The support of professional nurses to youth victims of physical violence at a community health centre in the Cape Flats

by

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DECLARATION

I declare that: ***The support of professional nurses to youth victims of physical violence at a community health centre in the Cape Flats*** is my own work and it has not been submitted for any degree or examination at any other university and that all the sources have been indicated and acknowledged by complete references.

Melitah Annastatia Selenga

November 2014

Signed: ……………………………..

ACKNOWLEDGEMENTS

Ideal patient's journey

It is important that we note that a critical part of the ideal patient's journey is the patient experience. The patient experience is influenced by many factors – the attitudes of staff, access to timely and appropriate care, the patient's confidence in the staff caring for them, and the quality of the care provided. Patient experience is also influenced by whether it meets the patient's expectations and the level of communication provided along all points in the patient journey. A positive patient experience is considered an important indicator of the effectiveness and quality of care.

Ontario Hospital Association (2011:11)

KEY WORDS

- Lived experiences
- Community health centre
- Trauma
- Youth
- Physical violence
- Nurses
- Cape flats
- Phenomenology
- Victims
- Actions

OPERATIONAL DEFINITIONS

The National Youth Policy (South Africa, 2000) defines *youth* as any person between the ages of 14 and 35 years. For the purpose of this study, the youth referred to male and female individuals between 18 and 27 years that were traumatised in informal settlements in the Cape Flats.

Physical violence refers to the intentional use of physical force or power – threatened or actual – against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation (WHO, 2011). A victim of crime is defined as a person who has suffered harm – including physical hurt – through acts that are in violation of our criminal law (South Africa Service Charter, 2006:6). In this study, violence refers to any kind of physical attack inflicted by someone else.

Traumatic events are defined as events that involve actual or threatened death, serious injury, or threat to the psychological or physical integrity of self or fellow human beings (Landes, Garovoy & Burkman, 2013). In this study, it refers to an experience that is painful, distressing, or shocking, which often results in lasting mental and / or physical effects.

Experience refers to what a person is living through and how he / she responds or reacts to the lived through events (Oxford School Dictionary, 1999:300). In this research study, experiences refer to lived experiences of nurse practitioners on traumatised youth who visit the clinic.

Cape Flats: The Cape Flats are deemed to comprise what are predominantly previously disadvantaged communities who inhabit the Cape Flats as a result a variety of reasons, which ranged from forced removals to voluntary migration (http://www.capeflats.co.za).

Level one hospital is a facility that, in addition to a range of other primary health care services, normally provides 24-hour maternity, accident, and emergency services with at least 30 beds where patients can be observed for a maximum of 48 hours (Cullinan, 2006). In this study, it refers to a Community Health Centre (CHC) in the Cape Flats.

A ***professional nurse*** is a person who is qualified and competent to independently practise comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice (Nursing Act 33, 2005: 35). In this research, the term nurse refers to a person working at a community health centre.

ABSTRACT

The Western Cape Province of South Africa has the worst multifactorial crime problem in the country. It has the fastest growing crime rate in many crime categories, such as rape and gun related incidents. The youth in the Cape Flats faces many challenges, such as drug abuse and high incidents of violent attacks. The youth who are exposed to violence are inclined to be violent themselves and are at a higher risk of psychopathology. The experiences of the youth after a violent physical incident were unclear. The purpose of this study is to describe actions for the support of professional nurses at a community health centre to youth victims of physical violence in the Cape Flats.

A phenomenological, exploratory, descriptive, contextual design was followed in this study. This study explored and described the lived experiences of youth victims of physical violence in terms of the support they received in a natural setting at a community health centre in the Cape Flats. Purposive sampling was used for the study, and data saturation determined the size of the sample, that was eight participants. Participants were male and female youth members between the ages of 18 and 27 years who had experienced a violent incident and visited a health care centre for follow-up treatment. They were given information sheets that explained the nature of the research project. Individual in-depth interviews were used to collect data. Interviews were conducted in one of the consultation rooms at a community health centre that was quiet and where minimal interruptions occurred.

The researcher sought permission from the participants to conduct the interviews and to audio record those interviews. All ethical principles were adhered to in this study; that is confidentiality, anonymity, withdrawal, autonomy, and informed consent. Trustworthiness was ensured during the research process. In cases where participants had experienced

psychological distress, they could be referred to a psychologist. However, none of the participants displayed any signs of emotional discomfort during the interviews.

Data was analysed using Creswell's six steps of open coding. All data would be kept under lock and key for five years after the research report has been made available.

Main themes that emerged from the data analysis were related to violent incidents that had a negative impact on the participant; participants applied defence mechanisms to deal with their trauma, and participants experienced care and support either negatively or positively.
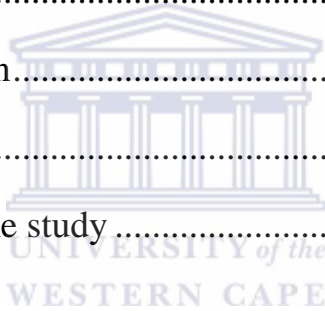
A recommendation of this study is the implementation of an in-service training programme to the nurses who care for the youth after violent physical incidents.

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CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND RATIONALE

The youth in South Africa aged between 15 and 34 had represented 37% of the South African population in 2008 and this figure increased to 42% in 2014 (United Nations Population Fund South Africa (UNFPA SA), 2014). The South African youth are faced with many challenges; such as unemployment, drug abuse, crime and violence. Not all youths are able to lead themselves forward beyond these challenges. In SA, the youth are exposed to violence on a daily basis. South Africa is one of the countries where the rate of fatal violence is five to eight times higher than the global average for females and males respectively (Matzopoulus, Vos, Norman, Schneider, Bladshaw, Jewkes & Abrahams, 2010:8). According to Norman, Matzopoulus, Groenewald and Bradshaw (2007:700), in the Western Cape alone, violence accounts for 12.9% of premature mortality second to HIV / AIDS related deaths at 14.1%. These rates are higher than the national average per hundred thousand of 129 instead of 115 males and 25 instead of 21 females.

