreted with a little caution

Data was analysed using SPSS version 17. The data derived from this study revealed that a little over half of respondents 54.8% (n=17) working in Thuthuzela Care Centres are very often happy about nursing victims of sexual abuse. Less than a half 38.7% (n = 12), of respondents indicated that they are not productive at work because they are losing sleep related to traumatic experiences of the people they nurse. Less than a half of the respondents 45.2% (n=14) reported that they sometimes, have intrusive, and/or frightening thoughts related to caring for victims of sexual abuse. ($p<.005$).

In this study the respondents were protected from any harm by a full explanation about the aim of the study, their rights to voluntarily participate and their freedom to withdraw from the study at any time during the study. This study attended the ethical principle related to right to fair treatment because ethical approval was sought from and granted by DUT Institutional Research Ethics Committee to the researcher before the research was commenced. In this study, the participants were not required to give their personal details to the researchers. The researcher used numbers to identify questionnaire distributed to the respondents.

Recommendations

Recommendations arising from this study are 22. (a) a mandatory programme of psychological intervention for the nurses is necessary. 23. (b) a psychologist should be readily available at the Thuthuzela Care Centres for counselling sessions, and 24. (c) all health districts should have Thuthuzela Care Centres. 25.Wellbeing of the nurses allocated to work in Thuthuzela Care Centres should be considered.

Conclusion

26.Findings from this data can be used to strengthen awareness programs and emphasize self-care techniques to minimize vicarious trauma in nurses caring for victims of sexual abuse in Thuthuzela Care Centres. 27.Consistent training and ongoing discussions about signs of vicarious trauma are important for nurses and other health professionals caring for victims of sexual abuse.

Key Words

Caring, victims, sexual abuse, vicarious post-traumatic stress, nurses, Thuthuzela Care Centre.

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LIST OF ACRONYMS

DSMIV TR	Diagnostic Statistical Manual the fourth Text Revised
DSM5	Diagnostic Statistical Manual the fifth
PTSD:	Post Traumatic Stress Disorder
DUT	Durban University of Technology
HIV	Human Immune Deficiency Virus
IREC	Institutional Research Ethics Committee
NPA:	National Prosecuting Authority
PEP	Post Exposure Prophylaxis
PTG	Post Traumatic Growth
PTSD:	Post-Traumatic Stress Disorder
SANE	Sexual Abuse Nurse Examiners
SOCA:	Sexual Offences and Community Affairs
WHO:	World Health Organisation
NPA:	National Prosecuting Authority
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SANE	Sexual Abuse Nurse Examiners

CHAPTER ONE

2.1 DEFINITION OF KEY CONCEPTS

Sexual abuse: an unwanted sexual activity, with perpetrators using force, making threats or taking advantage of the victims not able to give consent. Immediate reactions to sexual abuse include shock, fear, or disbelief. Long term symptoms include anxiety, fear, or post-traumatic stress disorder.

Vicarious traumatic stress: professionals who work with traumatised children and families take some of the psychological, physiological and the consequences of the abuse. Vicarious trauma is an aspect of any profession that involves caring for others, but can be much more acute for professionals who work with traumatised children.

Child sexual abuse: is any sexual contact with a child using force, threat, or deceit to secure the child's participation in or any sexual contact with a child who is incapable of consenting by virtue of age.

Victim: a person harmed, injured or killed because of crime, accident, other event or action. National policy guidelines for victims define a victim as someone who has suffered harm, including physical or mental and emotional suffering. In this study the victim refers to an individual who has been subjected to sexual abuse.

Healthcare workers: people engaged in actions whose primary intent is to enhance health.

Caring: is characterised by expert nursing, interpersonal sensitivity and close relationships. Caring is about giving attention to and taking responsibility for the need for care. For this study care means provision of health care that is defined as the prevention, treatment, and management of illness and the preservation of mental and physical wellbeing through the services that are offered by the medical and allied health professions.

Secondary traumatic stress: the trauma like symptoms experienced by some mental health care professionals because of working at length with trauma survivors, and is a by-product of exposure to and empathy for their suffering.

Nurse: a person registered in a certain category with the South African Nursing Council to practice nursing or midwifery (Nursing Act 33, 2005).

Post-traumatic stress disorder (PTSD): A: The person has been exposed to a traumatic experience in which both of the following factors were evident:

- He or she experienced, witnessed or faced an event that involved a threat to the physical integrity of self and others (i.e., the respondents 'female partners).

- He or she responded with intense fear, helplessness or horror. B: The person persistently re-experiences the traumatic event in one or more ways (Robertson, Allwood and Gagiano, 2007:147).

Post Traumatic Growth(PTG) is positive psychological changes that an individual experience as a result of struggle with highly challenging life circumstances synonymous with trauma, crisis or a stressful event.

2.2 **INTRODUCTION**

2.2.1 **BACKGROUND**

According to Dlakavu (2022:1) Thuthuzela is a Xhosa word which means comfort. The word comfort awakens feelings of warmth, freedom from emotional and physical concerns, safety, security, being pampered and above all reinforcing dignity, hope and positive expectations for the victims (Dlakavu. 2022:246), Thuthuzela Care Centres are one stop facilities that have been introduced as a critical part of South Africa's anti –rape strategy, (Dlakavu, 2022:247).

There have been a number of studies exploring vicarious post-traumatic stress for health care workers other than nurses caring for victims' sexual abuse but little is known about the risk for nurses, (Peternelj-Taylor, 2020:194). This is supported by Park, (2011: v) who found that emergency technicians, clinicians, volunteers, and fire fighters who participate in disaster situations are at risk of traumatic stress disorder, yet little information exist about the risk for nurses

Swain, Pillay, and Kliewer (2016:1) stated that traumatic stress may arise from different events often leading to post traumatic stress disorder (PTSD). Nurses involved in caring for sexually abused clients are exposed to vicarious post-traumatic stress as they are expected to listen and empathise with these clients.

Vicarious post-traumatic stress emphasizes cognitive changes due to cumulative exposure to traumatic events (Mc Cann and Pearlman ,1990:137), original author. Nurses share their compassion with traumatised people because of their caring nature. They also spend much

more time with the clients compared with other health care workers which make them more vulnerable to vicarious post-traumatic stress (Figley 1995: 37), original author.

Bloom (2003:459), describes vicarious traumatization as the cumulative transformative effect on the helper working with survivors of traumatic life events. The symptoms can appear much like those of PTSD, but also encompass changes in frame of reference, identity, sense of safety, ability to trust, self-esteem, intimacy and sense of control.

Swain, Pillay and Kliewer, (2016:1), state that the lifetime prevalence of PTSD is estimated at 1%- 2% in Western Europe, 6% to 9% in North America and just over 10% in countries exposed to violence. In South Africa, the lifetime prevalence for PTSD in the general population is estimated at 2.3%. This study will be assessing whether vicarious post-traumatic stress occurs in nurses caring for sexually abused clients of all age groups and gender.

Van Deusen and Way, (2006) indicated that professionals who work with offenders and perpetrators of violence can experience vicarious trauma because they must suppress their personal views and emotions. Vicarious traumatisation may consequently cause deleterious effects on the therapist both personally and professionally, ultimately becoming an occupational hazard of clinical work (Adams, Boscardino, and Figley 2006, Adams, Matto and Harrington, 2001)

Figley (1995:7), stated that compassion fatigue appeared to be the consequence of working with traumatized individuals. Empathic engagement with traumatized clients often requires the professional to discuss details of the traumatic experience, including role playing of the events, which are thought to be vital to the therapeutic process but can have an adverse emotional impact on the caregiver (Figley 2002a, 2002b). This leads to nurse's reduced capacity or interest in being empathic. Pearlman and Saakvine (1995: 31), indicated that it is an occupational hazard if a nurse develops a lack of interest and empathy while caring for victims of sexual abuse.

A study conducted by Holton, Joyner, and Mash, (2018:1) highlighted the lack of comprehensive adherence to counselling, fragmented management, the persistence of negative attitudes, long waiting times and the lack of written information for survivors as barriers to care, it was noted that survivors expressed a need for care by competent and empathetic staff, (Holton, Joyner and Mash. 2018:1). Empathy is crucial to all forms of helping relationship, (Rayland, 2017:18).

Rayland (2017:18) goes on to say that there is confusion about whether empathy a personality dimension, an experience emotion or an observable skill. Empathy involves the ability to

communicate an understanding of the victim's world. The concept of empathy used in this study is introduced to outline the nature of care that the nurses caring for victims of sexual abuse provide in supporting the victims. Nurses support the victims by understanding their victims, distress and providing supportive interpersonal communication, (Rayland 2017:18)

Sepeng, Makhado, and Sehularo, (2019:1) indicate that there are barriers to the psychological management of PTSD, assessments confirming diagnosis of PTSD, the use of various psychotherapeutic interventions, psychopharmacological management, and the involvement of various stakeholders. Post-traumatic stress is defined as a psychiatric disorder that occurs after exposure to a traumatic event, (Bryant, 2019:259).

Sexual abuse is a violation of human rights and a major public health issue, the impact of which extends far beyond the victim (Campbell, 2002; Morrison, 2007). Its impact on mental health can be as serious its physical impacts and may be equally long lasting.

Nurses are expected to assist sexually abused victims during acute periods and throughout their healing process. At times the nurse client relationship is extended even outside the work environment when nurses have to go to courts to the explain their findings during assessment. (Raunik *et al*, 2015: 123).

Helping health care workers who are repeatedly exposed to, and empathetically engage with the victim's narrative trauma is at risk of experiencing cognitive changes, (Raunik, Lindell & Beckman, 2015: 123).

The comparison of Diagnostic Statistical Manual fourth Text Revised (DSM IVTR) and Diagnostic Statistical Manual fifth DSM 5 indicates that post-traumatic stress can occur in an individual as a result of witnessing a traumatic event that occurs to others and experiencing repeated or extreme exposure to aversive details of a traumatic events .DSM 5 is the diagnostic category, criteria and textual descriptions meant to be employed by individuals with appropriate clinical training and experience (Adamczewska, N., 2020)

The positivist paradigm is underpinning this study (Polit and Beck, 2017:11), indicating that the evidence for this study was gathered according to an established plan, and using structured methods to collect the needed information.

2.3 **PROBLEM STATEMENT**

According to Bance, (2014:1) secondary traumatic stress has a negative impact on the job satisfaction of nurses caring for victims of sexual abuse. Bance (2014: 1), indicated that the consequences of work stress have been shown to be strongly inversely correlated with job

satisfaction. Job satisfaction is highly negatively correlated with intention to leave a workplace and or profession, Ahmed, Emad & Jaber, Manal & Albanna, Hussein (2022:2147-4478). There is an existing shortage of nurses in Thuthuzela Care Centres as each of these centres operates with less than ten nurses (Abrahams & Gevers, 2017: 959)

If vicarious post-traumatic stress is not identified and dealt with this can lead to increased staff turnover which is detrimental to patient care. Gibson, (2016:1), states that compassion fatigue is similar to burnout and emerges, when a nurse feels helpless and worthless.

South Africa and Kwa Zulu Natal is currently faced with a very high burden of sexual abuse, yet care for such cases provided by a limited number of nurses who are caring for victims of sexual abuse in non-governmental organisation. This is supported by the statistics of sexual violence which occurred in 2021/2022 where a percentage of 74.1% (11 200) of victims of different sexual offences were reported to the South African Police Services (Barnes :2022). These figures do not capture the extent to which rape survivors remain silent about their experiences. Increased staff turnover may occur if vicarious post-traumatic stress is not identified and dealt with, and detrimental to patient care. Vicarious post - traumatic stress may lead the nurse to resort to avoidant behaviour, and substance abuse (Gibson, 2016:19).

Most nurses are unaware of the nature and the extent of vicarious post-traumatic stress, lack supportive resources and have little or no training to recognise symptoms in themselves and others or how to respond to the resulting distress (Iyamuremye and Brysiewicz, 2015:60). Currently it is not known whether nurses caring for victims of sexual abuse suffer from vicarious stress or not because of the limited number of studies focusing on them in particular.

2.4 **THE SIGNIFICANCE OF THE STUDY**

The assessment of vicarious post -traumatic stress on nurses caring for victims of sexual abuse in Thuthuzela Care Centres will contribute to the improvement of services delivered in these Care Centres. This includes, debriefing, counselling and ongoing staff training and awareness to support and empower staff to ensure their wellbeing. The research may contribute to improve quality care as it may illustrate the need for support of nurses. 33.The research results may be used by managers to plan education and support for nurses and create awareness of the dangers of burnout and vicarious traumatic stress.

The significance of the study is to assist in understanding the burden of vicarious post-traumatic stress, compassion satisfaction, compassion fatigue, burnout and secondary trauma in nurses caring for victims of sexual abuse.

2.5 THE PURPOSE OF THE STUDY

The purpose of this study was to determine whether vicarious post-traumatic stress, burnout, compassion fatigue, compassion satisfaction and secondary traumatic stress occurs in nurses caring for victims of sexual abuse in Thuthuzela Care Centres in Kwa Zulu Natal.

2.6 OBJECTIVES OF THE STUDY

1. To determine whether nurses caring for victims of sexual abuse in Thuthuzela Care Centres experience any compassion satisfaction...

2. To determine if nurses caring for victims of sexual abuse in Thuthuzela Care Centres experience burnout

3.To describe the signs of vicarious post- traumatic stress if any, experienced by nurses caring for victims of sexual abuse.

4. To determine what strategies are used by nurses when coping with vicarious post-traumatic stress resulting from their job.

2.7 RESEARCH QUESTIONS

1. Are the nurses caring for victims of sexual abuse in Thuthuzela Care Centres experiencing any compassion satisfaction?

2. Do nurses caring for victims of sexual abuse in Thuthuzela Care Centres experience burnout?

3. What are the signs of vicarious post- traumatic stress if any, experienced by nurses caring for victims of sexual abuse?

4. What are the strategies used by nurses to cope with vicarious post-traumatic stress resulting from their job?

2.8 **THEORETICAL FRAMEWORK**

Stamm (2010:8), outlined that those who help people that have been exposed to trauma are at risk of developing negative symptoms associated with burnout, depression, and PTSD. Compassion fatigue is defined as a negative consequence of working with a significant number of traumatized individuals with a strong, personal, empathetic orientation (Figley.1995:135). The stress resulting from helping a traumatized person may result in compassion fatigue., (Figley 1995:135). Considering the purpose of the study which was to determine whether nurses caring for victims of sexual abuse in Thuthuzela Care Centres experience, compassion satisfaction and burnout this theoretical framework was found to be relevant.

The Professional Quality of Life (ProQol)test is a validated instrument to assess. ProQol is a 30 item self-report measure to assess the compassion satisfaction, compassion fatigue, burnout and secondary traumatic stress (Stamm ,2010:12) (Figure 1.1).

The test measures pleasure derived from being able to do your work well. In this case high scores indicate a greater satisfaction in the nurse when nursing the victims of sexual abuse. . The burnout dimension of this scale is associated with feelings of hopelessness and difficulty of the nurse to deal with their work of caring for victims of sexual abuse.

The terms secondary trauma and vicarious trauma are used interchangeable by many researchers. They are used to describe the narrative of trauma that occurs in the health care worker as a result of prolonged and repeated exposure to. and listening to different stories of victims. In this study the concept vicarious post - traumatic stress is used.

