

Voices of rape victims managed in an emergency department

CELIA J. FILMALTER, MARIANNE GOUS AND TANYA HEYNS

Department of Nursing Science, University of Pretoria, South Africa; E-mail:
celia.filmalter@up.ac.za

Abstract

Someone is raped every 35 seconds in South Africa. Rape victims seek healthcare from various facilities, including emergency departments. The management of rape victims is guideline driven and the way in which these victims perceive their initial management is not always taken into consideration. For healthcare providers to develop their practice, the voice of adult rape victims should be incorporated. Individual interviews were conducted with 10 participants in order to gain a deeper understanding of the rape victims' views of their initial management received in the emergency department. Content analysis was used to analyse the data. The participants voiced feelings such as; being left alone, the need for themselves to be involved during the management and the variant competencies of healthcare providers. These voiced views of the rape survivors should be incorporated in a practice development initiative to move current workplace culture in emergency departments towards a patient-centred culture.

Keywords: Adult rape victims, clinical forensic, emergency department, patient-centred, practice development, rape victim.

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Introduction

Only one in 25 rape victims report the incident to the police (Maschisa, Jewkes, Lowe-Morna & Rama, 2011). While reading this article, 28 people could be raped in South Africa – one every 35 seconds (SAPS, 2012). Rape is a global phenomenon and is regarded as a medical emergency as well as a violation of one's human rights (Jina, Jewkes, Manjanja, Mariscal et al., 2010; Donnely, 2012). Adults and children of both genders become victims of rape regardless of their social-economic status, age or culture (World Health Organization, 2003). Victims of rape are people who seek medical attention after the rape incident and only become survivors after the acute phase is over (Ledray, Burgess & Giardino, 2011; LaMonica & Pagliaro, 2013). It is, however, impractical to predict the exact timeline for the transition from rape victim to rape survivor (Ledray et al., 2011). The recovery from victim to survivor is dependent on the management the patient receives from the healthcare providers, who manage rape victims in the first few hours after the incident (Martsolf, Draucker, Cook, Ratcheneewan & Stidham, 2010).

Many rape victims that seek medical attention are referred to the emergency department for acute clinical forensic care (Patel, Roston, Tilmon, Stern et al., 2013). The management provided to rape victims in emergency departments in South Africa is based on the World Health Organization's (2003) guidelines and specifications from the National Management Guidelines for Sexual Assault (2003), with the intent to prevent re-victimisation. The combined specifications prescribe: a forensic examination; the completion of sexual-assault-evidence collection kit; administering post-exposure prophylaxis medication; documentation of examination and management; maintaining the chain of evidence; and referral to counselling and follow up (National Management Guidelines for Sexual Assault, 2003). The healthcare providers involved in the management of rape victims in an emergency department include nurses, medical examiners (doctors) and counsellors. Nurses and medical examiners in emergency departments are however inclined to sidestep rape victims and rather prioritise the management of people with injuries (Vetten & Jacobs, 2008). Victims of rape therefore can wait for long periods before management is commenced and thus contribute to the myths of rape – that somehow she deserved being raped (Suarez & Gadalla, 2011). On the other hand, if victims of rape are approached in a person-centred way it then causes feelings of value and protection that could assist the transition from rape victim to rape survivor (Martslof et al., 2011).

As custodians of physical and mental health, healthcare providers' could become more patient-centred in the management of rape victims. Practice development is an approach that can be followed to transform practice and workplace culture to become more patient-centred (McCormack, Manley & Titchen, 2013). Involving rape survivors to share their views of how they experienced their management in the emergency department is central in focusing a practice development initiative.

Methodology

A qualitative approach was used in the study to expand the understanding of the perceptions that the rape victims received during their management in the emergency department. One emergency department was used as the setting. The use of one emergency department ensured that the manner and environment in which the management was provided was similar for all the participants. The sample consisted of rape survivors 18 years and older who were in the period between three to six months after the rape incident. The sample was selected by counsellors who found the participants mentally and emotionally able and willing to participate. Their contact information was forwarded to the researchers where after communication with the participants was established. Informed consent was obtained following a discussion on the aim, involvement of participants, time spent on the interview, risks and the value of the research. Data

were collected from 10 participants through the use of an interview schedule. Although opinions differ on whether or not to collect data from rape survivors, by including them as participants in a research study contributes to the healing of themselves as well as to that of other victims of rape (Campbell & Adams, 2009).

The setting, date and time for the interview were negotiated with individual participants. Most participants preferred to be interviewed at their homes. Participants were assured of their right to withdraw at any stage of the study without pressure or adverse consequences even after informed consent had been obtained. The interviews could have exposed the participants to emotional discomfort or pain and therefore the focus of the interview was centred on the management that the participant received from healthcare providers in the emergency department. A counsellor that the participant was familiar with was on standby during each interview session in case the participant became distraught. None of the participants presented symptoms of distress or asked for a counsellor during or after their interviews.