The unemployment rate in the Western Cape Province reduced from 44% in 2009 to 40% in the first quarter of 2011 (Western Cape Provincial Treasury Report, 2011). However, the general lack of employment opportunities remained evident. Around 22.3% of the unemployed had diplomas and degrees while 19% of the population did not have any education beyond Grade 7 (Western Cape Provincial Treasury Report, 2011). According to the official statistics (SAPS in Legget, 2005), the Western Cape has by far the worst multifactorial crime problem in the country and in many crime categories, the fastest growing crime problem. This causes a great challenge in the health services, since a lot of the youth members get traumatised by these violent attacks. The Western Cape is known for its issues

of drug abuse and gang violence amongst the male youth population. According to Gie and Haskins (2007:4), Cape Town is identified as one of the cities with the highest murder rates in the world. It is also considered to be one of the "high-risk" cities for murder and is on par with Rio de Janeiro. Both cities have murder rates of more than 40 per 100 000 people.

The Cape Flats are well known for gang violence. Gang violence has a long history in South Africa, with membership of gangs sometimes beginning as early as the age of 12 (Legget, 2005). Therefore, the youth members are exposed to violence and fights at an early age either as a witness, or as a victim of a violent act.

According to Hetweck, Ziegler and Logsdon (2010:202), adolescents who are exposed to violence are inclined to be violent themselves and at a higher risk of psychopathology. This is a great concern for the mental health services in the Western Cape, especially in the Cape Flats, where the burden of mental illness is already at an alarming increase due to the illicit use of drugs and head injuries (Shields, Nadasen & Pierce, 2008:590). These mental health disorders become chronic and continue into adulthood, thus decreasing the productivity and influencing quality of life of the youth (Hertweck, Ziegler & Logsdon, 2010:202).

Psychological trauma due to violence can lead to serious long-term negative consequences that are often overlooked even by mental health professionals: "If clinicians or nurses fail to look through a trauma lens and to conceptualise client problems as related possibly to current or past trauma, they may fail to see that trauma victims, young and old, organise much of their lives around repetitive patterns of reliving and warding off traumatic memories, reminders, and affects" (Moroz, 2005:3).

Some youth members are able to move beyond these challenges and be productive adults while some of them end up in the mental health institutions and in the justice system (Burns, Jhazbhay, Esterhuizen & Emsley, 2010:181). When the youth members encounter a violent

incident, it is important that they have internal ability (e.g. self-leadership) to overcome the stressful event in order for the chances of developing mental illnesses to decrease (Sydanmaanlakka, 2004:1). This could only be possible when individuals are aware of their internal abilities through self-understanding.

As a professional nurse at a community health centre, the researcher observed an escalating number of youth with injuries related to physical violence seeking treatment at the emergency unit of the hospital. Those injuries included youth with gun-shot wounds, stab wounds, and injuries that resulted from physical assault. Therefore, the researcher was interested in understanding the lived experiences of the youth as victims of physical violence in the Cape Flats.

1.2   BACKGROUND TO THE PROBLEM

Violence is a well-known problem in South Africa and even more of a problem in Cape Town. The violent crime statistics in Cape Town were higher (118 per 100 000) than the national average (114 per 100 000) between 2005 and 2006 (Gie *et al*., 2007:7). The Western Cape Government has implemented many initiatives to combat crime and drug use amongst the youth, such as safer city programmes; e.g. visible policing, metro police presence, and building of recreational parks where the youth could pass time constructively; then they should be less involved in drugs and delinquent behaviour would be limited (Zille, 2013). These strategies include:

- Reducing the availability of alcohol in residential areas through the Western Cape Liqour Act (2009).

- Expanded Partnership Programme focused on community police forums, and many youth programmes that target the youth at risk.

Whether these initiatives have been successful is debatable.

Violence has detrimental effects on youth members (Shields *et al.*, 2008:58; Ward & Bakhuis, 2010:51). It does not only affect the youth, but the community in general because the youth is the future generation of this country. According to a study undertaken by Shields *et al.* (2008:593) in Cape Town, 93% of youth in the sample had seen someone being hit and 83% had seen someone being kicked and shoved. These children had also witnessed more serious forms of violence. The majority of participants (73.2%) in that study saw someone badly beaten up, saw someone being threatened with a knife (60.7%), 56.8% attacked with a sharp weapon, 45.4% threatened with a gun, 57.4% saw someone being shot, and more than a third of the participants reported seeing someone being killed.

Various kinds of violent incidents have negative consequences on individuals; such as loss of limbs, head injuries, as well as deformity of the face and other body parts. This has a negative impact on the person's self-image and self-esteem (Hanson, Self-Brown, Fricker-Elhai, Kilpatrick, Saunders & Resnick, 2006:1991).

Several studies concur that the exposure to violent incidents is associated with poor mental health outcomes (Hanson *et al.,* 2006:1992; Shields *et al.,* 2008:599; Hertweck *et al.,* 2010:208). Hanson *et al. (*2006:1990) conducted a study on 4 023 adolescents, aged between 12 17 years who have been exposed to some violent incidents. The majority of this sample had signs of post-traumatic stress disorder or had a major depressive episode following the violent incident. These adolescents also reported having used a range of substances as a way of coping with the traumatic experience.

Madan (2007) as cited in Shields *et al*. (2008: 589) conducted a study in a trauma unit and the labour unit in New Orleans on African American males of between the ages of 18 and 28. The results suggest that during times of economic hardship, certain population groups are at

higher risk of life-threatening injuries. This phenomenon is also observed in the Western Cape where the unemployment rate is high (Shields *et al*., 2008:590). Despite this robust association demonstrated in previous research between exposure to traumatic events and poor mental health outcomes in the youth (Foy, Ritchie & Conway, 2012:9), some youth who were exposed to violence maintained high levels of adaptive behaviour and exhibited good psychological functioning (Bonanno, Westphal & Mancini, 2011:1.2).

Trauma is defined as a physical or psychological threat to or assault on a person's physical integrity, sense of self, safety, survival, or the physical safety of another person who is significant to the child (Vermont, 2004:170). Physical trauma due to a violent incident could be due to a single experience, or an enduring or repeating event or events, which completely overwhelm the individual's ability to cope or integrate the ideas and emotions involved with that experience. The sense of being overwhelmed could be delayed by weeks, years, or even decades while the person is struggling to cope with the immediate circumstances (Moroz, 2005:2). Health and psychological effects of physical violence are well documented worldwide (Norman *et al.,* 2010:9). These effects have detrimental traumatic effects on individuals, personal relationships, community, and the society (Kolko, Hoagwood & Springgate, 2010:467).