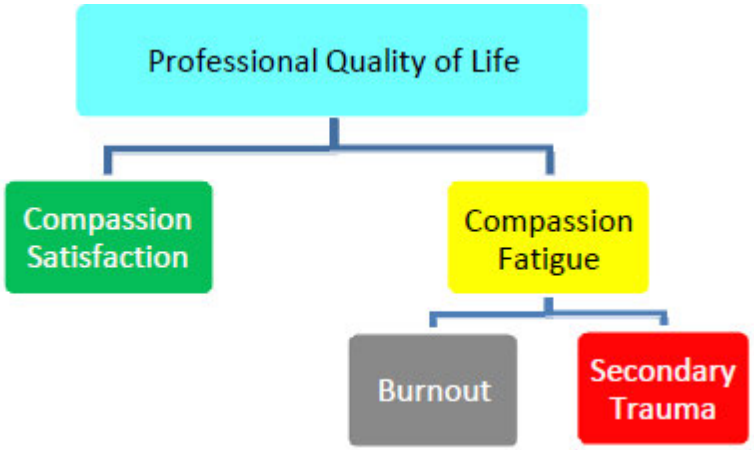

Figure 0-1 Theoretical framework

1.9 THEORETICAL PATHWAY TO VICARIOUS POST TRAUMATIC STRESS

The diagram below helps illustrate the elements of Professional Quality of Life. In the centre of the diagram are compassion satisfaction and compassion fatigue. Compassion Satisfaction is the positive aspects of helping victims of sexual abuse and Compassion Fatigue are the negative one. As can be seen, one work environment, client (or the person helped) environment and the person's environment all have a role to play. A poor work environment may contribute to Compassion Fatigue. At the same time, a person could feel compassion satisfaction that they could help others despite that poor work environment. Compassion Fatigue contains two very different aspects. Both have the characteristic of being negative. However, work-related trauma is discussed as the vicarious post-traumatic stress for the purpose of this study. While it is more than overall feelings of what we can call burnout, it is very powerful in its effect on a person. When both burnout and trauma are present in a person's life their life can be very difficult indeed. The diagram below shows a theoretical path analysis of positive and
negative outcomes of nurses caring for victims of sexual abuse including those who have experienced traumatic stress (Stamm, 2010: 12)

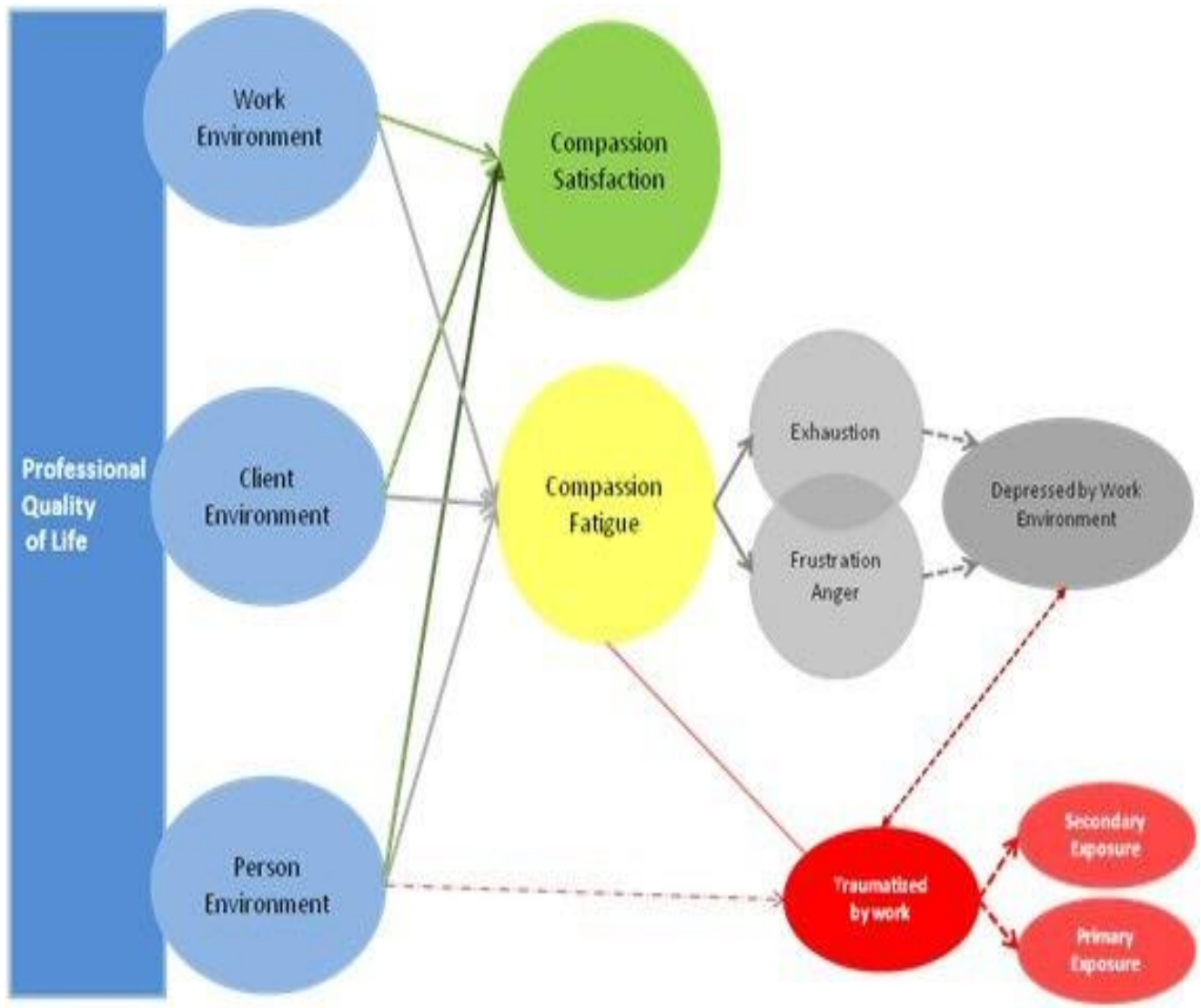

FIGURE 1-2 Theoretical Path Analysis

2.10 **CONCLUSION**

Nurses caring for victims of sexual abuse are at risk of experiencing vicarious post -traumatic stress due to the nature of the work they are doing. Nurses needs to be aware of this when they choose to work with the victims of sexual abuse. Organizations that employ them should also be aware of this phenomenon and be prepared to provide appropriate support when it occurs.

Nurses are at risk of getting vicarious post-traumatic stress like all other health care workers who work with trauma clients. Compassion fatigue occurs as a result of repeated exposure to victims of sexual abuse. This can lead to avoidant behaviour, substance abuse and may increase staff turnover.

CHAPTER TWO
LITERATURE REVIEW

2.1. INTRODUCTION

A literature review is conducted to generate an understanding of what is known about a particular situation, phenomenon, or problem and to identify the knowledge gaps that exist, (Grove, Burns, and Gray ,2013:40). Grove, Burns and Gray (2013: 40) refer to relevant literature as those sources that are pertinent or important in providing the in- depth knowledge needed to study a selected problem and purpose.

This section communicates the importance of identifying vicarious post- traumatic stress in nurses caring for sexual abused victims. It further looks at the concepts and legal prescripts of the South African Nursing Council (SANC). A number of electronic databases were searched during the literature review using the following search terms. nurses, caring, vicarious post- traumatic stress and job satisfaction. The databases that were used were Google Scholar, Medline, Psych med, ProQuest, Research Gate and CINHAL.

2.2. CONCEPTS

2.2.1. Vicarious Traumatization

McCann and Pearlman (1990:16. 17) derived their conceptualization of vicarious traumatization based on the evidence that listening to trauma narratives may bring up therapists' own trauma experiences. They proposed that clinicians could be affected even if material was unrelated there to own traumatic experience.

These assertions broadened the potential of vicarious trauma as phenomenon that could impact previously un-traumatized clinicians. Subsequent findings suggest correlations between exposure to trauma narratives, and risks for clinicians to experience intrusive thoughts and /or imagery prompted by the narratives even after client contact had ended (Russell and Cowan, 2018:3/7).

Interagency relationships and communication can also be affected by vicarious trauma (Horwath and Tidbury, 2009). A high staff turnover can bring less experienced professionals into high stress and high-pressure positions, increasing the likely damage that those situations may cause the professional (Horwath and Tillbury, 2009).

2.2.2. Post-Traumatic Stress

Atiwoli, Stein, Williams, McLaughlin, Petukhova, Kessler and Koenen (2013: 1) in their study on trauma and posttraumatic stress disorder in South Africa found that the most common traumatic events were unexpected death of a loved one and witnessing trauma occurring to others. Lifetime and 12-month prevalence rates of posttraumatic stress were 2,3% and 0,7% respectively, while the conditional prevalence of PTSD after trauma was 3,5%. PTSD conditional risk after trauma exposure and probability of chronicity were both highest for witnessing trauma.

2.2.3. Resilience in Treating Professionals

Winbald, Changaris and Stein, (2018:2), state that understanding the basic principles of risk and resilience in treating professionals and developing self-regulation/emotion regulation capacity could improve functioning and reduce risk of vicarious trauma (Pearlman and Saakvine, 1995, Baird and Jenkins, 2003, Pereira, *et al.,* 2016).

Risk factors for both secondary traumatic stress and vicarious trauma include a history of previous traumatic events, including exposure to client traumatic experiences and involves caseloads, hours with clients, percent of trauma clients in caseloads, and amounts of exposure over time. (Pearlman and Saakvine, 1995 (Brown, 1996). This study focuses on the exposure of nurses to sexually abused victims.

2.2.4. Post Traumatic Growth (Ptg)

Kang, Fang, Li, Liu, Zhao, Feng, Wang and Li, (2017: 452- 453) define post traumatic growth(PTG) as positive psychological changes that an individual experience as a result of struggle with highly challenging life circumstances synonymous with trauma, crisis or a stressful event. The authors continue to say that “PTG has been known as a positive psychological benefit, which involves a process to rebuild one’s cognitive schemas, and then provides individuals an opportunity to have a new life perspective, (Kang et al 2017:452- 453).

2.2.5. Difference Between Vicarious Post-Traumatic Stress and Secondary Traumatic Stress

There is only a slight difference between the terms vicarious post-traumatic stress and secondary traumatic stress. According to Benedict, (2012:5) These terms have been used interchangeable to describe the impact of a specific type of experience and outcome.

Vicarious traumatic stress is a permanent change in the service provider resulting from empathetic engagements with client's traumatic background (Pearlman\ and Saakvitne, 1995). Although there are some parallels to burnout, including symptoms such as exhaustion, feeling overwhelmed, isolated and disconnected, vicarious trauma is more pervasive impacting all facets of life including the body, mind, character and the belief system. The relationship of a person suffering from vicarious trauma to the outside world becomes altered.

Secondary traumatic stress or indirect traumatic stress occurs when a service provider relates to someone who has undergone a traumatic event or a series of traumatic events to the extent that they begin to experience similar symptoms of post-traumatic stress disorder that the trauma victim is experiencing (Biard and Kratcen, 2006). In secondary trauma, the traumatizing event of the victim becomes traumatizing for the provider (Perry, Conroy\ and Ravitz, 1991).

2.2.6. Negative Aspects (Compassion Fatigue)

The effects of compassion fatigue are multifaceted, including physical, emotional, social, spiritual and intellectual effects. Symptoms of compassion fatigue include boredom, anxiety, discouragement, intrusive thoughts, irritability, numbness, persistent arousal, sleep disturbance, intolerance, detachment and loss of compassion. Physical symptoms include increased blood pressure, weight gain, fatigue, neck stiffness, gastro intestinal problems, cardiovascular disease and diabetes (Upton, 2018:3) Thus it is important for nurses caring for victims of sexual abuse to be aware of these signs so that they get assistance before their mental and physical health is affected. Working in such an environment is both mental and physically emotionally demanding but, within which nevertheless compassionate nursing care is an expected professional and moral obligation. (Upton, 2018: 4)

Risk factors for both secondary traumatic stress and vicarious trauma include a history of previous traumatic events. Repeated exposure to client traumatic experiences includes caseloads, hours with clients, and amount of exposure over time increases risk for both vicarious trauma and secondary traumatic stress (Pearlman and Saakvitne, 1995). This study will focus on the exposure of nurses to sexually abused victims.

Mailer, (2011:1) conducted a study on sexual abuse nurse examiners (SANEs') experiences of vicarious trauma and burnout as a result of treating rape victims, and the coping strategies they implemented to reduce both. Data from interviews with 39 SANEs reveal that the hardest part of their job is when they become emotional drained. Two thirds (67%) of the participants confirmed that they experienced vicarious trauma, as they are continuously worried about the

victims they nursed after they left the hospital. More than 51% of participants specifically indicated that they have experienced emotional changes and burnout (Mailer\ 2011:1).

2.2.7. Positive Aspects (Compassion Satisfaction)

Not all nurses caring for victims of sexual abuse react and cope with vicarious traumatic stress in the same way. A quantitative online survey study of 365 health professionals of different qualifications found exposure to traumatic experiences of their clients to have positive predictors of compassion satisfaction. Amongst the positive outcomes mentioned in the study were increases peer support, self-care, social support and humour. These were regarded as aspects of vicarious PTG (Manning, 2016: 34).

This is supported by a study done by Reineke\ (2017:80), which found that literature has identified a number of variables that may be instrumental in individuals experiencing positive change following trauma and adversity, such as cognitive appraisal which include awareness, controllability of the traumatic event, problems and emotions through development of focused coping. Tedsschi and Calhoun (1995), provide a categorization of the benefits of living beyond trauma as: perceived changes in self, self-reliance, self-growth and resilience.

2.3. GLOBALLY

A qualitative research study conducted by Mailer (2011:1) found that counsellors, advocates and social workers who assist sexual victims experience vicarious trauma or psychological consequences as a result of their exposure to victim's traumatic experiences, however little is known about sexual nurse examiners experiences, therefore Mailer (2011:1) conducted a qualitative research that explored the SANEs' experiences of vicarious trauma and burnout as a result of treating sexual abused victims, and the coping strategies they implement to reduce both.

According to Bloom (1997) vicarious traumatization is a term that describes the cumulative transformative effect on the helper working with survivors of traumatic life events. The author stated that the presence of vicarious traumatization has been noted in many groups of helping professionals who have close contact with people who have experienced traumatic events.

Emery (1993:87-93) observes that nurses are frequently exposed to highly stressful and emotional on the job situations. These job situations include provision of empathetic support to sexually abused victims, severe illness or death of a patient. Nurses are frequently affected by vicarious trauma which influences different people in different ways.

2.3.1. The Impact of Working with Trauma Victims

The impact of working with victims of sexual abuse on nurses is related to the trauma they are exposed to, their own characteristics and how they do their work, (Coles 2004). Vicarious post-traumatic Stress can be triggered by either a one – off exposure to a significant issue or repeated exposure to a range of issues and incidents. It can have a profound impact on individuals and be no less debilitating than primary trauma (Pearlman and Saakvitne, 1995).

Winblad, Changaris, and Stein (2018:2) indicate that individuals who treat traumatized clients are at risk of developing symptoms of burnout, compassion fatigue and vicarious trauma. Professionals who develop these symptoms are less effective in their work, need to seek their own treatment, and can experience long-term negative health outcomes (Pearlman and Saakvine, 1995; Baird and Jenkins, 200, Winbald Changaris and Stein, 2018).

Nurses have been identified as experiencing high levels of occupational stress due to work overload, role conflict, aggression and working with traumatised patients, (Lim, Bogossian and Aher, 2010, Bance, 2014:2). Adverse consequences of occupational stress in nurses include absenteeism, low job satisfaction and leaving the job (turnover) (Bance 2014:2)

According to the World Health Organisation, (WHO, 2018), the child sexual abuse is the involvement of a child in sexual activity that he/she does not fully comprehend, is unable to give informed consent to, and for which the child is not fully developed to be able to give consent. Post-traumatic stress reactions impact upon the child's subsequent psychological and social maturation leading to atypical and potentially dysfunctional development, (South Eastern Centre against Sexual Assault & Family Violence CASA, 2015: 1). It is during this period when the sexually abused child comes into contact with nurses.

2.3.2. Physical and emotional consequences of vicarious post- traumatic stress

Coles, Astbury, Dartnall, and Limjerwala, (2014: 100) indicated that vicarious trauma can be a problem for those who work and research in areas where clients or participants are survivors of sexual violence. The most common emotional responses described were anger, guilt and shame, fear, crying, feeling sad and depressed.

Some symptoms described by researchers are more suggestive of vicarious post-traumatic stress. These symptoms include nightmares, fear, anger irritability, intrusive thoughts and difficulty in concentrating, whereas others describe a change worldview more in keeping with vicarious trauma. These symptoms can affect quality of care being provided to clients if they occur.

2.3.3. Compassion Fatigue

Compassion fatigue describes the empathetic exhaustion that service providers develop when helping others. In this literature survey compassion fatigue is used to refer to a unique set of symptoms that develop in nurses caring for victims of sexual abuse. Many nurses spend a significant amount of time establishing empathetic connections with traumatised clients but experience a diminished ability to sustain those connections because of the vicarious trauma that may occur in the process (Clemans, 2013, Figley, 1995).

2.3.4. Substance abuse and sexual abuse

Nardechia and Hungrige (2015), conducted a study on childhood sexual abuse and adult addiction. Men and women disclosed different rates of childhood sexual abuse. Only two diagnostic categories were statistically significant different between men and women. These diagnoses were post-traumatic stress and eating disorders. The results showed that 49% were abused as children and 53% childhood sexual abuse by exposure to pornography.