Participants were asked to disclose their perceptions of the management they received from the healthcare providers in the emergency department after the rape incident. Data saturation was obtained after the seventh interview as further participants did not reveal any new information. However, three additional interviews were conducted to confirm data saturation. The audiotapes were transcribed verbatim. Data analysis was done through content analysis. The data was read and re-read and codes were assigned to phrases used by the participants. The codes were reduced to themes, categories and sub-categories to ease the management of the data.

Ethical Considerations

The study was approved by the Research Ethics Committee of the University of Pretoria and the hospital concerned. Ethical principles of respect for human dignity, beneficence and justice were adhered to throughout the study.

Results

The data analysis is discussed in a way that follows the management sequence of the rape victims in the emergency department since the participants described the events in this order. Findings are supported by direct excerpts from the participants.

On arrival

The rape victims were shown by a nurse into a small but private examination room in the emergency department. Participants remarked that while waiting in the examination room, their waiting times were frequently extended without any explanations given by the nurses:

'... and then they [the nurses] left me there. You just lie there [in the emergency department], and then you have to wait.'

'... it was about seven o'clock in the morning. And the doctor first came at about 10 o'clock to begin the examination. And so for that whole time you have to lie there [in the emergency department]. They [the doctor and nurses] actually do nothing. What you know is what you see on television and what you read. You are not allowed to go to the toilet...'

'... there were long periods when I was alone.'

'... I don't know why the waiting period is so long.'

The forensic examination

The majority of the participants described the forensic examination as unpleasant but necessary. Before beginning an examination, the medical examiner, informed the rape victim of the components of the examination and the time it would take. Although it was anticipated that the participants would not reveal details of the examination, some willingly spoke briefly about it during their interviews:

'It [forensic examination] was somewhat uncomfortable, especially the swab thing. But they [the doctor and nurse] also told me that it would be sore. They also explained to me exactly how I should lie.'

'... the examination ... there is an additional degree of anxiety about what just happened to you and what is going to happen to you...'

'... because the examination on its own is a nightmare.'

The gender of the examiner was mentioned by two of the ten participants. One shared that she requested to be examined by a female, but as only a male medical examiner was on duty at the time the forensic examination, it had to be performed by him. This participant persisted throughout the interview to voice her need to have had a female doctor performing the examination. She shared that although the male doctor did nothing to make her feel uncomfortable, she would have preferred to be examined by a female because she believed she would have felt more relaxed. Another participant was examined by a female doctor and confirmed the first participant's views. Here are extracts from what these two participants said:

'...They must get female doctors. I was uncomfortable because I had to ... It was a male doctor and they [the nurses] had told me that there was no female doctor. And I felt really uncomfortable with the male doctor.'

'... it was a female doctor, which was nice. I think that I would have felt somewhat differently if it had been a male doctor.'

Initial counselling

The counsellor on call during the admission on the initial visit of the rape victim to the emergency department was contacted for an in-hospital consultation as per the guideline (National Management Guidelines for Sexual Assault, 2003). The value and importance of the presence and management of the counsellor during this initial visit evinced mixed reactions from the participants. Two participants felt that no counselling at all had actually taken place during the initial visit. These two participants reported that they were merely requested to describe what had happened. In contrast, the other participants regarded the visit of the counsellor as beneficial. Although one of these participants did acknowledge that no detailed counselling about the incident occurred during the counsellor's initial visit, it was comforting for her to know that the opportunity to consult a counsellor would be there in the future. Here are excerpts from what the participants said:

'... it [counsellor's visit] was good. You know, the knowledge that there is someone [the counsellor] who is giving her attention to that side of things [emotional support]...'

'... you talk a lot about that [the incident]. It's not easy. For me it was ... I don't know, the more I talk about it [the incident], the better it gets for me.'

Counselling is considered as an intensive intrusive process by some; a process that should be approached with utmost discretion and sensitivity and never enforced (Sanderson, 2013). A participant remarked:

'He [the counsellor] saw me that day, but I wasn't ready to talk about it then. I was actually still ... I would have preferred it if I could have chosen the counsellor myself... If I could have gone to my own psychologist. I think that they [the doctor and nurse] kind of forced me to speak to him [the counsellor].'

Management by healthcare providers

The level of self-confidence displayed by the healthcare providers during the management process was also remarked upon by participants during the interviews. Some of the healthcare providers seemed to be unsure of their actions and did not always appear to understand how they should handle the situation or the accessories in the sexual assault evidence collection kit. Fortunately, the

healthcare providers were always accompanied in these situations by another healthcare provider who was more experienced than they were.