1.3   PROBLEM STATEMENT

The youth in the Cape Flats are faced with various challenges in an environment of violence. The Cape Flats are known for incidents of gang violence and high levels of crime (Gie & Haskins, 2007:4). Violent incidents cause traumatic experiences and could have detrimental effects on their psychological and physical health (Shields *et al.,* 2008:58; Ward & Backhuis, 2010:51). At the community health centre, the researcher observed that professional nurses were unclear on how to support victims of physical violence. In order to address this

problem, the experiences of the youth as victims of physical violence should be known. That is the reason why this study aimed at answering the following questions:

- What are the lived experiences of the youth victims of physical violence on the support they receive at a community health centre in the Cape Flats?

- How could nurses at a community health centre support the youth victims of physical violence after a violent incident?

1.4   PURPOSE OF THE STUDY

The purpose of this study was to describe actions for the support of professional nurses at a community health centre who treat youth victims of physical violence in the Cape Flats.

1.5   OBJECTIVES

The objectives of this study were to:

- explore and describe the lived experiences of youth victims of physical violence on the support at a community health centre in the Cape Flats; and

- describe actions for the professional nurses at a community health centre to support the youth victims of physical violence.

1.6   METHODOLOGY

1.6.1   Research design

In qualitative research, the researcher aims at producing research results that are derived from a participant's subjective experience of reality. A phenomenological, exploratory, descriptive, contextual design was used in this study. A phenomenological design interprets an experience or fact by listening to the different stories of the participants. It examines the phenomena

through the subjective eyes of the participants. Phenomenology focuses on the subjectivity of reality, continually pointing out the need to understand how human beings view themselves and the world around them (Willis, 2007:53). An exploratory research design was followed to gain insight into the phenomenon of youth victims and physical violence, of which little was known (De Vos, Strydom, Fouche & Delport, 2011:96). The descriptive design enabled the researcher to gather detailed concrete descriptions of specific experiences from the participants. A contextual design was followed, since the study was conducted in the natural setting of a community health centre. Bowling (2005:312) states that contextual studies focus on specific events in "naturalistic settings" that are uncontrolled real-life situations.

1.6.2   Setting, population, and sample

The research setting for this study was an emergency unit at the Mitchells Plain Community Health Centre, situated in Mitchells Plain, Cape Flats in Cape Town. The reason why that setting was chosen was the fact that the researcher, while working at this community health centre, observed large numbers of youth with physical injuries; the researcher had access to young victims of violence. The study population consisted of youth who were victims of physical violence and who went to the community health centre for treatment.

Purposive sampling was used in this research study. The reason for using this sampling method was that participants were selected by the researcher because they had experienced and were knowledgeable about the phenomenon of interest (Streubert Speziale & Carpenter, 2007:29).

The sample of this study consisted of seven youths who were victims of physical violence and who attended follow-up visits at a community health centre.

1.6.3 Data collection process

The researcher negotiated access to the participants by submitting an ethical clearance letter (Registration number: 12/5/16) to the management of the institution (Appendix D). The managers of the institution were approached and the aim and objectives of the research project were explained to them. The researcher provided the participants with an information sheet (Appendix A) and a written consent form (Appendix B) for the participants to sign prior to the interviews being conducted. Individual in-depth interviews and observational notes were used to gather the data. Before an interview began, the researcher asked permission to take field notes, observation notes, as well as to use an audio recorder. The interviews were conducted in one of the consultation rooms at the community health centre. The researcher ensured that the room was quiet and that no interruptions occurred.

The participants who were at the community health centre at the time the researcher visited the community health centre were interviewed once they had indicated that they were willing to participate. The interviews lasted between 30 and 45 minutes. Audio recordings of the interviews allowed the researcher to capture data accurately. The researcher had made sure that the audio recorder was in good working condition before the interviews commenced. A pilot interview was conducted with one participant before the main study commenced, and the data answered the research question. Therefore, that interview was included in the main study.

1.6.4 Data analysis

The researcher followed Creswell's (2007:159) steps of open coding. These steps are discussed in Chapter 2.

1.7   ETHICAL CONSIDERATIONS

The purpose of the study was explained to participants verbally and in writing. The following ethical principles were considered and observed throughout this study:

Informed written consent: Participants gave informed written consent before participating in the study. Participation was free and voluntary (Hennik, Hutter & Bailey, 2011:68). Consent was also granted by participants for voice recordings and writing field notes during the interview.

Autonomy: the researcher respected the right to self-determination and freedom of the participants and did not coerce anyone to take part.

Confidentiality: According to Hennick, *et al.* (2011:71) in qualitative research, it is difficult to assure complete confidentiality because the researcher reports on the findings of the interview. However, only the researcher, supervisor, and an independent coder had access to the recordings. All data collected would be stored under lock and key, for five years after publication of the results.

Anonymity: The researcher ensured that all identifiable information was removed from the interview quotations and transcripts. Pseudonyms were used to protect participant's identities for publication purposes. Pseudonyms are used in research studies to safeguard the identity of participants in the analysis of data and / or in the published results of the study (Herron and Skinner, 2013:1700).

Beneficence: The results of the study seek to describe actions for the professional nurses at a community health centre to support the youth victims of physical violence. This research project intends to benefit the community where it has been conducted. This study potentially could cause the emotions of participants to reappear while they were relaying their stories.

The researcher was considerate (Offready & Vickers, 2010:113). Community health centre counselling services were available in the event of any participant who needed counselling after the research interview (Brink, Van der Walt and Van Rensburg, 2006:31). However, none of the participants showed any sign of distress during the course of the study.

Withdrawal: Participants were informed of their right to withdraw from the study at any time and without any explanation (De Vos *et al.,* 2011:116) and that withdrawal from the study would not in any way affect the care they should receive at the community health centre.

1.8   CONTRIBUTION OF THE STUDY

The youth in the Cape Flats are faced with many challenges, such as drug abuse and high incidents of violent attacks. This qualitative study aims at exploring and describing the lived experiences of youth members after a violent incident and at describing actions to support youth victims of physical violence at a community health centre.