2.3.5. Recognising Stress and Responding to It

Coles, Dartnall, and Astbury, (2013: 5) indicated that recognising that health care workers are under stress can be difficult when professional cultures discourage it. Many nurses have trained in systems that encourage them to be in control rationally rather than emotionally and to cover feelings of helplessness and powerlessness.

This can be problematic when nurses are stressed and hide it from their peers and colleagues. It has been suggested that partners, families, and friends are better at recognising the stress. Coles, Dartnall and Astbury (2013:1) also outlined that primary care professionals are increasingly being expected to identify and respond to family and sexual violence.

2.4. NATIONALLY

According to Bance (2014:1), occupational stress is a major concern in Canadian society, and nurses have been identified as a high-risk population. Bance (2014: ii) studied levels of occupational stress, vicarious trauma secondary traumatic stress and burnout in nurses caring for sexually abused victims and emergency nurses in Canada.

The findings showed no difference in the levels of occupational stress. This study will focus on exploring whether vicarious trauma, occurs among nurses in KwaZulu Natal as a result of caring for victims of sexual abuse. The level of job satisfaction and the impact on health will also be looked at.

Finklestein (2015: 25-31) investigated PTSD and vicarious symptoms among mental health professionals working in communities exposed to high levels of trauma related to rocket attacks from Gaza Strip.

The study also assessed the direct and vicarious traumatic exposure. The findings indicated that mental health professionals exposed to concurrent trauma and vicarious trauma are at increased risk of psychological distress and may require targeted interventions to boost their resilience. Choi, (2011:101) also states that professionals helping survivors of family violence or sexual assault are at risk of experiencing secondary traumatic stress

2.4.1. Vicarious Post Traumatic Growth

Manning- Jones de Terte and Stevens (2015:125) conducted a systemic literature review on vicarious post traumatic growth(PTG). Twenty-eight articles were reviewed which provided the first comprehensive review the vicarious (PTG). Seventeen studies assessed vicarious PTG using a measure designed for use with direct trauma survivors, three used a non-validated measures and the remaining eight used open ended questions.

Vicarious PTG was found to be highly similar to direct PTG. Manning-Jones, de Terte and Stevens also identified differences between the two along with the manifestations of growth unique to vicarious PTG. This study is aiming at finding out whether the vicarious PTG can occur as a result of caring for victim of sexual abuse and if there is vicarious PTG for nurses caring for these victims.

2.5. MENTAL HEALTH OF HEALTH PROFESSIONALS CARING FOR VICTIMS OF SEXUAL ABUSE

A qualitative study conducted by Romano (2014) examined the impact of trauma therapy work on mental health care professionals who work with traumatised clients. The results of the study indicated that there were no differences in mental health care professionals' scores of vicarious trauma, secondary traumatic stress and burnout based on differences of mental health care professionals' exposure to traumatised clients.

(Bux, Cath wright and Collings, 2016: 88), conducted a qualitative study investigated 10 caregivers following the disclosure of sexual abuse of a child under their care. In their study thematic analysis of data revealed that caregivers experienced multiple forms of emotional, psychological and situational distress, concern for the child, alienation, coping style and grief. The findings suggested that not only do the caregivers experience vicarious traumatisation but also that this impacted their parenting abilities.

2.6. SIGNS AND SYMPTOMS OF POST-TRAUMATIC STRESS

Severe trauma sufferers may re- experience traumatic event through intrusive thoughts and images including flashbacks and nightmares. Numbing of thoughts and feelings related to trauma allows an individual to disconnect from awareness of her or his external and internal experiences, particularly when emotions become overwhelming (van der Kolk, 1987 cited by Mash Pow, 2014).

Nurses who are affected by symptoms of PTSD find the emotional deregulation a hindrance in their job responsibilities and detrimental to their wellbeing. This includes the nurses (Mash Pow, 2014). Because the symptoms of vicarious traumatic stress turn to mimic those of the direct trauma, it may be nearly impossible to delineate whether measured symptoms of traumatic stress are the result of direct trauma or secondary traumatic stress amongst the disaster responders (Mash Pow, 2014:6). For this study disaster responders will be nurses caring for sexually abused victims.

Ben- Portal, (2015:1) which states that in recent years there has been growing interest by therapist implications of treating victims of sexual abuse. The concept vicarious post- traumatic growth relates to the positive implications of treating trauma victims. The study compared vicarious PTG amongst 143 domestic violence therapists versus 71 therapists working at social service departments in Israel.

In addition, an attempt was made to identify background characteristics and personal factors as well as environmental factors that contribute to vicarious PTG, with emphasis on the contribution of secondary traumatization. The findings revealed that vicarious PTG was slightly above the moderate level. Among the therapists working at social service departments, vicarious PTG was higher. Whereas secondary traumatization contributed significantly to vicarious PTG as a linear variable and as curvilinear variable, (Ben- Porat, 2015:1).

This is supported by the study of Froman, (2014) who examined the impact of trauma therapy work on mental health professionals who work with traumatized clients. A hierarchal regression equation was used to explore whether secondary traumatic stress and vicarious trauma predicted vicarious PTG. Froman (2014), examined negative and positive effects of therapy work. The results of the study showed no difference on mental health professionals' scores of vicarious trauma, burnout and secondary traumatic stress based on differences of mental health professionals' exposure to traumatized victims.

Whereas Froman (2014) found that there were significant differences between high and low exposure caseload groups on scores of vicarious PTG. Participants in the high, 87% exposure,

groups had significant score of vicarious post traumatic growth than in low 13% exposure group.

Similarly, Rogers (2016: ii) conducted a study on secondary traumatic stress scale in telephone counsellors in South Africa. Results indicated that the majority of counsellors reported experiencing a low to average level of symptoms associated with secondary traumatic stress and a relatively high level of compassion satisfaction. Therefore, for this study the duration and the impact of exposure of nurses caring for sexually abused victims will be looked at.

The theoretical framework used in this study is the professional quality of life (ProQol). This is one of the theories that explains that professional quality of life in the caring profession in relation to compassion satisfaction. It connects the experience of the work environment with thoughts, feelings and action.

According to Stamm (2010: 8) the backbone of a true caring nursing profession is compassion, where a nurse provides empathy to the victims of sexual abuse without being judgemental. Professional quality of life incorporates two aspects, the positive (compassion satisfaction) and the negative (compassion fatigue).

The positive aspects are when a nurse experiences job satisfaction about their work and the environment in which they work. Compassion fatigue has two aspects. The first aspects include anger, frustration, exhaustion and depression which is typical of burnout. The second aspect is the negative feeling driven by fear of work related trauma (Stamm, 2010:8). Nurse s working in Thuthuzela Care Centers are vulnerable to experiencing secondary trauma as they are witnessing victims of sexual abuse in execution of their duties. (Figley 2002: 1435; Stamm 2010:13).

2.7. LOCALLY

2.7.1. The Thuthuzela Care Centre Model

The Thuthuzela Care Centre Model is led by the National Prosecuting Authority's (NPA's) Sexual Offences and Community Affairs Unit (SOCA)**,** in partnership with national government departments and donors as a response to the urgent need for an integrated strategy for prevention, response and support for sexual and gender-based violence victims (Strydom, 2016). Since its establishment in 1999 the SOCA Unit has developed best practices and

policies that seek to eradicate victimisation of women and children, while improving prosecution, particularly in the areas of sexual offences, maintenance, child justice, domestic violence, and trafficking in persons (Strydom, 2016: 2)

2.8. ACQUIRED IMMUNE DEFFICIENCY SYNDROME (AIDS) MYTHS AND SEXUAL ABUSE

Sivela, (2016:1188) conducted a study on the dangerous AIDS myths and the impact of myths about HIV and AIDS in South Africa. The virgin cure myth is a false belief by an adult who had been diagnosed with HIV/AIDS that if that person have sex with a virgin will result in that particular person being cured of the disease (Sivela, 2016). The virgin cure myth was outlined as one of the most influential and powerful AIDS myth in increasing the prevalence children sexual abuse in South Africa.

The child abuses tracking study done by the University of Cape Town (UCT) children institute in 2017, found that children were most at risk in their own homes and younger children especially were most likely to be abused by a relative or someone they knew- 80% of under four years' old who were abused were related to their abusers (Nxumalo and Philander, 2017). This indicates the type of trauma nurses are exposed to while executing their duties.

2.9. CHALLENGES OF WORKING WITH TRAUMATISED VICTIMS

Sui and Padmanabhanunni, (2016:1) state that traumatic events are highly prevalent in South African society and psychologists who work with survivors of trauma have been identified as particularly at risk of being adversely affected by their work, and experiencing vicarious trauma.

In their study they explored the experiences of a group of South African psychologist who work predominantly with trauma survivors. Individual semi- structured interviews were conducted with six psychologists (females=67%).The predominant type of trauma encountered by the participants in clinical practice was interpersonal trauma in the form of physical and sexual abuse (83%). All participants reported symptoms of vicarious trauma including disruption in cognitive schema, symptoms characteristic of post-traumatic stress disorder and somatic symptoms.

Working with victims of sexual abuse can be emotionally challenging. Working with children can make it even more so because of bearing and witnessing physical trauma which may be evident during assessment. The mandatory reporting of the findings is used for forensic evidence. The court proceedings are lengthy and they may take place months, or even years

after the event had occurred. This predispose nurses to vicarious PTSD, (Sui and Padmanabhanunni,2016:1)

2.10. LEGAL ASPECTS OF CARING FOR VICTIMS OF SEXUAL ABUSE

Legal aspects are defined as things that relate to the law (English dictionary). In South Africa the Criminal Law (Sexual Offences and Related Matters) Amendment Act of 2007 stipulates that victims of rape must receive post exposure prophylaxis (PEP) for HIV infection when they are treated at the public hospitals and clinics.

The Sexual Offences and related Matters Act further mentioned that PEP should be free of charge. South African legislation therefore guarantees all survivors of rape and sexual violence the right to access PEP (Barday 2017:3). It is therefore imperative for nurses caring for victims of sexual abuse to provide the appropriate advice and guidance about PEP adherence, that is not enough as the same nurses have to provide counselling before administration of medication. Further counselling to be provided for the sexual abuse itself (Randa *et al* 2023:3)

2.11. STANDARDS AND NORMS FOR PRIMARY HEALTH CARE

In 2000, the National Department of Health brought out a document entitled “The Primary Health Care Package for South Africa- a set of norms and standards”. One of the sections highlights PHC responsibilities regarding domestic violence and sexual assault. The document recognises the need for interdepartmental and inter-sectoral collaboration in delivering services. The responsibilities outlined in that document include that:

- Every clinic should establish working relationships with the nearest police officer and social welfare officer by having visits from them at least twice a year.
- A member of staff of every clinic must have received training in the identification and management of sexual, domestic and gender related violence. The training should include gender sensitivity and counselling.
- The clinic staff are required to fast track in a confidential manner any rape victim to a private room for appropriate counselling and examination.
- All cases of sexually transmitted disease in children are managed as cases of sexual offence or abuse.
- When a person presenting at a clinic alleges to have been raped or sexually assaulted the allegations is assumed to be true and the victim is made to feel confident they are believed and are treated correctly and with dignity.

- A detailed medical history is recorded on the patient record card and a brief verbal history of the alleged incident is taken and noted- with an indication that these are not a full account. These notes are kept for 3 years.
- Staff explain that referral is necessary to an accredited health practitioner and arrangements are made expeditiously and while awaiting referral emergency medical treatment is given with the consent of the victim:
- The victim is given information on the follow up service and the possibilities of HIV infection and what to discuss with the accredited health practitioner at the hospital or health centre.
- Victims are not allowed to wash before being seen by an accredited health practitioner.
- A female health worker attends to women who have been raped or abused and if this is not possible (e.g. a male district surgeon comes to the clinic) then another woman is present during examination.
- The victim is given brief information about the legal process and the right to lay a charge.
- The document emphasises that all patients should be referred to the next level of care when their needs fall beyond the scope of competence of the clinic staff.
- The document also states that referral is necessary to a trained and accredited health provider.

Given the current situation with few providers trained to conduct examinations after sexual assaults and domestic violence in most provinces (Webster, 2002), the implementation of the standards and norms at PHCs is not possible and feasible. The document referred to above seeks to set in place principles and practice that can be implemented by provinces for delivery of sexual assault services.

The guidelines, outlined in this sexual assault policy document recognise the need to have trained health providers providing the care for and conducting examinations of patients after sexual assault. It seeks to take account of recent evidence and development in delivering effective and holistic health care after sexual assault.

In terms of the Child Care Act (74 of 1983) and the Aged Persons Amendment Act (100 of 1988), it is important that nurses do not see the legal framework as impinging on their primary professional responsibilities which are to their patients. Unless the patient decides to report the incident to the police the health care worker's role will be confined to that of meeting the health needs and providing information.

It is not the responsibility of the nurse to determine which crime has (or has not) been committed or to draw conclusions about the reasons why the sexual assault occurred. The Act stipulates that it is very important for nurses to respect patients' decisions regarding involvement of the police in the case.

The Act also mandates the nurse to report the sexual assault of children and the elderly to the police. This shows how much vicarious post -traumatic stress the nurse must undergo.

If the legal cases are to be pursued medico-legal evidence deemed to be critical. South African Police Services and the criminal justice system recognise the importance of medico- legal evidence. A new sexual assault evidence collection kit (SAECK) has been introduced to improve the collection of evidence and all evidence undergoes DNA analysis. The description of the extent of the harm suffered by the patient may influence the sentence.

Kim, Song, and Windsor, (2022), states that assessing the validity of behaviours and statements of the suspected victims of child abuse in the absence of definite physical evidence poses many challenges. The accuracy and reliability of child's allegations are affected by factors such the consistency of the account, vocabulary appropriate to the child's developmental level, lack of motivation to fabricate the account, appropriate affect, spontaneity and consistency with corroborative evidence (Perry and Wrightsman,1991).

2.12. MORBIDITY ASSOCIATED WITH SEXUAL VIOLENCE

(Khan, and Arendse, 2022: 459) indicated that systematic reviews for quantifying the health impact of violence against women for the Global Burden of Disease Study have shown a wide range of psychological morbidity associated with sexual abuse. These psychological effects are much more prevalent than physical morbidity, although most services emphasise developing responses to the latter, while mental health gets inadequate, often cursory attention during the acute post rape period.

Calitz. *et a*l (2014:1), found that 49 (4.0%) of the children and adolescents treated at the Thuthuzela Care Centres were diagnosed with PTSD, of whom most were female (63,3%). Approximately 22% of the participants had comorbid major depressive disorder. The main traumatic event in both groups was witnessing the death of the close relative (32.7%) followed by sexual assault which was found to be at 25%. All these victims are attended to by the nurses who they provide care and empathy.

Survivors of rape often develop a cluster of symptoms. These are PTSD, depression, obsessive compulsive disorder, panic attacks, substance abuse and suicide ideation. (World Health Organisation, 2013, Resnick, Aciemo and Klipatrick. 1997; Uilman et.al 2007).

According to Lund, *et al* (2008), the impact of rape on mental health is well known and is a widespread problem in South Africa, but mental health services for rape victims are scant. In general South Africa does not have well integrated mental health services within acute health care.

2.13. OCCUPATIONAL SPECIFIC DISPENSATION

In 2007, Occupational Specific Dispensation (OSD) was introduced for public sector employees in South Africa which is unique to each identified occupation in the public service. The purpose of OSD was to improve government's ability to attract and retain skilled employees (George and Rhodes 2012: 6)

This also poses a challenge in management strategies such as rotation of staff who are working with victim's sexual abuse victims as it does not offer equal benefits such as remuneration to employees who work in different departments (George and Rhodes 2012: 6). It becomes difficult for managers to do the reshuffling of staff even if the staff performance seems to be deteriorating because of vicarious post- traumatic stress, (George and Rhodes 2012: 6)

A study by (Reineke 2017:1), explored the psychological dynamics of adversarial growth in the practitioners of the critical occupation- emergency medical care. Being subjected to stressful and traumatic events does not necessarily result in only negative outcomes. Growth may occur through adversity. Reineke (2017:1)

It should be noted that due to the high-risk conditions they work under, the possibility of experiencing trauma is increasingly being added to the vicarious trauma South African paramedics are exposed to while executing their duties. Paton and Smith (1996) note that compared to data collected from the general population, professional workers may be exposed to demanding and recurring traumatic stimuli.