Two of the participants specifically mentioned that they were under the impression that one or more of the healthcare providers were either new to the job, in training, or else that they lacked experience in the management of rape victims. The participants described a lack of confidence they observed from healthcare providers who sometimes seemed preoccupied with other problems and unsure about what to do. Following are verbatim quotes from participants related to these issues:

'... I more or less gained the impression that they [the doctor and nurse] were relatively new [to the job] because they asked a great number of questions to each other...'

'...they [the doctor and nurse] were not familiar with the story [the forensic examination].'

Owing to the fact that the management of rape victims is aimed at preventing re-victimisation, the preferences mentioned by participants during the interviews give insight into ways of ensuring that the victims do not suffer any further trauma (Martsolf et al., 2010). Some participants remarked on the choices they were offered by the healthcare providers during their initial visit.

'... they [the nurses] asked me whether it would be a problem for me to see a male counsellor ... I told them that it wasn't a problem for me. The counsellor said that many people [females] closed themselves up to a male counsellor.'

'... they [the nurses] didn't tell him [my friend] to leave the room ... they [the nurses] asked me whether it was all right if he remained there, and I said that I would prefer to have him remain. Then she [the nurse] said to me that it was alright, that it was my choice.'

'... he [the counsellor] asked me whether I would like to see him. And so I said, "No" ...'

'... and then she [doctor] sat down with me and she called the nurse and said, "If you are not comfortable to speak to me, here is someone else" and that's when I spoke to a nurse that could speak my language'.

Discussion

Participants reported feelings of being left alone for long periods of time. Rape victims can interpret being left alone as a form of rejection and judgement (McGregor, Du Mont, White & Coombes, 2009). To prevent such feelings arising in rape victims necessitates better communication, sharing in choices made during management and being managed by competent healthcare providers.

Good communication is an important factor in the management of patients receiving any form of healthcare services (Engel, Heisler, Smith, Robinson, Forman & Ubel, 2009). For the victims of rape, clear and frequent communication is even more important as victims often feel degraded and humiliated (Fehler-Cabral, Campbell & Patterson, 2011). Healthcare providers who have the ability to sensitively respond and communicate with victims of rape can contribute to the latter's healing (Martsolf et al., 2010). Communication is a basic skill of healthcare providers that needs to be utilised in a thoughtful manner when working with a vulnerable population such as victims of rape (Fehler-Cabral et al., 2011). The purpose of sensitive communication is aimed at reassuring the patient and in restoring some sense of control (McGregor et al., 2009).

Victims of rape need to feel in control of what happens to them during the management process (Fehler-Cabral et al., 2011). The victims of rape in this study voiced that they wanted to have choices: they wanted to decide whether or not they needed a counsellor; they also wanted to be able to choose between being examined by a male or female medical examiner.

Counsellors providing a service to victims of rape in the emergency department are there to render emotional support directly after the assault and to assess the victim for future support needed (Linden, 2011). In this study the emotional support was a predominantly positive experience for the victims of rape and it was reported that counselling contributed to their healing (Ahrens et al., 2009). However, one participant in the study wanted to see her own psychologist. If it is feasible, bringing in a known psychologist could be allowed since the need of the rape victim overrides the guidelines followed during emergency department management (McGregor et al., 2009).

The gender of the healthcare providers did not appear to be a concern when the rape victims spoke about the counsellor. Conversely, the gender of the medical examiner proved to be a source of distress for two of the participants. Access to a female examiner should be a minimum standard for every healthcare facility (Kelly & Regan, 2003; World Health Organization, 2003). Female medical examiners could decrease the anxiety associated with the forensic examination (Kelly & Regan, 2003). Rape victims should be given a choice regarding the gender of the medical examiner. However, further studies examining the attitudes of rape victims towards the gender of the medical examiner are needed if practice is to be informed.

The participants furthermore reported that they had the impression that the doctors and nurses were not familiar with the procedures to be followed during the forensic examination. This comes as no surprise, as very little time is spent in the curriculum of doctors and nurses on clinical forensic care (Jina, Jewkes,

Christofides & Loots, 2013). The participants did also report that at least one of the healthcare providers involved in their forensic examination seemed to be familiar with the procedures. However, Jina et al. (2013) found in their study that the confidence of healthcare providers exceeds their knowledge level of forensic examination procedures. The discipline of clinical forensic care is dynamic and requires life-long learning among healthcare providers that come into contact with rape victims (Jina et al., 2013).

Conclusion

Rape occurs at an alarming rate in South Africa and victims seek clinical forensic care at emergency departments. Healthcare providers should develop their practice continuously by involving the rape survivors as service users to move the current workplace culture towards being patient-centred. Healthcare providers in emergency departments should be aware that their actions and abilities to care and being able to correctly perform the forensic examination have a significant impact on the healing that transforms a rape victim into a rape survivor. The results from this study can be used by healthcare practitioners to develop their practice.

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