1.9   OUTLINE OF THE STUDY

The study is organised as follows:

Chapter 1

Introduction and background to the study: This chapter provides an introduction to all the chapters of the study. A detailed description of the participants and the study setting as the study site is offered. The purpose of the study and an overview of the impact of violent attacks are explained.

Chapter 2

In this chapter, the research methodology is discussed. The reason for using a qualitative design is described and the limitations of using this design are highlighted. A phenomenological research design was used to explore the lived experiences of the youth patients who were victims of physical violence. Details of the study design, sampling, data collection and data analysis are presented and the measures to ensure trustworthiness of the research are described.

Chapter 3

The researcher presents and discusses the research findings. The participants' demographic data, as well as the summary of themes that emerged from the research are presented. The three main themes are discussed in detail, including anecdotes from the transcripts for the voices of the participants to directly support the data analysis process. Findings of the study are supported by literature.
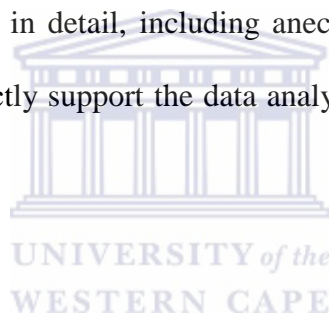
Chapter 4

This chapter contains the conclusion of the study and recommendations for actions to effectively support victims of physical violence. The implications of this study on practice, further research, and nursing education are described. Finally, the researcher outlines the limitations of the study.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

Research methodology is the process that directs researchers in preparing and implementing a study in a manner most likely to accomplish the eventual goal (Burns & Grove, 2009:218). The research process in this study involved a systematic endeavour to explore and describe the lived experiences of youth victims of physical violence at a community health centre in the Cape Flats. Participants visited the centre for their follow-up treatments after six months, after their first consultations.

2.2 RESEARCH DESIGN

The researcher followed an exploratory, contextual, and a descriptive phenomenology approach.

2.2.1 Qualitative design

This study adopted a qualitative research design instead of a quantitative design. A qualitative research design is useful when a researcher attempts to identify with the social processes in its particular context, while exploring the subjective nature of human life, with the aim of developing an understanding thereof (De Vos *et al.*, 2011:308). Qualitative research involves the analysis of words in order to explore and describe a situation, process, or experience (Hickson, 2008:48). In this design, a researcher analyses the data as it unfolds during the data collection process and the subjective nature of the process is acknowledged. Quantitative research, on the other hand, focuses on the control of all components in the actions and the representation of the participants, as well as the relationship between the variables (Henning,

Van Rensburg & Smit 2005:3). Qualitative research could provide a much more holistic view of the problem under exploration, including information that cannot be reduced to numbers (Hickson, 2008:51).

Quantitative researchers use deductive reasoning, which is moving from the general to the particular. On the other hand, in this study inductive reasoning was used. The researcher started with the detail of the experience and move toward a more general picture of the phenomenon of interest (Creswell, 2009:155-157).

2.2.2   Descriptive phenomenology

Phenomenology is an approach that aims at exploring the ways in which people conceive of and interpret the world (Hickson, 2008:54). Creswell (2007:57) and Burns and Grove (2005:55) regard a phenomenological study as a study that describes the meaning of the lived experiences of a phenomenon by individuals. It examines human experiences through the descriptions that are provided by the people involved, together with a comprehensive audit trail of the data collection, capturing, and analysis processes (Brink, Van der Walt & Van Rensburg, 2012:122).

There are two schools of phenomenology. ***Descriptive phenomenology*** aims at 'uncovering and describing the essence of the phenomena of interest' (Watson, McKenna, Cowman & Keady, 2008:233; Bryman, 2012:30). It involves the direct exploration, analysis and description of a phenomenon under study as free as possible from unexamined presumptions in order to maximise intuitive presentation (Streubert, Speziale & Carpenter, 2007:82). Husserl (1859-1938) believed that the fundamental recognition of an experience is the ultimate ground and meaning of knowledge (Watson *et al.*, 2008:233). On the other hand, *interpretive phenomenology* was developed by Heidegger (1889-1976), and it aims at the

interpretation of the phenomena with the purpose of exposing the hidden meanings (Watson *et al*., 2008:233).

Descriptive phenomenology was used in this study because that afforded the participants an opportunity to express their own lived experiences of the phenomenon; therefore, the researcher used bracketing.

In descriptive phenomenology, a researcher has a specific role:

Bracketing: A critical aspect of phenomenology is the need for a researcher to suspend his or her personal views or preconceived ideas about the phenomenon under study (Hickson, 2008:55; Watson *et al*., 2008:232).

Intuiting: A researcher tries to develop an awareness of the lived experiences. In this instance, the researcher became absorbed in the phenomenon without layering it with what she had bracketed out (Brink *et al*., 2012:122). During that process, the researcher was totally immersed in the phenomenon under study. The researcher began to develop an understanding of while the participants were describing the phenomenon (Streubert Speziale & Carpenter, 2007:85).

Reduction: This required the researcher to avoid all abstraction, all theorising, all generalisations, and even all beliefs in the existence of what we call "real" or "not real". Theories need to be reviewed in terms of how they inform experience. In the phenomenological reduction, one needs to strip away the theoretical or scientific conceptions and thematisations that overlay the phenomenon one wishes to study and that prevents one from seeing the phenomenon in a non-abstractive manner.

Analysing: This is when the researcher compares and contrasts descriptions of the phenomenon under study (Brink *et al*., 2012:122). That allowed the researcher to identify

recurring themes by reviewing data a couple of times. The researcher dwelled on the data to ensure pure and accurate description (Streubert Speziale & Carpenter, 2007:85).

Describing: Phenomenology focuses on describing what all participants have in common while they are experiencing a phenomenon first hand (Creswell, 2007). This is the final step in a phenomenological study when a researcher communicates how individuals in a study experience a phenomenon by sharing his or her findings with other interested parties.

2.2.3   Exploratory design

An exploratory design is conducted when a researcher examines either a new interest, when the subject of interest is relatively new, or when it has not been explored in detail (De Vos, *et al.,* 2011:95). Since this study addressed an under researched topic, it sought to explore the topic to gain some preliminary insights into the key issues with the purpose of stimulating future research (Hesse-Biber, 2011:10). The researcher approached the participants having suspended her prior expectations in a process of epoché or bracketing. This design required the use of in-depth interviews to explore the lived experiences of the participants (Clark & Creswell, 2011:206).