Paton and Violanti, (1996: 206) cited by Reineke (2017) outlined that the emergency medical care industry provides essential services to the community and may thus be described as critical profession, not only in terms of the nature of the work, but also as far as the occupational effects it may render on those who work in it. It is made up of job related realities that can exert a critical impact on the employees wellbeing and performance effectiveness. In this study this will be looked at for nurses who are specifically caring for sexually abused victims.

Gevers and Abrahams (2015: 16) conducted a quantitative study on health care workers caring for sexually abused victims. Some of their participants responded by saying that they

become short tempered and irritable with other team members and others would stop taking calls from survivor or appointments for the periods of time when they felt overwhelmed with stress or vicarious stress.

2.14. THE MANAGEMENT OF SURVIVORS OF SEXUAL VIOLENCE

The Kwa Zulu Natal Department of Health (2001) document titled “The Management of Survivors of Sexual Violence and Abuse” stipulates the principles to apply to any type of violent incident presented below:

2.14.1. No one should be turned away.

A survivor of violence must not be turned away and be referred to another health institution. It also states that it is irrelevant from which geographic area the survivor originates.

2.14.2. Reporting to the police

Health care practitioner must establish whether the matter was reported to the police or not:

If the patient wishes to report the incident, contact the police station in the area in which the incident occurred. The healthcare practitioner must ask the police to come to the health care institution to take a statement from the patient. If not, discuss the advantages and disadvantages of reporting the incident. If an adult patient refuses to report the incident, the health care practitioner should still perform a full forensic examination and record the findings in case the patient changes her/his mind.

2.14.3. Medical assessment

A patient who has sustained injuries must be assessed and treated in the nearest casualty/ trauma unit. Once stabilized the casualty officer may be referring the patient to the Crises Centre Care (Thuthuzela) for forensic examination. The Department of Health (2001), document further states that under no circumstances must an injured survivor refer to the referring institution for forensic assessment and medical management.

2.14.4. Timing of medico-legal examination

The medico-legal examination of the patient must be done after the medical assessment has been completed and ideally within two hours of the patient presenting in an institution. Where the patient is admitted the medico-legal examination is conducted in the ward.

2.14.5. Venue

The health care practitioner must respect the dignity of the patient and all the survivors must be interviewed in a private room or Crises Care Centre

2.14.6. Emotional support

Patients suffer mental trauma that may or may not be obvious. The health care practitioner must be caring and supportive.

2.14.7. Consent

Consent for the medical examination, treatment, collection of specimens for medical, and forensic purposes, disclosure of medical information and HIV test must be voluntary and informed and must be obtained in writing on the prescribed form or recorded in the patient records. Any patient over the age of 14 can consent to a medical examination.

2.14.8. Presence of a third person

It is important that a third person (with whom the patient is comfortable with) to be present during examination of the patient.

2.14.9. Post medical examination procedures

Forensic specimens and exhibits must be sealed, labelled and kept under lock and key in a special cupboard or refrigerator, until sent to the laboratory.

2.14.10. Medical treatment

Physical injuries must be treated appropriately. In cases of sexual assault there is the need to treat and counsel regarding prevention of pregnancy, and treatment of sexually transmitted disease.

2.14.11. Referring for counselling

If the patient is suicidal or has suffered severe emotional trauma, she or he must be referred for immediate counselling and management or admitted in the ward. The patient must be advised regarding the options of the post trauma counselling. The patient may be referred to the hospital social worker, mental health services or to a NGO support group.

2.14.12. Recording of the findings

The report should be comprehensive and all the necessary information must be recorded in the patients' file during and after each consultation or examination. The results of the findings must be recorded in a prescribed (J88) form. A copy must be retained in the hospital records and the original J88 be returned to the investigating officer (Kwa Zulu Natal Department of Health, 2001).

The above indicates the extent of secondary or vicarious post-traumatic stress the health care workers caring for sexually abused victims are exposed to as a result of following the prescribed procedures by the Department of Health.

2.15. SAFETY AND SECURITY OF HEALTH CARE WORKERS, VICTIMS OF SEXUAL ABUSE, HEALTH RECORDS AND FACILITY

The guidelines for medico legal care for victims of sexual abuse (2016:22) state that there should be adequate measures to protect staff, patients, health records and the facility itself.

It also outlines thee strategies that can be used which include the use of a guard that controls access, surveillance cameras, adequate lighting, lockable doors and cabinets, as well as fire prevention equipment. This shows that working in this environment can be stressful, before and after attending to sexually abused victims. Nurses and other health professionals in South Africa work under high stress in the public sector where a chronic shortage of health providers and other resources are persistent (Sprague.*et al*, 2015: 1598).

2.16. POSITIVE AND NEGATIVE EFFECTS OF CARING FOR SEXUALLY ABUSED VICTIMS

West. (2016) states that previous research has indicated that providing care to trauma victims has both negative and positive effects on quality of life of care givers. Negative effects of caregiving may have included: experiencing symptoms of vicarious trauma, compassion fatigue, secondary traumatic stress and burnout. In contrast positive effects include PTSD, compassion fatigue, and vicarious resilience.

Gevers and Abrahams, (2015:16) conducted a survey of lay counsellors providing services for child and adolescent rape survivors. Most of the service providers interviewed in their study had no specialised child, adolescent training and found working with the young survivors not as easy as working with adults.

One lay counsellor in an urban clinic indicated that it was only through her experience that she learnt to chat to children while playing with them in the play area to engage them. With adolescents she found it helpful to meet with teen separate from parents to begin talking about other things so that they see that you are interested in them.

Gevers and Abrahams, (2015:16) found many service providers especially lay counsellors describe their work of helping survivors to be fulfilling and spoke of being privileged. However, all service providers also noted it can be very difficult with a lot of stress as there is a lot of work.

One of the service providers found it to very draining and said that one can become very depressed and angry hearing the details of the survivors' rape traumas, dealing with the child or elderly survivors, seeing physical injuries, feeling helpless or not knowing how to help survivors. Some providers explained the work with survivors as touching them because they are the people too.

Some of the manifestations of this stress as reported by the service providers included feeling afraid while at home, in the community or when commuting and becoming overprotective of their children and not allowing them to go out.

Hester (2015: ii) explored suffering, for the practitioner's reflections a on peace building program for youth exposed to traumatic stress in intergroup conflict. Hester (2015: ii) found that exposure to traumatic stress within intergroup conflicts poses unique risks not only to the neurological and social development of youth, but also to capacities of youth to fully participate in peace building intervention.

2.17. CONCLUSION

This chapter reviewed the literature relating to nurses caring for victims of sexual abuse in Thuthuzela Care Centres. It covers the issues and caring of victims of sexual abuse internationally, nationally and locally. The focus of this study was to determine whether nurses caring for victims of sexual abuse in Thuthuzela Care Centres experience vicarious post-traumatic stress or not, as a result of their repeated exposure to different stories of the victims.

Legal aspects, signs and symptoms of post-traumatic stress, challenges faced by nurses caring for victims of sexual abuse as well as positive and negative effects of caring for victims of sexual abuse were presented.

3. CHAPTER THREE
METHODOLOGY

3.1. INTRODUCTION

Research methods are the steps, procedures, and strategies for gathering and analysing data in research investigation, Polit and Beck, (2012: 349). The purpose of research methodology is to inform the reader about the steps followed and tools used in investigating the phenomenon of interest.

This section covers the research design, research paradigms, research setting, population, sampling method, research tool, data collection, data analysis, validity, and reliability, ethical considerations and data management, dissemination, and storage.

3.2. RESEARCH PARADIGMS

Brink., van der Walt. and van Rensburg. (2012:25), describe a paradigm as a set of assumptions about the kind of entities in the world, how these entities work and proper methods to use for constructing and testing theories of these entities.

Polit and Beck (2008:13) define a paradigm as a way of looking at natural phenomena that encompasses a set of philosophical assumptions and guides one's approach to enquiry. The paradigm that will be used for this study is positivism, which is also known as logical positivism. Brink, van der Walt and van Ransburg (2012:25) describes positivism as a systematic way of doing research that emphasise the importance of observable facts. This paradigm is used because positivists value objectivity and hold their personal beliefs and biases in check as far as possible during research to avoid contaminating the phenomena under investigation (Polit and Beck, 2012:14). Therefore, the researcher assumed that there is a probability that nurses caring for victims of sexual abuse might experience vicarious post-traumatic stress.

3.3. RESEARCH APPROACH

The study used the quantitative research method (Grove, Burns and Gray 2013: 25) which uses of structured interviews, questionnaires, or observations, scales and physiological measures that generate numerical data. Grove, Burns and Gray (2013: 25) state that statistical analyses are conducted to reduce and organize data, describe variables, examine and determine relationship and differences among groups.

In this study a secondary trauma scale and a specific questionnaire that addresses the objectives will be used to assess the impact of vicarious post- traumatic stress on nurses caring for sexually abused victims. The study will include the self-reporting of demographic data to objectively gather specific information required for the research.

Rogers (2014:27) stated that self-reporting questionnaire ensure confidentiality and can potentially maximise honesty of response which is particularly useful when covering issues which may be viewed as socially un acceptable such as could be the case in this study where nurses may not want to be perceived to be affected by their work (Barker, Pistrang and Elliot 2002, cited by Rogers 2014:27).

3.4. RESEARCH DESIGN

A non- experimental descriptive design was used to assess the vicarious post-traumatic stress levels of nurses caring for sexually abused victims. Brink, van der Walt and van Ransburg (2012:112) stated that there is no manipulation of the independent variables and therefore no intervention, nor is the setting controlled. The major purpose of non- experimental research is to describe phenomena, and explain the relationship between variables (Brink, van der Walt, and van Ransburg 2012:12).

Polit and Beck (2012:270) state that the purpose of descriptive studies is to observe, describe and document aspects of the situation as it naturally occurs. Descriptive designs insist on the careful portrayal of ordinary conscious experience of everyday life, a depiction of things as people experience them. (Polit and Beck 2012:270). The descriptive design was used for this study to enable nurses to complete the questionnaire on how they feel in the process of caring for victims of sexual abuse.

3.5. RESEARCH SETTING

The research setting is described as “a specific place or places where data are collected.” (Brink, van der Walt and van Ransburg 2012:59). The decision about where the study was conducted was based on the nature of the research questions and the type of data that needed to be collected (Brink. van der Walt and van Ransburg 2012:59) The chosen locations were accessible Thuthuzela Care Centres in KwaZulu - Natal. Thuthuzela Care Centres are non - governmental organisation where victims of sexual abuse are attended to. Thuthuzela Care Centres are multi- sectorial in nature. They are a collaboration between the Department of Social Development, National Prosecuting department, Department of Health, South African Police Services and other independent organisations such as Life Line, Child Line, and crises centres. Victims of sexual abuse are taken care of, in the medical wards.

3.6. POPULATION

The population is all the elements (individuals, objects, or substances) that meet certain criteria for inclusion in each universe, Grove, Burns and Grey (2013:44). The target population is the entire set of elements about which the researcher would like to make generalisation, (LoBiondo- Wood and Haber 2010:222) The target population for this study was the nurses caring for sexually abused victims in Thuthuzela Care Centres irrespective of their nursing categories. According to the Nursing Act (No. 33 of 2005: 4), a nurse is a person registered in order to practice nursing or midwifery. Nursing means a caring profession practised by a person who is registered to support, care and provide comfort and dignity for people until death (Nursing Act no. 33 of 2005:4)

3.7. SAMPLING

Grove, Burns and Gray (2013: 351) state that sampling involves selecting a group of people, events, behaviours, or other elements with which to conduct a study. In this study a convenience method of sampling was used. A convenience sampling is referred to as availability sampling and it involves the choice of readily available respondents for the study, Brink, van de Walt and van Ransburg (2012:140).

The convenience approach sample was chosen for this study because it is beneficial when time is a constraint as it is a simple method. Convenience sampling also allows the researcher to generate a large sample in a short period of time. This type of sampling in a quantitative study is only used when samples are unobtainable by other means of quantitative study. (Brink et al, 2012:140).

3.8. INCLUSION AND EXCLUSION CRITERIA

The inclusion criteria are also known as the eligibility criteria or the distinguishing descriptors ((Polit and Beck,2012:274). The researcher used these criteria to decide who will participate in the study. In this study the doctors and nurses that were not available for various reasons in Thuthuzela Care Centres irrespective of their nursing category were included in the study.

The exclusion criteria which is also known as the delimitation allows the researcher to exclude certain elements, Brink *et al* (2012:131). In this study doctors and other nursing staff that were not available for different reasons were excluded.

3.9. LIMITATION OF THE STUDY

The limitations of this study was that the population number obtained for the study was at total 31 nurses caring for victims of sexual abuse in Thuthuzela Care Centres in KwaZulu Natal.The limitation in this study is that the literature reviewed is limited to other healthcare professionals excluding the nurses. Therefore, the results cannot be generalized to all other healthcare professionals caring for victims of sexual abuse in Thuthuzela Care Centers. In addition, this study also has further limitations as the sample size is limited to consecutive sampling thus, involves recruiting all of the people from accessible population who meet the eligibility criteria over a specific time and intervals or for a specified sample size.

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3.10. DATA COLLECTION

Grove, Burns and Gray (2013: 46) describe data collection in quantitative research as involving obtaining numerical data to address the research objectives, questions or hypothesis. Data collection was by means of a self- completion questionnaire, the Professional Quality of Life scale. Validated instrument called Professional Quality of Life scale, (ProQol), which assesses, compassion satisfaction, compassion fatigue, secondary traumatic stress and vicarious post- traumatic stress. This questionnaire had been used by a number of researchers across the globe. It is included nearly in 200 peer reviewed papers, 130 dissertations and many unpublished studies, (Stamm, 2010:9).

3.10.1. Data Collection Instrument

The ProQol is a validated instrument which assesses compassion satisfaction, compassion fatigue, secondary traumatic stress and vicarious traumatic stress. This questionnaire had been used by a number of researchers across the globe. It is included nearly in 200 peer reviewed papers, 130 dissertations and many unpublished studies, (Stamm, 2010:9). Permission to use the instrument was obtained online (Annexure B). This instrument consists of three subscales- compassion satisfaction. Questions are answered using a Likert scale.

Section 1 dealt with demographic information of the respondents of this study. Section 2, dealt with the experiences of the nurses caring for victims of sexual abuse in terms of quality of life that includes compassion satisfaction numbers 1-8, 24,29, 30, burnout, (numbers 9, 10, 11, 13), vicarious post-traumatic stress, (numbers 14, 19, 21, 23, 25, 26, 28) and finally with coping strategies. Based on the above information the instrument measured what it was supposed to measure. Compassion satisfaction is about pleasure of being able to do your work well (Stamm 2012:12). Secondary traumatic stress is an element of compassion fatigue.

Secondary traumatic stress is about work-related secondary exposure for people who have experience an extremely traumatic stressful event. Burnout is associated with feelings of hopelessness and difficulties in dealing with your work effectively. (Wang, *et al*, 2020:103-147).

Rogers (2014:27) stated that self-reporting questionnaires ensure confidentiality and can potentially maximise honesty of response which is particularly useful when covering issues which may be viewed as socially unacceptable is the case in this study where nurses may not want to be perceived to be affected by their work.

3.10.2. Validity

According to Brink, van der Walt and van Rensburg (2012::109), the instrument is about how accurately the instrument measures what it is supposed to measure, given the context in which it is applied. Botma *et al.* (2010: 37), stated that the validity indicates whether the conclusion of this study is justified based on the design and the interpretation. The data collection instrument of this study measured all the aspects included in vicarious post-traumatic stress, secondary traumatic stress, compassion satisfaction and burnout. All of these being in line with the objectives of the study. Face validity was used in the study to measure validity. Face validity was used to measure the extent to which the instrument looks, as if it is measuring what it supposed to measure (Polit and Beck 2012:720).

3.10.3. Reliability

Botma *et al* (2010: 38) state that reliability represents consistency of measurement achieved. This means that a valid instrument when applied to a different group may yield the same result. The researcher must always have proof of the reliability of the instrument. The reliability of compassion satisfaction and secondary traumatic stress are shown to be adequate (Padmanabhanuni, 2020: 388)

3.10.4. Data Collection Process

After obtaining permission from the DUT Institutional Research Ethics Committee, the KwaZulu Natal Department of Health (DoH), and five of the Thuthuzela Care Centres data was collected, analysed and interpreted. Respondents were asked to sign informed consent forms after a full explanation and a letter of information explaining the study. Respondents were informed of their right to withdraw from the study at any time during the process without suffering from any prejudice.

An appointment was made with the Thuthuzela Care Centres operational managers and appropriate dates were agreed upon to collect data. Data was then collected on the different dates that were arranged.