2.2.4   Contextual design

A contextual design was used because the researcher wanted to describe and understand the experiences in the concrete context of the natural environment where they occurred (Babbie, 2013:85). This study was conducted in the participants' natural setting. The data was collected at the site where the participants had experienced the phenomenon (Creswell, 2009:175) and all the interviews were conducted at a community health centre where they were assisted and treated after they had experienced physical violence in the community.

Phenomenological studies examine human experiences through the descriptions that are provided by the people involved (Brink *et al*, 2006:113). These experiences are referred to as lived experiences.

2.3   RESEARCH SETTING

In 2013, the South African population was 52.9 million. The Western Cape represents 11.4 percentage of the total population of South Africa (Statistics South Africa, 2013:3). Cape Town is the capital city of the Western Cape Province.

The Cape Flats are plagued by gang violence and high levels of crime (Crime Statistics South Africa, 2013). According to Crimestats SA, in 2013 Mitchells Plain reported the highest number of crimes and it was graded as the hotspot for criminal activities in South Africa (Appendix C, Figure 1 and 2). Drug-related crimes, theft, and common assault accounted for over 14 670 incidents reported during 2012. Mitchells Plain and Khayelitsha are the two largest Cape Flats in the Western Cape. The boundaries of Mitchells Plain are formed by Vanguard Drive to the west, Swartkop Road to the east, the railway line to the north, and the False Bay coastline to the south. The community health centre – the research setting – is located in this area.

2.4   POPULATION AND SAMPLE

Burns and Grove (2009:714) describe a population as the entire set of individuals, objects, events, or elements that meet the sampling criteria for inclusion in a study. In this study, the study population was referred to as youth members who were victims who have been treated for at least six months after their first visit at the CHC due to physical harm as a result of violence.

A sample is a subset of a population that a researcher selects for a study (Burns & Grove, 2009:721). Participants should have knowledge and experience, be able to articulate and reflect, have time for an interview, and be willing to participate in a study. According to De Vos (2011:391), in a phenomenological study, there are no rules for the sample size and the sample size depends on what the researcher wants to know, the purpose of the study, what will be credible, and what could be achieved with the time and resources available. The size of a sample depends on whether data saturation has been reached when no new themes and categories emerge. There were eight participants interviewed for this study before data saturation occurred.

Purposive sampling was used in this study. Purposive sampling refers to the researcher selecting the sample based on knowledge of the population (Streubert Speziale & Carpenter, 2007:85). This sampling method is based on the assumption that a researcher wants to discover or understand a defined phenomenon (Burns & Grove, 2009:368). The researcher selected the participants who were knowledgeable and experienced with regard to the phenomenon of interest. Creswell (2009:178) affirms that qualitative researchers purposefully select the participants or sites that would best assist them to understand the problem and to answer the research question. Eligibility criteria describe characteristics that must be shared by all participants in the study. In this study, those criteria were:

Inclusion criteria

- Male and female youth between the ages of 18 and 35 years. The researcher chose this age group, since teenagers younger than 18 legally required their parents' consent to be interviewed for research purposes.

- Participants were victims of physical violence during the previous six months; victims of some degree of physical violence were more likely to knowledgeable about the phenomenon under study. Exclusion criteria

- Youth who were referred to level 2 or level 3 hospitals for further treatment. These patients might have received a degree of emotional support at the hospital they were referred to. It was more likely for them to cope with what they had experienced.

- Youth that was taking anti-depressants due to the effects of the physical violence, since medication would influence the account of their experiences. Also, the medication might assist them to cope better with the occurrences of their physical abuse.

2.5   METHOD

2.5.1   Gaining access to the participants and preparing the field

Authorisation to conduct the study was obtained by submitting the proposal to the Senate Committee of the University of the Western Cape and the Health Research Committee of the Provincial Government of the Western Cape (Appendix D). Subsequently, a letter was written to the facility manager and the nursing operational manager of the community health centre to brief them on the purpose and outline of the study and about the ethical clearance obtained.

As suggested by Creswell (2009:90) and Hickson (2008:132), a meeting with the gate keepers was important and was required in order for them to understand the recruitment procedure. This meeting resulted in the clinical staff (especially nurses) assisting with the process of recruiting. The nursing staff members were informed about the inclusion and exclusion criteria for participation in this study to enable them to identify and refer possible participants to the researcher.

While the patients were waiting in the waiting room, the staff members informed the possible participants of the nature of the study and asked whether they would be prepared to meet with the researcher. The rationale for including the nurses as gatekeepers was to minimise the possible risk of coercion by the researcher while the patients were in a vulnerable and fragile state of mind due to the physical violence that they had experienced.

After a patient had agreed to meet with the researcher, the researcher took him / her to a private room. After an introduction, the researcher explained the purpose of the study and provided an information sheet (Appendix A). The researcher also verbally explained the nature of the study to each participant and the researcher started the interview with less threatening questions because she wanted to put participants at ease without asking intimidating questions.

2.5.2   Informed consent

According to Hickson (2008:106), informed consent is 'an ongoing agreement by a person to receive treatment, undergo procedures, or participate in research after risks, benefits, and alternatives have been adequately explained to them'. After the participants read the information sheet and understood the nature of the research, they received consent forms to sign before the interviews commenced (Creswell, 2009:89) (Appendix B). During the interview, the researcher was on the lookout for possible signs of discomfort and informed the participants that the interview could be ended at any time without explanation, should they feel uncomfortable to continue with the study. No participant showed any signs of discomfort during the interviews.

2.5.3   Data collection instruments

2.5.3.1   Interviews

In-depth individual interviews were conducted in this study. In phenomenological research, open-ended and unstructured interviews are regarded as primary data collection methods (Watson, *et al*., 2008:237). Conducting in-depth phenomenological interviews requires a researcher to be sensitive and have good interviewing skills (Bryman, 2012:30). Being a mental-health nurse, the researcher knew that interviewing skills were important tools when exploring people's experiences, feelings, perceptions, and thoughts. In-depth and unstructured interviews allowed the participants to express the issues and events that they experienced as important in explaining and understanding patterns and forms of behaviour (Bryman, 2012:471).