Respondents (day staff and night staff) were accessed during their lunch breaks and 30 minutes of their lunch was used to fill in the questionnaire. Special codes were allocated to each questionnaire to ensure anonymity.

The researcher was available to collect data for day duty staff and a special box was provided for the respondents on night duty into which answered questionnaires were posted. The night duty team leaders were requested to keep the answered questionnaires in a safe place until the following morning. Data will then be analysed and kept in the cupboard under lock and key for five years. The key to that cupboard will only be accessed by the researcher. The electronic version of data will only be accessed using a password.

3.11. DATA ANALYSIS

Data analysis reduces, organizes, and gives meaning to collected data (Grove, Burns and Gray 2013: 46). Data was computed using SPSS version 19. A statistician assisted with data analysis. Graphs and bar charts were used for interpretation of the results. Brink, van der Walt and van Rensburg (2012: 58), explains that statistics convert and condense data, into an organised and visual presentation or picture in a variety of ways so that data has meaning for the readers of the research report. Descriptive statistics were used to describe and summarise the data. Statistics was then put on the tables and analysed.

3.12. ETHICAL CONSIDERATIONS

According to Botma, *et al.* (2010), the researcher must be conversant with the ethical principles of conducting research involving human beings. This study observed the principles of ethics as described below:

3.12.1. Beneficence

The principle of beneficence is grounded in the premise that, a person has a right to be protected from harm and discomfort and that one should do good and above all no harm, (Botma *et.al*. 2010). In this study the respondents were protected from any harm by a full explanation about the aim of the study, their rights to voluntarily participate and their freedom to withdraw from the study at any time during the study. Each questionnaire given to respondents had a unique number. The respondents were informed not to write their names on the questionnaire. Brink, van der Walt and van Rensburg (2012:35) emphasized that the

respondents should always be protected from any physical, emotional, psychological, spiritual or legal abuse.

3.12.2. Justice

The principle of justice is described by Brink, van der Walt and van Rensburg (2012: 36) as giving respondents the right to fair selection and treatment. The following aspects were covered regarding the principle of justice.

3.12.3. Right to fair treatment

Brink, van der Walt and van Rensburg (2012:37), state that a researcher has a responsibility to conduct their research study in an ethical manner from the conceptual and planning phases through the implementation to the dissemination of data,

When humans are used as respondent's care must be exercised to ensure the rights of those humans are protected (Polit and Beck,2012). This study attended to this because ethical approval was sought from and granted by DUT Institutional Research Ethics Committee to the researcher before the research was commenced.

3.12.4. Right to full disclosure

Information is an important aspect of participation because it informs because it is behind the decision of the respondents' to be involved in the study. (Brink, van der Walt and van Rensburg 2012:39) state that information can be in the following ways:

- Written form where an information leaflet is given to respondents to read.
- Verbal form where the researcher discusses all the information with the respondents.
- Taped form where the researcher uses audio, or video recordings to share information.

In this study an information letter was given to the respondents to read and familiarize themselves with the study and what was expected on them. Any questions that the respondents had were answered prior to them signing the consent form and answering questionnaire.

3.12.5. Informed Consent

The ethical principles of voluntary participation and protecting participants from harm are formalized in the concept of informed consent (Babbie and Mouton 2001 cited in Brink, van der Walt and van Rensburg 2012:42). After distribution of the information letters, the participants were given the right to choose whether to participate in the study or not.

3.12.6. Confidentiality

Polit and Beck (2012) describe confidentiality as “protection of participants in a study such that individual identities are not linked to information provided and are never publicly divulged”. Brink, van der Walt and van Rensburg (2012:42) state that the process of ensuring confidentiality refers to the researchers’ responsibility to prevent data gathered during the study from being linked to the individual participants, divulged, or made available to any other person. The respondents should know that whatever they share with the researcher is shared with confidence and will not be linked to them. In this study confidentiality was ensured by not sharing information given by the respondents to anybody that was not linked to the study.

3.12.7. Anonymity

Brink, van der Walt and van Rensburg (2012 44) state that respondents who agree to participate in the research have a right to expect that information collected from or about them remains anonymous and confidential. It is also important for the researcher to not be able to link the respondents with their data to maintain anonymity. In this study, the participants were not required to give their personal details to the researchers. The researcher used numbers to identify questionnaires distributed to the respondents.

3.13. CONCLUSION

The study used a quantitative method of research using a questionnaire that was divided into two parts The first part of questionnaire consisted of demographic information of the respondents. The second part included questions about compassion satisfaction, compassion fatigue and secondary traumatic stress which is explained as vicarious post- traumatic stress in this study.

Data was collected by administration of questionnaires to the respondents by the researcher. Respondents were asked to sign informed consent forms after a full explanation and a letter of information explaining the study. Respondents were informed of their right to withdraw at any time during the process.

4. CHAPTER 4
RESULTS

4.1. INTRODUCTION

The purpose of this study was to assess the presence of vicarious post-traumatic stress in nurses caring for victims of sexual abuse in Thuthuzela Care Centres in KwaZulu Natal. A Professional Quality of Life scale (ProQol), version 5 (2009) compassion satisfaction and compassion fatigue questionnaire was adopted for use in this study. Demographic data was added to the questionnaire.

The discussion of the results obtained from the analysis of the data will be presented in this chapter. The data collected from the respondents was analysed with assistance from statistician using SPSS version 19. Graphs and tables have been used to describe and summarise the data results.

4.2. SAMPLE REALIZATION

The total population of nurses working in Thuthuzela Care Centres in KwaZulu Natal is 80, however there was an accessible population of 60 nurses of all nursing categories. A sample of 31(51.66%) respondents participated from five Thuthuzela Care Centres. The respondents that were obtained from each Thuthuzela Care Centre ranged between two to three per day per shift.

The researcher visited five Thuthuzela Care Centres to get respondents on different shifts to participate. Data was not collected from three Thuthuzela Care Centres because they did not give the researcher permission to collect data from their staff. There are no Thuthuzela Care Centres in uThukela District because Ladysmith is utilising Crises Centres to assist the victims of sexual abuse and only one nurse is working there.

4.3. THE DATA COLLECTION INSTRUMENT

The data collection instrument consisted of a total of 30 questions for nurses caring for victims of sexual abuse at Thuthuzela Care Centres in Kwazulu Natal irrespective of the nurse's category. The instrument was divided into sections namely:

Section A: Demographic Data

Section B: Compassion Satisfaction, Compassion Fatigue, Secondary Traumatic Stress

4.4. PRESENTATION OF THE DATA

Section A: Demographic Data

4.4.1. Gender

All the respondents (N=31) 100% were female.

4.4.2. Age

The majority of the respondents who participated in this study were between the ages of 36 to 45, years, (n=14, 45,2%), and very few were above the age of 56 years (n= 1,3.2%) (Figure 4.1)

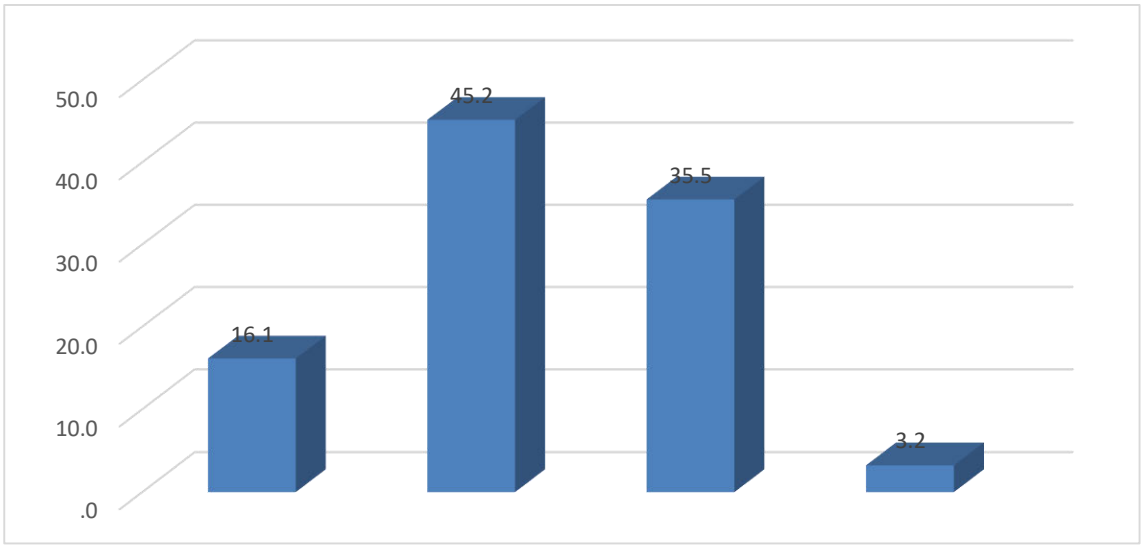

Figure 4-1 Age

4.4.3 Nursing category

Respondents to the survey in the Thuthuzela Care centres were predominantly enrolled nurses (n=14, 45,1%), with (35.5 %, n=11), being registered nurses with midwifery. Just under 10% (9.7%, n=3) were registered nurses with the same number of registered nurses with additional qualifications (9,7%, n=3).

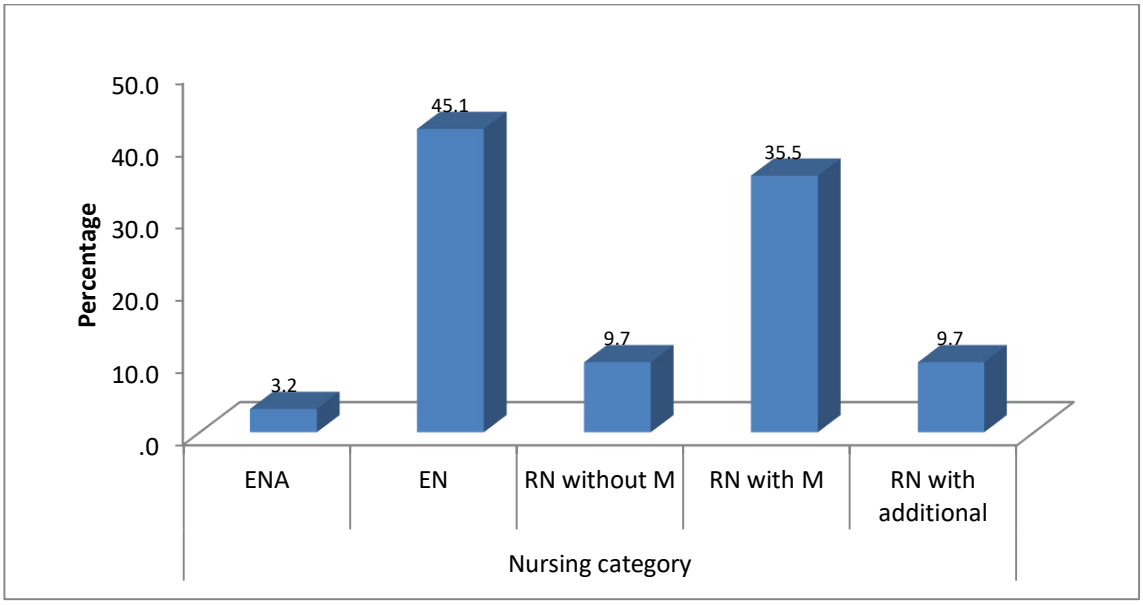

Figure 4.2 Nursing Category

4.5 WORKING EXPERIENCE

The average length of the respondents was 14.71 years and the average number of years worked at Thuthuzela Care Centres was 5. 72 years, (Table 4.1)

Table 4.1 Working experience

	Nursing experience	Years at Thuthuzela
N	31	31
Mean	14.71	5.72
Std. Deviation	9.892	4.144
Minimum	2	0
Maximum	40	19

2.6 SECTION 2: ITEMS MEASURING QUALITY OF LIFE

4.4.3. Respondents experiencing compassion satisfaction

In this study the experiences of nurses working in Thuthuzela Care Centres was explored regarding whether they were happy, satisfied and feel connected to the work that they do. A further assessment was done in terms whether they like their work, and whether they are at the place that they wanted to be in and more over if they were satisfied with their work of

caring for victims of sexual abuse. This was done to integrate the experience of the respondents in accordance with the theoretical framework of this study, which is professional quality of life and the practice of caring for victims of sexual abuse in Thuthuzela Care Centres. Compassion satisfaction connects the experience of the work environment with thoughts, feelings and action, (Stamm, 2010:8).

4.4.4. Compassion satisfaction

Table 4.2 shows that just over half of the respondents (54.8%, n = 17) indicated that they were 'often happy while only one respondent (3.2%) indicated they were rarely happy(p<.0001). Seventeen respondents (54.8%) reported that they very often gain satisfaction whereas only one respondent (3.2%)reported to never gaining satisfaction from being able to nurse people. (p<.0001). A little over one third (35.5% n= 11) of respondents reported that they feel connected to others. Over half of the respondents (67.7%, n= 21) reported that they like their work as a nurse, (p 0.05).

A significant number of respondents (n=21, 67,7%) stipulated that they very often, like their work as a nurse (p<.001). Five (16.2%) respondents reported never, rarely or only sometimes liking their work as a nurse. A significant majority of respondents (n=18, 58.1%) stipulated that they very often felt they are the people they always wanted to be. (p<.001). Just under a quarter (22.6%, n=7) of respondents indicated they often felt they are the person they always wanted to be.

In response to the item "my work makes me feel satisfied", a little over half of the respondents, (51.6% n=16) indicated that they very often, felt like this, while less than a third (32.3%, n=10) reported that their work often makes them feel satisfied (p<.001). A significant majority of respondents (n=23, 74.2%) reported that they very often felt happy that they had chosen to do this work, with a further 22.6% (n=7) of the respondents' reporting that they are happy that they chose to do this work. (p<001)

Fourteen respondents (45.2%)reported that they had happy thoughts and feelings very often about those they nurse and how they could help them, and 32.3% (n=10) reported that they often had these thoughts (p<.001).

A significant majority of respondents (n=23, 74.2%)stipulated that they are proud of what they can do to care for victims of sexual abuse (p<.001). Just less than half (n=14, 45.2%) of respondents reported to very often have thoughts that they are a "success" as a nurse (p<0.05) and a little more than a third (38.7%, n= 12) of the respondents reported to sometimes feeling invigorated after working with those they nurse.

Table 4.2 Compassion Satisfaction (n =31)

Item	Responses as Frequency (%)					Chi-square goodness-of-fit		
	Never	**Rarely**	**Sometimes**	**Often**	**Very often**	X^2	Df	p-value
I am happy	-	1 (3.2)	7 (22.6)	***17 (54.8)***	6 (19.4)	17.837	3	0.001*
I get satisfaction from being able to nurse people	1 (3.2)	-	4 (12.9)	9 (29.0)	***17 (54.8)***	18.935	3	<.001*
I feel connected to others	1 (3.2)	1 (3.2)	9 (29.0)	9 (29.0)	***11 (35.5)***	14.968	4	0.005*
I like my work as a nurse	2 (6.5)	1 (3.2)	2 (6.5)	5 (16.1)	***21 (67.7)***	45.613	4	<.001*
I am the person I always wanted to be	-	5 (16.1)	1 (3.2)	7 (22.6)	***18 (58.1)***	20.484	3	0.008*
My work makes me feel satisfied	1 (3.2)	1 (3.2)	3 (9.7)	10 (32.3)	***16 (51.6)***	28.194	4	<.001*
I have happy thoughts and feelings about those I nurse and how I could help them	1 (3.2)	3 (9.7)	3 (9.7)	10 (32.3)	***14 (45.2)***	19.806	4	<.001*
I am proud of what I can do to care for victims of sexual abuse	-	2 (6.5)	2 (6.5)	4 (12.9)	***23 (74.2)***	40.355	3	<.001*
I have thoughts that I am a "success" as a nurse	-	1 (3.2)	5 (16.1)	11 (35.5)	***14 (45.2)***	13.258	3	0.005*
I feel invigorated after working with those I nurse	8 (25.8)	6 (19.4)	***12 (38.7)***	3 (9.70	2 (6.5)	10.452	4	0.033*

4.6.2 Respondents experience of Burnout

In spite of the respondents having reported high compassion satisfaction (43.15 Table 4.8), there is an average degree of burnout (22.82 Table 4.8) amongst the nurses working in Thuthuzela Care Centres. Table 4.3 shows that a little more than a third (38.7%, n= 12) of the respondents reported to never finding it difficult to separate their personal life from their life as a nurse. (p<008). Only three (9.7%) respondents reported to often not being as productive at work because they were losing sleep over traumatic experiences of a person they nursed. (p< 017). Less than half of the respondents (41.9%, n=13) reported to sometimes feeling worn out because of their work as a nurse. (p<.001).