2.5.3.2   Preparation of interviews

The researcher identified a consultation room at the hospital that was not in use on the days that the researcher visited the hospital. The main objective was to ensure a relatively quiet and private space where the participants could talk freely without the risk of being overheard by other people (Watson, *et al*., 2008:284; Bryman, 2012:472).

The interviews were conducted at a convenient time for the participant. When a participant was in a rush on the day he or she visited the day hospital, an alternate appointment was made for the interview to take place. A box of tissues and a glass of water was available for the participants during the interview. The participants were informed that the interviews were going to take about 30 to 45 minutes.

At the beginning of the interviews, the participants were asked some demographic information (Chapter 3). They were informed that this information would not reveal their

names anywhere in a report and that it would be stored in a safe cabinet where only the researcher and the supervisor would have access. One broad, central question was asked (Creswell, 2007:110). The question was: *"How was it for you visiting the community health centre after the physical violent incident?"* After that, probing questions followed that encouraged participants to elaborate on their experiences, to provide details about their experiences to achieve clarity, and to focus on the lived experience (Broom, 2005:68).

Probing questions were:

- Please tell me what happened to you?

- What do you mean?

- Tell me more…

- What did you mean by…?

All interviews were audio recorded with (Creswell, 2009:183) recording equipment that was in working order. That ensured the proper capturing of all information that the participants gave. The recording equipment was checked thoroughly before each interview started (Hennick *et al.*, 2011:119).

During each interview, the researcher wrote field notes in a separate notebook (Hennick *et al*., 2011:131). The field notes were kept to describe observations made during the interview that documented the non-verbal cues; such as gestures, tone of voice, repetition that the participants displayed during the interview.

Polit and Beck (2004:393-394) propose that a researcher documents the field notes immediately after interviews and keeps it with each transcript of the audio recorded interview.

2.5.3.3   Strengths and limitations of phenomenological in-depth interviews

In-depth individual interviews provide a researcher with information about people's personal experiences and life stories (Hennik, *et al*., 2011:131). It is useful for sensitive topics because participants are reluctant to share some personal information when they are part of a bigger group (Creswell, 2009:179). However, with in-depth interviews a researcher needs skills in building rapport, as well as probing and listening to interviewees (De Vos *et al*., 2011:343). The researcher was mentored by her supervisor to conduct the interviews.

2.5.3.4   Pilot interview

Hennick *et al*. (2011:120) concur that it is important for a researcher to conduct a pilot interview with a small number of participants. One pilot interview was conducted that informed the researcher about the practical aspects of the interview, for example building rapport with the participants and introspection of the level of interviewing skills. That assisted the researcher to become familiar with the probing questions to ask during the interviews and to be more confident (Bryman, 2012:263). The main aim of a pilot qualitative interview is to identify whether the research question would be answered with the information that is gathered (Hennick *et al*., 2011:120).

The application of a pilot interview in this research proved to be of great assistance in and added to the learning experience. The transcript of that interview assisted the researcher to reflect on the process and the content of the interview. The results of the pilot interview formed part of the main study, since it provided the researcher with the data needed to answer the research questions. A further seven interviews were conducted before data saturation occurred. Data saturation happens when no new categories and relevant themes are emerging from the participants' contributions during the research interviews (Corbin & Strauss, 2008:148; Bryman, 2012:426).

2.5.4   Data analysis

Merriam (2002:14) suggests that data analysis in phenomenology should be done concurrently with data collection in order to make necessary adjustments during the process of data collection. The researcher followed the steps of open coding (Creswell, 2007:159). The researcher:

- in the process of bracketing, began with a full description of her own experiences of the phenomenon;

- organised and prepared the data for analysis in accordance with sources of information. This process involved the transcribing interviews and typing of field notes;

- read through all data thoroughly; that process commenced immediately after the first interview was completed (Bryman, 2012:576). That assisted the researcher to deal with manageable amounts of data. After the researcher had read all data, she then reflected on the general meaning;

- developed statements and grouped those statements into meaningful units called categories. After that step, the researcher once again read the transcripts to establish whether there were no additional categories that needed to be grouped together;

- use multiple coding as another way of improving the rigor of this study (Brookes, 2007:32). That process involved an independent researcher / coder who cross-checked coding in order to reduce the subjectivity of the data analysis process; and

- interpreted the independent coding to reflect on its content. That reflection included the researcher's personal interpretation and / or meaning derived from a comparison between the findings of other authors. The researcher acknowledged that the word 'experience' had various meanings for different individuals. Those experiences are presented as results of the study.

From the data analysis and literature support, actions were described for professional nurses on supporting youth victims of physical violence at a community health centre in the Cape Flats.

2.5.5   Data triangulation

Bryman (2012:717) defines data triangulation as the use of more than one method or source of data collection in a study of a social phenomenon in order to cross-check the findings. In this study, the data was analysed by taking into account the information collected during the interviews and the written field notes. According to Denzin (1970:310) as cited in Bryman (2012:392), data triangulation is used by qualitative researchers to refer to a process of cross-checking findings derived from the interviews and the notes taken by the researcher. Triangulation also ensured dependability of the study.

2.5.6   Bracketing

Bracketing is the most important process in a phenomenological study. It is defined as the process that requires a researcher to endeavour and ensure that his preconceived ideas about the topic under study do neither contaminate the data collected, nor the findings. In this study, the researcher ensured that her preconceived ideas did not interfere with the data collected.

The researcher became interest in the study phenomenon after she had worked for about two years as professional nurse in the emergency unit at the community health centre.

> *I experienced the frustration of the patients that had to wait hours before being*
>
> *consulted by the nurses in the emergency unit. Although I endeavoured to stay*
>
> *open to positive and negative feedback, I may have influenced the participants'*
>
> *responses unconsciously by verbal and non-verbal means. I was also aware of the*

power-relation that exists between the researcher and the participant, which may

also influence the participants' answers during the interviews.

The researcher endeavoured to remain objective at all times throughout the data collection process and did introspection before each interview to attempt limit bias as much as she could. The researcher also refrained from conducting an extensive literature review on the phenomenon under study that could have possibly affected the data collected and the findings based on the data analysis (Streubert-Speziale & Carpenter, 2007:83). The researcher considered literature only after the data collection and analysis of data had been completed.

2.6   TRUSTWORTHINESS OF THE STUDY

Trustworthiness is a measure to ensure rigor in qualitative research without sacrificing relevance. The researcher used Lincoln and Guba's (1985) model to ensure qualitative rigor as cited in Brink *et al*. (2012:172). Particular criteria were used to evaluate the quality of the data in this study; namely credibility, dependability, confirmability, transferability, and reflexivity.

2.6.1   Credibility

Guba and Lincoln (1989) in Kotch (2006:92) claim that a study is credible when it presents faithful descriptions and when readers recognise the experience when they are confronted by it. The researcher did that by using direct quotations from the participants' interviews. The researcher wrote field notes to record the content and the process of interactions that included reactions to various events or information. These notes were included in the data analysis (triangulation) process. The findings were confirmed by an expert in qualitative research, the researcher's supervisor, and an independent coder also verified the findings.

2.6.2   Dependability

According to Shenton (2004:72), findings are auditable when another researcher can clearly follow the decision trail used by a researcher. In this study, the supervisor and an independent coder conducted such an audit. Holloway (2005:143) emphasises the need for a researcher to ensure dependability through accounting for the data while displaying process, procedure, and outcome of the research. This was done by taking field notes when the researcher noted all aspects observed during the data gathering process and for data triangulation purposes.

2.6.3   Confirmability

Confirmability refers to the extent to which this study can be confirmed or validated by other researchers (independent coder) that confirms the objectivity of the study (Polit & Beck, 2008:539). The data must reflect the voice of the participants and not that of the researcher. Furthermore, the interpretation should not be fuelled by the researcher's imagination (Brink, *et al*., 2012:173). The researcher did that by documenting the procedures which enable the researcher to continually check the data throughout the study and also by using the direct quotations of the participants to substantiate their points of view.

2.6.4   Transferability

Transferability refers to 'the extent to which the findings can be transferred to other settings or groups' (Thomas & Magilvy, 2011:153). This study provided a detailed description of a qualitative nature about the population and the study setting in question, that is the youth who are victims of physical violence at a community health centre. The strategies used to enhance transferability (Brink *et al*. 2012:172) in this study were:

- using **thick descriptions** of participants' experiences and reporting on them;
  and

- conducting the interviews and probing the participants until **data saturation** was reached.

2.6.5 Reflexivity

Reflexivity is described as a researcher's awareness and engagement with aspects of his or her role or possible influence in the process (Streubert Speziale & Carpenter, 2007:36). Denzin and Lincoln (2011:124) describe reflexivity as a process of reflecting critically on the self of the researcher, the "human as instrument". They also emphasise the need for self-introspection during the research process.

Karnieli-Miller, Strier and Pessach (2009:282) emphasise the need to put the participant at ease. Whilst it was an advantage for the researcher to understand the participants' experiences and what could possibly emerge from the study, she needed to be clear in her role as interviewer and not that of a professional nurse.
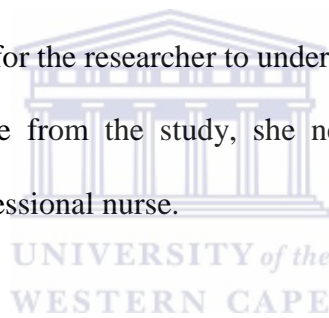
2.7 CONCLUSION

Chapter 2 highlights the research methodology followed in the descriptive phenomenology approach of this study. The trustworthiness and ethical principles followed during the process are described, and the chapter ends with pointing out the role of reflexivity in the research process.

CHAPTER 3

RESEARCH FINDINGS

3.1   INTRODUCTION

In this chapter, the process of qualitative data analysis using Creswell's (2007) steps of open coding is discussed. The different themes of the study are presented and discussed with reference to literature. The researcher also refers to direct *quotations* of the participants. The research question that had to be answered was: *What are the lived experiences of the youth victims of physical violence on the support received at a community health centre in the Cape Flats?*

3.2   DEMOGRAPHIC DETAILS OF THE PARTICIPANTS IN THE STUDY

Eight interviews were conducted, including the pilot interview (Table 3.1). Their ages ranged between 18 and 27 years and they were mainly males.

Table 3.1:   Demographics of the participants

Patient	Age	Gender	HLOE	Occupation	Employment status
Patient 1	24	Male	Matric	Unemployed	Unemployed
Patient 2	22	Male	Grade 11	Unemployed	Unemployed
Patient 3	27	Male	Matric	Unemployed	Unemployed
Patient 4	23	Male	Matric	Cleaner	Employed
Patient 5	22	Male	Grade 10	Contractor	Employed part-time
Patient 6	18	Male	Grade 11	Salesman	Employed
Patient 7	21	Female	Matric	Student	1st year

Patient	Age	Gender	HLOE	Occupation	Employment status
Patient 8	25	Female	Grade 11	Unemployed	Unemployed

3.3 THEMES

In essence, the participants experienced a violent incident in a negative way. The experienced impacted the participants on physical, psychological, social, and occupational levels. Participants mostly used defensive coping strategies to deal with the trauma. They had diverse experiences of care and support that ranged from very positive to negative. The diverse experiences of participants were captured in the three themes that emerged from the study findings. Those negative experiences related to violent incidents that impacted the participants on all levels of their being. As a result, the participants applied defensive coping strategies to deal with the trauma and had diverse experiences on care and support.

The themes with the relevant categories are presented in Table 3.2.

Table 3.2:   Themes and categories

Theme	Category	Sub-category
Violent incidents where negative experiences that impacted participants on all levels of their being	Physical injuries	
	Psychological strain	Negative emotions; such as sadness, anger, and worry
	Social strain	Lonely Isolated
	Occupational concerns	Ability to lead a productive work-life

Theme	Category	Sub-category
Applied defensive coping strategies to deal with the trauma	Denial Rationalisation Blame	
Diverse experiences of care and support	Positive experiences	Care
		Holistic support
	Negative experiences	Lack of attentive care
		Lack of information that lead to participants feeling vulnerable
		Lack of psycho-social support

3.3.1 Violent incident were negative experiences that impacted the participants on all levels of their being

The impact of a violent attack affects an individual on all levels of their being and interferes with the well-being of an individual. Haan (2008:31) defines violence as a behaviour involving physical violence intended to hurt, damage, or kill. His definition also includes the emotional and psychological impact of violence. The World Health Organisation (2002:4) defines violence as: 'The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation'. Violence is, therefore, viewed as interpersonal and the perpetrator may not have a relationship with the victim (Kelly, 2010:61). It affects an individual holistically, since its

interrupts their state of complete physical, mental, and social well-being (WHO, 1948:100). This definition has not been amended since 1948. The participants in this study confirmed their experiences as an interruption of their complete state of well-being.