Ten (32.3%) respondents reported sometimes feeling overwhelmed because their case load seemed endless. (p<013). Just over half of the respondents (n=17, 54.8%) reported that because of nursing victims of sexual abuse, they have felt "on edge" about various things (p<.001). More than a third of respondents (38.7%, n =12) reported to sometimes feeling "bogged down" by the system.

Table 4.3: Respondents experience of burnout

Item	Responses as Frequency (%)					Chi-square goodness-of-fit		
	Never	**Rarely**	**Sometimes**	**Often**	**Very often**	X^2	Df	p-value
I find it difficult to separate my personal life from my life as a nurse	***12 (38.7)***	8 (25.8)	8 (25.8)	1 (3.2)	2 (6.5)	13.677	4	0.008*
I am not as productive at work because I am losing sleep over traumatic experiences of a person I nurse	12 (38.7)	8 (25.8)	7 (22.6)	***3 (9.7)***	1 (3.2)	12.065	4	0.017*
I feel worn out because of my work as a nurse	2 (6.5)	8 (25.8)	***13 (41.9)***	5 (16.1)	3 (9.7)	12.710	4	<.001*
I feel overwhelmed because my case work load seems endless	3 (9.7)	9 (29.0)	***10 (32.3)***	7 (22.6)	2 (6.5)	8.194	4	0.013*
Because of my nursing of victims of sexual abuse, I have felt "on edge" about various things	3 (9.7)	6 (19.4)	***17 (54.8)***	4 (12.9)	1 (3.2)	25.613	4	<.001*
I feel "bogged down" by the system	3 (3.2)	10 (32.3)	***12 (38.7)***	3 (9.7)	3 (9.7)	12.710	4	<.001*

4.4.5. Signs of vicarious traumatic stress

Table 4.4 shows that less than half of the respondents (n=13, 41.9%) indicated that they sometimes avoid certain activities or situations because they remind them of frightening experiences of the people they nurse (p=0.050). Ten (32.2%) of the respondents indicated that they often to very often avoided certain activities or situations because they reminded them of frightening experiences of people they nursed.

A little more than a third (35.5%, n = 11) of respondents reported that they sometimes feel depressed because of the traumatic experiences of the people they nurse, while (9.7%, n=3) indicated that they very often feel depressed because of the traumatic experiences of the people they nurse. Less than half the respondents (45,2%, n=14) indicated sometimes feeling as if they are experiencing the trauma of someone they have nursed. (p<.017). Less than half the respondents (41%, n= 13) indicated they were often preoccupied with more than one person they nursed. Just over a third of the respondents (35.4%, n= 11) reported to sometimes feeling jumpy or startled by unexpected sounds, (p<.010.). Less than half respondents (32.2%, n=10) sometimes while only five respondents (16%) reported that they might have been affected by the traumatic stress of those they nurse.

Table 4.4: Signs of vicarious traumatic stress

Item	Responses as Frequency (%)					Chi-square goodness-of-fit		
	Never	**Rarely**	**Sometimes**	**Often**	**Very often**	X^2	Df	p-value
I avoid certain activities or situations because they remind me of frightening experiences of the people I nurse(d)	4 (12.9)	4 (12.9)	***13 (41.9)***	5 (16.1)	5 (16.1)	9.484	4	0.085
Because of my caring for victims of sexual abuse, I have intrusive, frightening thoughts	5 (16.1)	3 (9.7)	***14 (45.2)***	2 (6.5)	7 (22.6)	14.645	4	0.050
I feel depressed because of the traumatic experiences of the people I nurse	5 (16.1)	8 (25.8)	***11 (35.5)***	4 (12.3)	3 (9.7)	6.903	4	0.141
I feel as though I am experiencing the trauma of someone I have nursed	4 (12.9)	3 (9.7)	***14 (45.2)***	7 (22.6)	3 (9.7)	14.000	4	0.007*
I am preoccupied with more than one person I nurse	1 (3,2)	4 (12.9)	7 (22.6)	***13 (41.9)***	6 (19.4)	12.710	4	0.013*
I jump or am startled by unexpected sounds	7 (22.6)	10 (32.3)	***11 (35.5)***	2 (6.5)	1 (3.2)	13.365	4	0.01*
I think that I might have been affected by the traumatic stress of those I nurse	6 (19.4)	9 (29.0)	***10 (32.3)***	5 (16.1)	1 (3.2)	8.194	4	0.085

2.9 **COPING STRATEGIES**

Table 4.5 shows that a little more than a third (35.5%, n=11) of the respondents indicated that they never felt trapped by their job as a nurse, while a quarter (25.8% n=8) reported that they sometimes felt trapped by their job as a nurse (p=.046). Less than half (48,4%, n=15) indicated that they very often have beliefs that sustain them. (p=.003). Only six (19.3%) reported to rarely or sometimes having beliefs that sustain them. A little less than half (45.2%, n=14) of the respondents indicated that they are very often pleased with how they keep up with nursing techniques and protocols, while a third (32.3%) reported that the are often pleased with how they keep up with nursing techniques and protocols. (p<.008).

Just under half of the respondents (48.4%, n=15) reported that very often believed they could make a difference through their work and 41.9% (n=13) often believed they could make a difference though their work (p<.001). A significant majority of the respondents (77.4%, n=24) reported that they very often felt they were caring people (p<.001). Two (6.5%) respondents reported rarely feeling like a very caring person.

Table 4.5: Coping strategies

Item	Responses as Frequency (%)					Chi-square goodness-of-fit		
	Never	**Rarely**	**Sometimes**	**Often**	**Very often**	X^2	Df	p-value
I am pleased with how I can keep up with nursing techniques and protocols	-	3 (9.7)	3 (9.7)	10 (32.3)	***14 (45.2)***	11.867	3	0.003*
I believe I can make a difference through my work	1 (3.2)	-	2 (6.5)	13 (41.9)	***15 (48.4)***	20.484	3	0.001*
I am a very caring person	-	2 (6.5)	-	5 (16.1)	***24 (77.4)***	27.548	2	0.004*
I feel trapped by my job as a nurse	***11 (35.5)***	6 (19.4)	8 (25.8)	1 (3.2)	4 (12.9)	9.667	4	0.046*
I have beliefs that sustain me	-	1 (3.2)	5 (16.1)	10 (32.3)	***15 (48.4)***	14.290	3	0.003*

4.5. VALIDITY AND RELIABILITY

Factor analysis with Promax rotation was applied to the 30 items measuring the three constructs (compassion satisfaction, burnout and secondary traumatic stress) in order to elicit the latent structure that applies to the current study. Items, that cross-loaded onto multiple factors or those that did not load strongly enough onto any factor, were systematically dropped from the analysis. What remained after these exclusions was a three factor structure involving 10 items that accounted for 61.72% of the variance in the data. The KMO (Kaiser-Meyer-Olkin) measure of sampling adequacy yielded a relatively low value of .521 which is likely due to the limited sample size. It is, however, considered by some to be adequate and indicates adequacy of the data. Bartlett's test of sphericity was significant thus indicating that the variables are related and therefore suitable for factor analysis. Rotation converged in 5 iterations.

4.6. FACTOR ANALYSIS

The factor loadings are shown in Table 4.6 and further information about the factors are summarized in Table 4.7

Table 4.6: Factor loadings

	Factor		
	1	2	3
27 I have thoughts that I am a "success" as a nurse	.828		
20 I have happy thoughts and feelings about those I nurse and how I could help them	.818		
18 My work makes me feel satisfied	.793		
30 I am happy that I chose to do this work	.751		
19 I feel worn out because of my work as a nurse		.773	
4R I do not feel connected to others		.678	
10 I feel trapped by my job as a nurse		.639	
17R I am not the person I always wanted to be		.545	
28 I can't recall important parts of my work with trauma victims			.950
25 Because of my caring for victims of sexual abuse, I have intrusive, frightening thoughts			.661

Table 4.7: Constructs in the data

Factor	Construct	Items included	Percentage variance extracted	Cronbach's alpha (reliability)
1	Compassion satisfaction (CS)	18, 20, 27, 30	26.96	.782
2	Burnout (BO)	4R, 10, 17R, 19	22.59	.567
3	Secondary traumatic stress (STS)	25, 28	12.17	.662

4.7. CONSTRUCTS IN THE DATA

The reliability of compassion and secondary traumatic stress are both shown to be adequate. Cronbach's alpha of .567 for burnout indicates that results need to be interpreted with a little caution.

Scoring of these composite variables is done by calculating the sum of the scores across the items included in the construct. These variables are then rescaled to reflect scores as if there are 10 items included in each construct. This is done so that the interpretation of the scores can be done according to that given for the ProQol scales. Using the criteria given with the ProQol scales, analysis shows that compassion satisfaction is high, while both burnout and secondary traumatic stress are average (Table 4). Table 4.9 explains the classification of scores.

Table 4.8 Levels of compassion satisfaction, burnout and secondary traumatic stress

Construct	Average of the rescaled scores taken across the sample	Actual classification
Compassion satisfaction (CS)	43.15	High
Burnout (BO)	22.82	Low
Secondary traumatic stress (STS)	28.39	Low

Table 4.8 Classification of scores according ProQOL

Theoretical cut-off values	Theoretical classification
22 or less	Low
23 to 41	Average

4.8. CORRELATIONS BETWEEN THE CONSTRUCTS

The correlation was done to establish the relationship between burnout, compassion satisfaction and secondary traumatic stress. While no significant correlations exist, a moderate positive correlation between burnout and secondary traumatic scale is found to be marginal, r = .325, p=.074.

Table 4.9: Correlation between the constructs

	Secondary Traumatic Scaled	Burnout Scaled	Compassion satisfaction Scaled
Compassion satisfaction scaled Pearson Correlation	0.1	0. 126	0.093
Sig (2-tailed)	-	0. 498	0.620
N	31	31	31
Burnout scaled Pearson Correlation	0.126	1	0.325
Sig(2-tailed)	0. 498		0.074
N	31	31	31
Secondary traumatic scaled Pearson	0.093	0.325	1
Sig (2-tailed)	0.620	0.074	
N	31	31	31

Cronbach's alpha of .567 for burnout indicates that results need to be interpreted with a little caution. Scoring of these composite variables was done by calculating the sum of the scores across the items included in the construct. These variables were then rescaled to reflect scores as if there were 10 items included in each construct. This was done so that the interpretation of the scores could be done according to that given for the ProQol scales. Using the criteria given with the ProQol scales, analysis showed that compassion satisfaction was high, while both burnout and secondary traumatic stress were average, (Table 4.8)

Table 4.10: Reliability

Factor	Construct	Items included	Percentage variance extracted	Cronbach's alpha (reliability)
1	Compassion satisfaction (CS)	18, 20, 27, 30	26.96	.782
2	Burnout (BO)	4R, 10, 17R, 19	22.59	.567
3	Secondary traumatic stress (STS)	25, 28	12.17	.662

4.9. THE VALIDITY AND RELIABILITY

The validity and reliability of ProQol is shown on the Table 4.12 as it was used by different authors in different research studies. The first part shows that ProQol is reliable and valid to utilise to assess whether the any professional experience support in execution of their work or not, whereas the second part indicates that ProQol can be used to assess the level of occupational disease experienced by staff in an organisation. Therefore, ProQol is the reliable and valid scale to utilise to the experience of nurses caring for victims of sexual abuse.

Table 4.12 Validity and reliability

Reference	Validity	Reliability
Kessler J.M and Fukui S 2020. Factor structure of the professional quality of life scale among direct support professionals: factorial validity and scale reliability *Journal of Intellectual Disability Research* 64 (9): 681 - 689	Confirmatory factor analysis confirmed the factorial validity following some modifications	These modifications also improved the reliability. Cronbach`s alpha for BO improved from 0.78 (10 items) to 0.82 (seven items), and the for STS improved from 0.82 (10 items) to 0.85 (eight items). The CS retained the original 10 items and alpha remained as 0.92.
Dang W, Cheng W, Ma H, Lin J, Wu B, Ma N, Wang R, Xu J, Zhou T, Yu X. 2015. Reliability and validity of Professional Quality of Life Scale among government staff in earthquake - stricken areas in China. *Chinese Journal of Industrial Hygiene and Occupational Diseases* 33(6):440-443	P value was 0.88 in the chi-square test of confirmatory factor analysis model. Goodness-of-fit indices of ProQOL-30 included GFI=0.895 NFI=0.856, CFI=0.895, RMSEA=0.063, and AGFI=0.912. P value was 0.91 in the chi-square test of confirmatory factor analysis model test. Goodness-of-fit indices of ProQOL-28 were GFI =0.913, AGFI =0.924, NFI =0.900, CFI =0.913, and RMSEA =0.031 ProQOL-28 has good reliability and validity among government staff in the earthquake-stricken areas in China.	The Cronbach's α coefficients of the three subscales were 0.864, 0.569, and 0.742 respectively, and the split-half reliabilities were 0.829, 0.490, and 0.677, respectively. For the ProQOL-28 as an optimised version of ProQOL-30, the Cronbach's a coefficients for burnout and trauma/compassion fatigue increased to 0.616 and 0.757, respectively

4.10. CONCLUSION

The study has shown that a high percentage of nurses had compassion satisfaction. The compassion fatigue was also average at (28.39%). Overall vicarious post-traumatic stress level was at the average (22.82%), and The results of the study indicate that vicarious post-traumatic stress levels exist in nurses caring for victims of sexual abuse at Thuthuzela Care Centres.

5. CHAPTER 5: DISCUSSIONS OF THE FINDINGS,

CONCLUSIONS AND RECOMMENDATIONS

5.1. INTRODUCTION

This chapter covers the discussion of the findings from this study, conclusions and recommendations. The purpose of this study was to determine whether vicarious post-traumatic stress occurs in nurses caring for victims of sexual abuse in Thuthuzela Care Centres in Kwa -Zulu Natal. The objectives were: (i) to determine whether nurses caring for victims of sexual abuse had compassion satisfaction. (ii) to determine if nurses caring for victims of sexual abuse experienced burnout (iii) describe the signs of vicarious post- traumatic stress if any, in nurses caring for sexually abused victims. (iv) to determine coping strategies used by nurses when coping with the vicarious stress of their job.

5.2. SOCIO DEMOGRAPHICS

This study found that the average age of the nurses working in Thuthuzela Care Centres was middle aged. All respondents in this study were female. Zafra (2015: 103) states that nursing a female dominated profession. According to Zafra (2015: 103), traditionally, females have been prescribed, as nurturing individuals. Nurturing is fundamental to nursing taking care of individuals and nursing them back to health.

5.3. QUALITY OF LIFE OF THE NURSES CARING FOR VICTIMS OF SEXUAL ABUSE IN THUTHUZELA CARE CENTRES

Compassion satisfaction in nurses caring for victims of sexual abuse in Thuthuzela Care Centres was found to be high. Secondary traumatic stress which is described as vicarious traumatic stress in this study and burnout were found to be average.

This corresponds with another study by, Letson *et al*. (2020:732), who indicated that compassion satisfaction at work is brought about though socializing with family, friends and talking with their life partners which assists them to distress.

Furthermore, a study by Lynch, Shuster, and Lobo (2018:1423) found that the majority of participants (71%) reported high levels of caregiver burden, moderate to low levels of the compassion fatigue concepts of burnout (59.5%) and secondary traumatic stress (STS) (50%), and moderate levels of compassion satisfaction (82.7%). Experiencing compassion satisfaction, practising multiple and frequent self-care strategies lowered burnout risk.

5.4. BURNOUT

This study found that just over half of respondents indicated that they sometimes feeling "on the edge" about several things because of their nursing of victims of sexual abuse. Burnout was originally conceptualized as a response to job stress produced by the demands of helping clients in great need (Maslach and Jackson, 1982). Secondary traumatic stress increased burnout risk (Kim *et al*, 2017:981).

According to Queiros, Carlotto, Kaiseler, Dias and Pereira (2013: 330), burnout has received extensive attention from researchers over the last 35 years. Additionally, burnout has recently been considered to be a public health problem. (Gill- Monte, 2009)

Nurses are considered to be particularly susceptible the danger of burnout, due to the very stressful nature of their work, which has a negative impact on their mental and physical capacity and their efficacy and productivity (Gill-Monte, 2009, Hudek-Knezevic, and Krapic, 2011, cited in Queiros, *et al*., 2013;331)

Figley (1995) developed the concept of compassion fatigue in recognition of the constellation of symptoms often experienced by those who provide helping services to victims of traumatic events. Often used interchangeably with the term secondary traumatic stress, compassion fatigue is characterized by symptoms mirroring PTSD in that the clinician re-experiences the client's traumatic event, engages in avoidance/numbing of reminders, and experiences persistent arousal as a result of being exposed to knowledge of the client's trauma (Adams., Boscardino and Figley. 2006:108). More over a study done by Kelly, Johnson., Bay, and Todd, (2021:11) indicated that 61% of the nurses caring for victims, experience burnout. This supports the results of this study which indicated that over a half of respondents revealed that they experience burnout.

Caring for victims of sexual abuse require emotional intelligence, self-awareness and the ability to recognise how they are feeling and act on this. They need to develop social skills to manage emotions in relationships and be able to assess situations while interpreting and responding to the needs of others (Goleman 1998: ii). It is essential for nurses to feel safe in opening up about any potential secondary traumatic stress symptoms they have. Social

support can be valuable in reducing secondary traumatic stress symptoms (Morrison and Joy 2016). Evidence shows that having a supportive network with colleagues is a positive way to prevent the development of vicarious traumatic stress (Lavoie, et al. 2011:73)

5.5. THE SIGNS OF VICARIOUS POST-TRAUMATIC STRESS

The findings of this study indicate that less than half of the respondents reported that they sometimes feel depressed while very few indicated that they very often feel depressed because of the traumatic experiences of the people they nurse. Less than half number of the respondents indicated that they are not as productive at work, because they are losing sleep over traumatic experiences of the people they nurse. Less than half of respondents reported that they sometimes have intrusive, frightening thoughts while less than a quarter reported that they very often have intrusive, frightening thoughts because of their caring for victims of sexual abuse.

A qualitative study by Nen, et al. (2011: 153), found that participants reported having trouble sleeping due to their involvement with the victims of sexual abuse. Furthermore, a study by Hunt, (2018) revealed that participants explained that hearing stories of sexual trauma often disturbed the way they view themselves in the world, causing them to question the safety of themselves and others. Similarly, Kennedy and Booth (2022: 8) found that vicarious traumatization manifests as physical and emotional symptoms of distress, which can disrupt a nurse's ability to provide competent care. Specifically, the results demonstrate that these mediators for compassion fatigue explain 27% of the variance in nurses' emotional exhaustion, 16% of the variance in their depersonalization, and 22% of the variance in their sense of accomplishment at work., (Sainsbury,2015:116). This confirms the results of this study which indicated an average number of nurses (35.5%, n = 11) caring for victims of sexual abuse experience signs of vicarious traumatic stress.

5.6. COPING STRATEGIES USED BY NURSES IN COPING WITH VICARIOUS STRESS OF THEIR JOB.

This study found that less than a half the of respondents indicated that they very often have beliefs that sustain them and still more reported often having such beliefs. More than three quarters of respondents in this study reported that they are pleased with how they keep up with nursing techniques and protocols.

This is supported by the results of a study conducted by, Setti, Lourel and Argentario. (2021:261) who found that affective commitment is an important coping resource that protects individuals such as nurses caring for victims of sexual abuse against negative including

burnout and posttraumatic symptoms. Peled-Avram, (2017:26) indicated that about 9 % of respondents in their study had a high-average level of vicarious traumatization, and another 14 % had high levels of vicarious traumatization (very high and extremely high). These findings suggest that beyond personal characteristics, the level of exposure to traumatized clients has a significant effect on nurses caring well-being of for victims of sexual abuse.

5.7. LIMITATIONS OF THE STUDY

The current study only focused on the nurses caring for victims of sexual abuse from five Thuthuzela Care Centres that were accessible to the researcher. In the Thuthuzela Care Centres that were visited the number of nursing staff was limited because some were on vacation leave, sick leave, and maternity leave, thus the findings of this study cannot be generalized to all nurses caring for victims of sexual abuse.

5.8. RECOMMENDATIONS

There is clearly scope for research specifically with nurses caring for victims of sexual abuse and the existence of vicarious post- traumatic stress in all healthcare settings. There should be services of this nature (Thuthuzela Care Centres) in all health districts in KwaZulu Natal. The South African Occupational Health and Safety Act requires employers to provide a healthy safe work environment. Employers have a legal obligation to provide health services for occupational disease which include psychological services.

5.8.1. Nursing Management

Based on the findings of this study it is recommended that psychological services such as debriefing be done on regular basis. Access for nurses who are having mental health challenges related to their work in the Thuthuzela Care Centres should be available. There should be policies and procedures to guide management regarding psychological service.

5.8.2. Nursing Research

It is recommended that there be more studies done on the assessing vicarious trauma in nurses caring for victims of sexual abuse.in all healthcare settings. and other nursing environments where nurses are exposed to traumatic incidents and victim’s stories.

5.8.3. Nursing Practice

The nursing practice recommendation is that all nurses working in Thuthuzela Care Centres should be given a mandatory debriefing. There should be in-service training on: a) how to deal

with the victims so that they develop coping skills in the execution of their job to avoid stressing out easily, b) effects of working in these settings, c) and self-care management of their stress

5.9. CONCLUSION

This chapter dealt with the discussion of findings, limitation of the study as well as recommendations. It is clear that vicarious post-traumatic stress is a predictable outcome of significant exposure to traumatized people. This may occur at different times in different individuals whose nature of work expose them to traumatized people. In this study it is specifically the result of exposure of nurses to victims of sexual abuse. Therefore, it is the responsibility of all these organisations to have a realistic plan, implement, monitor and evaluate the effectiveness to benefit the employees of such departments. This will enhance compassion satisfaction which is required in caring for the victims of sexual abuse.

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ANNEXURES

Annexure A

House no.1

Grouper Gardens

Newlands East

4037

21/ 11/18

The Author

Beth Hudnall Stamm, PHD

ProQol org

Info@proqol.org

Re: REQUEST FOR PERMISSION TO USE PROQOL SCALE CONDUCT A RESEARCH STUDY

I am presently registered for Master's Degree at Durban University of Technology in the Department of Nursing. My student no.is (21853113). The proposed title of my study is assessment of vicarious post-traumatic stress in nurses caring for victims of sexual abuse in Thuthuzela Care centers in KwaZulu Natal.

I hereby request permission to use ProQol scale and reformat it in a template form to fit the type of Likert scale suit my study. Data will be collected by means of questionnaire that will be given to nurses caring for victims of sexual abuse. Participation is voluntary and informed consent will be obtained from all participants. Confidentiality will be maintained at all times. Please find attached copy of my research proposal.

Sincerely:

N. H. Hlomuka(Researcher) Dr Penny Orton (Supervisor).

Annexure B

Permission to Use the ProQol

Thank you for your interest in using the Professional Quality of Life Measure (ProQol). Please share the
following information with us to obtain permission to use the measure:

Please provide your contact information:

Email Address

nhlanhlohlomuka15@gmail.com

Name

Nonhlanhla Hlomuka

Organization Name, if applicable

Durban University of Technology

Country

South Africa

Please tell us briefly about your project:

Assessment of vicarious post-traumatic stress on nurses caring for victims of sexual abuse in Thuthuzela Care Centres

What is the population you will be using the ProQol with?

Nurses working in Thuthuzela Care Centre regardless of their categories

In what language/s do you plan to use the ProQol?

Listed here are the languages in which the ProQol is currently available
(see https://proqol.org/ProQol_Test.html). If you wish to use a language not listed here, please select "Other"
and specify which language/s.

English

The ProQol measure may be freely copied and used, without individualized permission from the ProQol office,
as long as:

You credit The Centre for Victims of Torture and provide a link to www.ProQOL.org;

It is not sold; and

No changes are made, other than creating or using a translation, and/or replacing "[helper]" with a more
specific term such as "nurse."

Note that the following situations are acceptable:

You can reformat the ProQol, including putting it in a virtual format

You can use the ProQol as part of work you are paid to do, such as at a training: you just cannot sell the measure itself

Does your use of the ProQol abide by the three criteria listed above? (If yes, you are free to use the ProQol

immediately upon submitting this form. If not, the ProQol office will be in contact in order to establish your

permission to use the measure.)

Yes

Thank you for your interest in the ProQol! We hope that you find it useful. You will receive an email from the

ProQol office that records your answers to these questions and provides your permission to use the ProQol.

We invite any comments from you about the ProQol and the experience of using it at proqol@cvt.org. Please

also contact us if you have any questions about using the ProQol, even if you noted them on this form. Note

that unfortunately, our capacity is quite limited so we may not be able to respond to your note: however, we

greatly appreciate your engagement.

Annexure:C

Institutional Research Ethics Committee
Research and Postgraduate Support Directorate
2nd Floor, Berwyn Court
Gate 1, Steve Biko Campus
Durban University of Technology
P O Box 1334, Durban, South Africa, 4001
Tel: 031 373 2375
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics
www.dut.ac.za

28 April 2020
Ms N H Hlomuka
House No. 1
Grouper Gardens
Newlands east
4037

Dear Ms Hlomuka

Assessment of vicarious post-traumatic stress in nurses caring for victims of sexual abuse in Thuthuzela Care Centres in KwaZulu Natal
Ethical Clearance number IREC 189/19

The Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letter.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.
Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC Standard Operating Procedures (SOP's).

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely
Professor J K Adam

Chairperson: IREC

Annexure D

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DIRECTORATE: Senior Manager: Medical

Physical Address

Tel: 0319078317 **Fax:** 0319061044

Email address: myint.aung@kznhealth.gov.za d

Enquiry: Dr M AUNG

Ref No: 08/RESH/2022

Date: 11/05/2022

TO: Nonhlanhla Hazel Hlomuka

RE: LETTER OF APPROVAL TO CONDUCT RESEARCH AT PMMH

Dear Researcher;

I have pleasure to inform you that approval has been granted to you by PMMH to conduct research on **"Assessment of vicarious post-traumatic stress in nurses caring for victims of sexual abuse in Thuthuzela Care Centres in KwaZulu Natal"**.

Please note the following:

1. Please ensure this office is informed before you commence your research.
2. The institution will not provide any resources for this research.
3. You will be expected to provide feedback on you finding to the institution.

The management of Prince Mshiyeni Memorial Hospital reserves the right to terminate the permission for the study should circumstance so dictate.

With kind regard

MYINT AUNG
Senior Medical Manager & specialist in Family Medicine
MBBS, DO(SA), PGDip in HIV (Natal), M.Med.Fam.Med (natal), PhD
Tel: 031 9078317; Fax: 031 906 1044
myint.aung@kznhealth.gov.za

GROWING KWAZULU-NATAL TOGETHER

Annexure E

THE NPA POLICY FOR REQUESTS TO CONDUCT RESEARCH IN THE NATIONAL PROSECUTING AUTHORITY

Version	V02
Revision	0.1
Author	Kefentse Mojaki-Moremogolo
Contributors	The Research Management Team
Editor	Thomas Tshilowa & Dr David Broughton
Policy Owner	Director: Research Management
Date Approved by Executive Committee	
Effective Date	Date of approval
Reference Number	2/6/P
Classification	Not applicable
Supersedes (previous policy)	Policy Standard on Request to Conduct Research in the National Prosecuting Authority, 2017
Superseded by (if no longer in effect)	

Notice

Annexure F

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langalibalele Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email: [redacted]
www.kznhealth.gov.za

DIRECTORATE:
Health Research & Knowledge Management

NHRD Ref: KZ_202003_017

Dear Ms N H Hlomuka
(DUT)

Approval of research

1. The research proposal titled **'Assessment of vicarious post-traumatic stress in nurses caring for victims of sexual abuse in Thuthuzela Care Centers in KwaZulu-Natal'** was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

   The proposal is hereby **approved** for research to be undertaken at the selected Thuthuzela Centers situated at RK Khan, Port Shepstone, Mahatma Gandhi, Ngwelezana, Madadeni, Prince Mshiyeni Memorial, Edendale, Addington and Ladysmith hospitals provided that you obtain the support letters from the relevant districts or the District Health Services Director as advised on your online application (Ref KZ_202003_017).

2. You are requested to take note of the following:
   a. *Kindly liaise with the facility manager BEFORE your research begins in order to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.*
   b. *Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.*
   c. *Provide an interim progress report and final report (electronic and hard copies) when your research is complete to* ***HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200*** *and e-mail an electronic copy to hrkm@kznhealth.gov.za*
   d. *Please note that the Department of Health shall not be held liable for any injury that occurs as a result of this study.*

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 25/03/2020

Fighting Disease, Fighting Poverty, Giving Hope

Annexure G

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address : R.K. Khan Circle
Physical Address : CHATSWORTH
Tel: [031] 4596001 Fax:[031] 4011247 Email:Dianne.naicker@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
R.K. KHAN HOSPITAL
OFFICE OF THE SENIOR
MANAGER: MEDICAL SERVICES

ENQUIRIES: DR B.S. MADLALA

16 FEBRUARY 2022

Ms N.H. Hlomuka
House No. 1
Grouper Gardens
Newlands East
4037

Dear Ms Hlomuka

RE: PERMISSION TO CONDUCT RESEARCH STUDY: ASSESSMENT OF VICARIOUS POST-TRAUMATIC STRESS IN NURSES CARING FOR VICTIMS OF SEXUAL ABUSE IN THUTHUZELA CARE CENTRES IN KWAZULU-NATAL

Permission is granted to conduct the above study at this institution.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures protocols and guidelines of the Institution with regards to this research.

2. Please ensure this office is informed before you commence your research and your University's Ethics approval must be attached.

3. **You will be expected to provide feedback on your findings to this institution.**

4. You will be liaising with: OM C.G. Cele
Unit Manager
TCC
Tel: 031-4596098

Yours faithfully

DR B.S. MADLALA
SENIOR MANAGER: MEDICAL SERVICES

Fighting Disease, Fighting Poverty, Giving Hope

Annexure: H

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

PORT SHEPSTONE REGIONAL HOSPITAL
Private Bag X5706, PORT SHEPSTONE, 4240
11 Bazley Street, PORT SHEPSTONE 4240
Tel: 039-6886208 Fax: 039-6821514

KWAZULU-NATAL DEPARTMENT OF HEALTH
PORT SHEPSTONE REGIONAL
HOSPITAL

Reference: HRKM140/15
Enquiries: Mr. LI Hlabe
Date: 09 March 2022

Dear Ms. NH Hlomuka
(UKZN) Student

Dear Sir

RE: PERMISSION FOR RESEARCH STUDY PROPOSAL TITLED: "ASSESSMENT OF VICARIOUS POST-TRAUMATIC STRESS IN NURSES CARING FOR VICTIMS OF SEXUAL ABUSE IN THUTHUZELA CARE CENTRES IN KWAZULU-NATAL" TO BE CONDUCTED BY MS. NH HLOMUKA)

Your application dated 07/03/2022 refers

Authority to conduct the above mentioned research at Port Shepstone Regional Hospital has been approved by the Department of Health Research Committee. You are therefore granted the permission to access the institution and consult with the relevant supervisors on the dates when you will avail yourself for the research.

You are also requested to communicate your findings with the institution

Kind regards

Ms. BC Ndlovu
Chief Executive Officer
Port Shepstone Regional Hospital

5

Annexure: I

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

MAHATMA GANDHI MEMORIAL HOSPITAL

Postal Address : Private Bag X 13, Mount Edgecombe, 4300
Physical Address: 100 Phoenix Highway, Phoenix,4068
Tel: 031 502 17919 Fax: 086 575 6612 Email address: nancy.bridgemohun@kznhealth.gov.za
www.kznhealth.gov.za

Office of the Medical Manager

Reference: Research 03/2022

Date: 13 June 2022

MS N H HLOMUKA
DUT

RE: PERMISSION TO CONDUCT RESEARCH AT MAHATMA GANDHI MEMORIAL HOSPITAL

I have pleasure in informing you that permission has been granted to you by Mahatma Gandhi Memorial Hospital to conduct research. Title of research : Assessment of vicarious post-traumatic stress in nurses caring for victims of sexual abuse in Thuthuzela Care Centres in KwaZulu Natal."

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. Please ensure this office is informed before you commence your research.
3. The Hospital will not provide any resources for this research.
4. You will be expected to provide feedback on your findings to the Hospital.
5. You are required to contact this office regarding dates for providing feedback when the research has been completed.

DR C PERSAD
MEDICAL MANAGER

Annexure: J

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DIRECTORATE:
MEDICAL SERVICES
SENIOR MANAGER : MEDICA L SERVICES

Postal Address: Private Bag x 20021 Empangeni 3880
Physical Address: Thanduyise Road- Empangeni 3880
Tel:035-9017273 Fax: 0865196873 Email address : tobias.gumede@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Mr TB Gumede
Date: 02.03.2022

To: Ms. N.H. Hlomuka
Durban University of Technology
Durban 4000

Dear Sir / Madam

RE: PERMISSION TO CONDUCT RESEARCH AT NGWELEZANA TERTIARY HOSPITAL

I have pleasure in informing you that permission has been granted to you by Ngwelezana Tertiary Hospital Ethics and Research Committee to conduct research titled **"Assessment of vicarious post-traumatic stress in Nurses caring for victims of sexual abuse in Thuthuzela Care Centre in Kwazulu-Natal"**

Please note the following:-

1. The committee recommended that participants who indicate that they are stressed are provided with follow-up support and counselling.
2. Therefore the committee recommend that you put a qualitative aspect of the study.
3. Please ensure that you adhere to all policies, procedure, protocols and guidelines of the Department of Health with regards to research.
4. Confidentiality of hospital information, including staff and patients or contact information must be kept confidential at all times, patient records are not to be removed from the hospital premises nor you are not allowed to photocopy/ photograph them.
5. This Facility will not provide any resources for this research.
6. You will be expected to provide feedback on your findings to the facility.
7. The Department of Health and hospital's staff will not be held responsible for any negative incidents and or consequences including injuries and illness that may be contracted on site.
8. You are requested to make contact with **Dr RS Moeketsi, Senior Manager: Medical Services** at Ngwelezana Tertiary Hospital once you are ready to commence your study.

We would like to take this opportunity to wish you all the best in your future endeavours.

Thank you,

Recommended/ Not recommended by:

DR RS MOEKETSI
SENIOR MANAGER: MEDICAL SERVICES
CHAIRPERSON, ETHICS AND RESEARCH COMMITTEE
NGWELEZANA TERTIARY HOSPITAL

DATE 02/03/2022

Approved/ Disapproved by:

MRS C.N.N. MKHWANAZI
ACTING CHIEF EXECUTIVE OFFICER
NGWELEZANA TERTIARY HOSPITAL

DATE 03/03/2

ANNEXURE: K

House No.1

Grouper Gardens

Newlands East

4037

The CEO

R.K. Khan Hospital

Private Bag X004

Chatsworth

4093

Re: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am presently registered for Master of Health Sciences (Nursing) - degree at Durban University of Technology in the Department of Nursing. My student no.is: (21853113). The proposed title of my study is assessment of vicarious post- traumatic stress in nurses caring for victims of sexual abuse in Thuthuzela Care centers in Kwazulu Natal.

I hereby request permission to the conduct study at the Thuthuzela Care centre. Data will be collected by means of questionnaire that will be given to nurses caring for victims of sexual abuse. Participation is voluntary and informed consent will be obtained from all participants. Confidentiality will always be maintained. Please find attached copy of my research proposal.

Sincerely:

N.H.Hlomuka.(Researcher) Dr Penny Orton(Supervisor)

ANNEXURE: L

House No.1

Grouper Gardens

Newlands East

4037

The CEO

Port Shepstone Regional Hospital

Private Bag X5706

Port Shepstone

4240

Re: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am presently registered for Master of Health Sciences (Nursing) - degree at Durban University of Technology in the Department of Nursing. My student no.is: (21853113). The proposed title of my study is assessment of vicarious post- traumatic stress in nurses caring for victims of sexual abuse in Thuthuzela Care centers in Kwazulu Natal.

I hereby request permission to the conduct study at the Thuthuzela Care centre. Data will be collected by means of questionnaire that will be given to nurses caring for victims of sexual abuse. Participation is voluntary and informed consent will be obtained from all participants. Confidentiality will always be maintained. Please find attached copy of my research proposal.

Yours sincerely:

N.H.Hlomuka.(Researcher): Dr Penny Orton(Supervisor):

ANNEXURE: M

House No.1

Grouper Gardens

Newlands East

4037

The CEO

Mahatma Ghandi Hospital

Private Bag X13

Mount Edge combe

4068

Re: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am presently registered for Master of Health Sciences (Nursing) - degree at Durban University of Technology in the Department of Nursing. My student no.is: (21853113). The proposed title of my study is assessment of vicarious post- traumatic stress in nurses caring for victims of sexual abuse in Thuthuzela Care centers in Kwazulu Natal.

I hereby request permission to the conduct study at the Thuthuzela Care centre. Data will be collected by means of questionnaire that will be given to nurses caring for victims of sexual abuse. Participation is voluntary and informed consent will be obtained from all participants. Confidentiality will always be maintained. Please find attached copy of my research proposal.

Yours sincerely:

N.H. Hlomuka. (Researcher) Dr Penny Orton(Supervisor)

ANNEXURE: N

House No.1
Grouper Gardens
Newlands East
4037

18/02/2022

The CEO
Ngwelezane Hospital
Private Bag X 20021
Empangeni
3380

Re: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am presently registered for Master of Health Sciences (Nursing) - degree at Durban University of Technology in the Department of Nursing. My student no.is: (21853113). The proposed title of my study is assessment of vicarious post- traumatic stress in nurses caring for victims of sexual abuse in Thuthuzela Care centers in Kwazulu Natal.

I hereby request permission to the conduct study at the Thuthuzela Care centre. Data will be collected by means of questionnaire that will be given to nurses caring for victims of sexual abuse. Participation is voluntary and informed consent will be obtained from all participants. Confidentiality will always be maintained. Please find attached copy of my research proposal.

Sincerely:

N.H. Hlomuka. (Researcher) Dr Penny Orton(Supervisor)

Date: 18/02/2022

ANNEXURE: O

House No.1
Grouper Gardens
Newlands East
4037

The CEO
Madadeni Regional Hospital
Private Bag X6642
Newcastle
2940

Re: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am presently registered for Master of Health Sciences (Nursing) - degree at Durban University of Technology in the Department of Nursing. My student no.is: (21853113). The proposed title of my study is assessment of vicarious post- traumatic stress in nurses caring for victims of sexual abuse in Thuthuzela Care centers in Kwazulu Natal.

I hereby request permission to the conduct study at the Thuthuzela Care centre. Data will be collected by means of questionnaire that will be given to nurses caring for victims of sexual abuse. Participation is voluntary and informed consent will be obtained from all participants. Confidentiality will always be maintained. Please find attached copy of my research proposal.

Sincerely:

N.H. Hlomuka. (Researcher) Dr Penny Orton(Supervisor)

ANNEXURE P

House No.1
Grouper Gardens
Newlands East
4037

The CEO
Prince Mshiyeni Hospital
Private Bag X 07
Mobeni
4080

Re: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am presently registered for Master of Health Sciences (Nursing) - degree at Durban University of Technology in the Department of Nursing. My student no.is: (21853113). The proposed title of my study is assessment of vicarious post- traumatic stress in nurses caring for victims of sexual abuse in Thuthuzela Care centers in KwaZulu Natal.

I hereby request permission to the conduct study at the Thuthuzela Care centre. Data will be collected by means of questionnaire that will be given to nurses caring for victims of sexual abuse. Participation is voluntary and informed consent will be obtained from all participants. Confidentiality will always be maintained. Please find attached copy of my research proposal.

Sincerely:

N.H. Hlomuka. (Researcher) Dr Penny Orton(Supervisor)

ANNEXURE Q

House No.1
Grouper Gardens
Newlands East
4037

The CEO
Eden dale Hospital
Private Bag X509
Plessislaer
3216

Re: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am presently registered for Master of Health Sciences (Nursing) - degree at Durban University of Technology in the Department of Nursing. My student no.is: (21853113). The proposed title of my study is assessment of vicarious post- traumatic stress in nurses caring for victims of sexual abuse in Thuthuzela Care centers in KwaZulu Natal.

I hereby request permission to the conduct study at the Thuthuzela Care centre. Data will be collected by means of questionnaire that will be given to nurses caring for victims of sexual abuse. Participation is voluntary and informed consent will be obtained from all participants. Confidentiality will always be maintained. Please find attached copy of my research proposal.

Sincerely:

N.H. Hlomuka. (Researcher) Dr Penny Orton(Supervisor)

ANNEXURE: R

House No.1
Grouper Gardens
Newlands East
4037

The Health Research and Knowledge Management Company
KwaZulu Natal Department of Health
Private Bag x 9051
Petermaritzburg
3200
Dear Sir/Madam

RE- REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am presently registered for Master of Health Sciences (Nursing) - degree at Durban University of Technology in the Department of Nursing. My student no.is: (21853113). The proposed title of my study is study is assessment of vicarious post- traumatic stress in nurses caring for victims of sexual abuse in Thuthuzela Care centers in KwaZulu Natal. I hereby request permission to conduct study at the hospitals where Thuthuzela Care Centers are situated.

Data will be collected by means of questionnaire that will be given to nurses caring for victims of sexual abuse. Participation is voluntary and informed consent will be obtained from all participants. Confidentiality will always be maintained. Please find attached copy of my research proposal. Please find attached copy of my research proposal.

Yours sincerely

N. Hlomuka

ANNEXURE: S

LETTER OF INFORMATION

Title of the Research Study:

Assessment of vicarious post-traumatic stress on nurses caring for victims of sexual abuse in Thuthuzela Care Centers in KwaZulu Natal

Principal Investigator/s/researcher:

Nonhlanhla H. Hlomuka, B Hon (Nursing Education)

Co-Investigator/s/supervisor/s:

Dr Penny Orton (PHD) Nursing

Brief Introduction and Purpose of the Study:

Greetings to you and thank you for considering participating in my study

There have been a number of studies exploring vicarious post-traumatic stress for various health care workers caring for victims of sexual abuse, but little information is known about the risk for nurses. The purpose of this study will be to determine whether vicarious post-traumatic stress occurs in nurses caring for victims' sexual abuse in Thuthuzela Care Centers in Kwa Zulu- Natal.

Outline of the Procedures:

You are requested to respond honestly in a questionnaire provided by writing a number which best describe your experience in the last thirty days or more than 44 days. Consider each question about you and your current work situation.

This questionnaire measures compassion satisfaction, fatigue, signs of vicarious post-traumatic stress and secondary traumatic stress related with repeated exposure to victims of sexual abuse. It should be answered by a nurse by who interacts with the victims of sexual abuse in the execution of their duties regardless of the nurses' category. It will take 30 minutes of your lunch break to fill in this questionnaire. There will be no follow ups done after the respondents have completed the questionnaire. There is no risk and any form of adverse action attached with filling in questionnaire as anonymity will be maintained. Please do not put your name onto the questionnaire.

Risks or Discomforts to the Participant:

There are no risks in participating in this study, and participating is voluntary.

Benefits:

This study is expected to benefit you indirectly through the results which will be provided to Thuthuzela Care Centers management and hopefully strengthen the implementation of debriefing programmes and encourage the nurses to attend.

Reason/s why the Participant May Be Withdrawn from the Study:

Participation is voluntary and may withdraw at any time if you feel uncomfortable by participating in this study. There will be no adverse consequences for the respondent should you choose to withdraw.

Remuneration

Respondents will receive no monetary remuneration, but they will be provided with a pen after completing the questionnaire as a token to acknowledge their participation.

Costs of the Study:

Respondents are not expected to cover any cost towards the study.

Confidentiality:

There should be no respondents name written on the questionnaire. Special codes will be allocated to each questionnaire. The completed questionnaires will be kept in a box and then locked cupboard for period of five years. They will then be shredded with the shredding machine. The electronic information related to the study will be kept in a special folder and be locked with the password protected computer which only the researcher can access. Electronic information will also be deleted completely after five years by the researcher.

Research-related Injury:

There is no risk or any form of adverse action anticipated related to participation in this study. There will be no compensation for respondents.

Persons to Contact in the Event of Any Problems or Queries:

Supervisor:

Dr Penny Orton, tel no. 031 373 2375, Email: pennyo@ dut.ac.za,

Please contact the researcher:

Ms. Nonhlanhla H. Hlomuka, Cell no: 0604770529, or Email: nhlanhlohlomuka15@gmail .com

My Supervisor: Dr Penny Orton, tel no. 031 373 2375 , Email : pennyo@ dut.ac.za or the Institutional Research Ethics Administrator on 031 373 2375. Complaintș can be reported to the Director: Research and Postgraduate Support, Prof S Moyo on 031 373 2577 or moyos@dut.ac.za

General

All potential respondents are rest assured that participation in this study is voluntary and the number of respondents expected in this study is 80. A copy of this information letter will be issued to the respondents. The information letter and consent form was not translated to isiZulu because all the respondents are the nurses and they understand English and the researcher will be available for clarity of any question that may arise pertaining the study.

ANNEXURE Y

Instrument (Questionnaire)

Select the ONE option that applies best to you. There are no right and wrong answers.

SECTION 1

Demographic Information

6 What is your gender

Male	Female

7 What is your age?

18 – 25 years	26 – 35 years	36 – 45 years	46 -55 years	56+ years

8 What category of nurse best describes you? (Select **ONE** option only)

ENA	
EN	
Registered Nurse without midwifery	
Professional Nurse with midwifery	
Professional Nurse with an additional qualification	

9 How long (in years and months e.g. 2 years 1 month) have you been nursing?

_____ years _____ months

10 How long (in years and months) have you been working at Thuthuzela centre?

_____ years _____ months

SECTION 2

Adapted from PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL) Version 5 (2009)
Compassion Satisfaction and Compassion Fatigue

When you nurse people, you have direct contact with their lives. As you may have found, your compassion for those you nurse can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a nurse. Consider each of the following questions about you and your current work situation. Select the number from 1 to 5 that honestly reflects how frequently you experienced these things in the ***last 30 days*****.**

	1 = Never	2 = Rarely	3 = Sometimes	4 = Often	5 = Very Often
1 I am happy					
2 I am preoccupied with more than one person I nurse					
3 I get satisfaction from being able to nurse people					
4 I feel connected to others					
5 I jump or am startled by unexpected sounds					
6 I feel invigorated after working with those I nurse					
7 I find it difficult to separate my personal life from my life as a nurse					
8 I am not as productive at work because I am losing sleep over traumatic experiences of a person I nurse					
9 I think that I might have been affected by the traumatic stress of those I nurse					
10 I feel trapped by my job as a nurse					
11 Because of my nursing of victims of sexual abuse, I have felt "on edge" about various things					
12 I like my work as a nurse					
13 I feel depressed because of the traumatic experiences of the people I nurse					

	1 = Never	**2 = Rarely**	**3 = Sometimes**	**4 = Often**	**5 = Very Often**
14 I feel as though I am experiencing the trauma of someone I have nursed					
15 I have beliefs that sustain me					
16 I am pleased with how I can keep up with nursing techniques and protocols					
17 I am the person I always wanted to be					
18 My work makes me feel satisfied					
19 I feel worn out because of my work as a nurse					
20 I have happy thoughts and feelings about those I nurse and how I could help them					
21 I feel overwhelmed because my case work load seems endless					
22 I believe I can make a difference through my work					
23 I avoid certain activities or situations because they remind me of frightening experiences of the people I nurse(d)					
24 I am proud of what I can do to care for victims of sexual abuse					
25 Because of my caring for victims of sexual abuse, I have intrusive, frightening thoughts					

26 I feel "bogged down" by the system					
27 I have thoughts that I am a "success" as a nurse					
28 I can't recall important parts of my work with trauma victims					
29 I am a very caring person					
30 I am happy that I chose to do this work					

Thank you for taking time to answer this questionnaire

Annexure U: Editting Certificate

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EDITING CERTIFICATE

Re: **NONHLANHLA H. HLOMUKA**
DUT Master's dissertation: **ASSESSMENT OF VICARIOUS POST-TRAUMATIC STRESS IN NURSES CARING FOR VICTIMS OF SEXUAL ABUSE IN THUTHUZELA CARE CENTRES IN KWAZULU-NATAL**

I confirm that I have edited this dissertation and the references for clarity, language and layout. I returned the document to the author with track changes so correct implementation of the changes and clarifications requested in the text and references is the responsibility of the author. The intellectual content of the document is the responsibility of the author. I am a freelance editor specialising in proofreading and editing academic documents. My original tertiary degree which I obtained at the University of Cape Town was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I was a part-time lecturer in the Department of Homoeopathy at the Durban University of Technology for 13 years and supervised many master's degree dissertations during that period.

Dr Richard Steele
17 March 2023
per email