Theme 1 comprises four categories; namely physical injuries, psychological strain, social strain, and occupational concerns.

3.3.1.1   Physical injuries

Studies conducted in the Cape Flats found that 50% of youth had been exposed to violence as either a perpetrator, or a victim (Van der Merwe & Dawes, 2000:2; Swart, Seedat, Stevens & Ricardo, 2002:387). Exposure to community violence resulted in physical (body) injuries. The participants reported injuries that had a direct impact on their physiological functioning. Participants reported physical ailments due to the violent attack.

"…they started stabbing me… and I was bleeding a lot…'' (P3)

The patient suffered blood loss due to the injury. That blood loss disrupted the body's normal functioning and could lead to death or disability.

Slazinger, Fieldman, Sctockhammer and Hood (2002:429) found that young people who had an injury that resulted in blood loss had a decreased resting pulse rate and experienced sleep disturbances.

The exposure to an attack left permanent scars to a participant:

"…I now have this 4cm scar in my face…" (P8)

The physical harm created anxiety and uncertainty for the unknown:

"...I was very scared because I did not know if my hand would work again... I

couldn't even move my fingers." (P4)

The participants mentioned that during the attack they strived to survive and needed to fight for their lives, leading to physical injuries:

"...I defended with the arm... he could have stabbed me anywhere..." (P2)

Exposure to violence has immediate and long term consequences, such as death and disability that reduce the quality of life (Slazinger, Fieldman, Sctockhammer & Hood, 2002:429) The damaging effects of violence are debilitating and have major physical consequences; such as brain injuries, bruises, and chronic pain (WHO, 2007:7).

One of the participants mentioned his fear of permanent brain damage due to the violent incident that he was involved in:

"...I was very concerned because, I thought of the [brain] *damage that could have happened to me." (P6)*

Traumatic brain injury is one of the most devastating injuries an individual could sustain, whether it is caused by an accident or whether it is an intentional act (Butcher, McHugh, Lu, Steyenberg, Hernandez, Mushkudiani, Maas, Mamarou & Murray, 2007:281).

3.3.1.2   Psychological strain

Strains are an individual's response to stressors. In this study, the stressor is the violent act perpetrated against an individual. According to Tromp, Van Rheede and Blomme (2010:120), strain is experienced when the environmental demands or constraints are perceived by the individual to exceed his or her capabilities. Violence may be associated with a range of

emotional responses, and these experiences are often frightening and overwhelming to an individual.

The participants recalled the experience to be psychologically exhausting:

"I was scared at first..." (P3)

"I was just scared when they [perpetrators] *approached me." (P4)*

According to Grant, McCormick, Poindexter Poindexter, Simpkins, Janda, Thomas, Campbell, Carleton and Taylor (2005:515), youth who are exposed to violence may have more internalise symptoms, such as anxiety and depression.

Another participant expressed the need to respond to the act of the perpetrator:

"I felt aggressive, it [incident] *made me feel aggressive... I was overwhelmed by the incident..." (P3)*
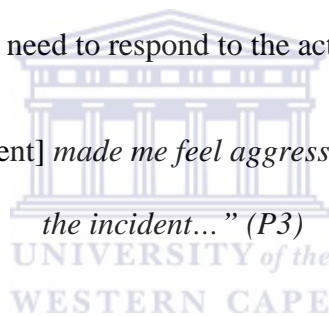
A participant mentioned the horror of being in such a situation for the first time:

"It was nerve wrecking; I had never been stabbed before. I was therefore terrified..." (P5)

"I thought they were gonna kill me..." (P3)

Kelly (2010:62) found that the youth were exposed to high levels of community violence. The study found that the exposure to violence left the youth and adolescents with feelings of aggression and anxiety, which later resulted in rule-breaking behaviour and increased their chances of participation in gangs and gang activities. Injuries in terms of mental functioning due to the physical injuries of victimisation might coexist with psychosomatic symptoms,

especially characterised by post-traumatic stress disorder and grief reactions that were also associated with victimisation.

The participants described the feelings and experiences of anxiety disorders as a result of being exposed to a violent attack.

"I was scared at first, but stopped feeling fearful… after the first knock…" (P1)

"I did not feel anything, I was just scared…" (P2)

"…I was overwhelmed by the incident…" (P3)

"I think of what happened sometimes… I get flashbacks, and it is quite difficult for me." (P6)

A study shows that exposure to violence is associated with a range of emotional reactions (Ho, Cheung, You, Kam, Zhang & Kleiwer, 2013:1; Kelly, 2010:67). These reactions range from stress disorders, anxiety disorders, as well as feelings of hopelessness and helplessness.

Cooley-Strickland, Quille, Griffin, Stuart, Bradshaw and Furr-Holden (2009:132) found that the exposure to the external trauma roots exaggerated neurotransmitter activity and was linked to aggression and hypersensitivity, as well as physiological and subjective hyperarousal. The sensitivity of the incidents was expressed by the participants:

"Those guys could have killed me…" (P7)

"I thought I was gonna die…" (P5)

Those participants felt hopeless, and at some point wanted to give up on life. The violent experiences also exacerbated the feelings of aggression and anger for some participants.

"I felt aggressive, it made me feel aggressive, and the fact that it wasn't meant for

me…" (P3)

Exposure to community violence is associated with aggressive behaviour (Kelly, 2010:62). Coley-Strikland *et al*. (2009:134), concur that the depressive symptoms are evident in youth who had been exposed to environmental adversity like being a victim of violence.

3.3.1.3   Occupational concerns

The participants explained how the violent attack resulted in a social strain. They could not go to work for a certain period of time during their recovery. They were unable to function shortly after the incident; therefore, their work was affected. Most of the participants were casual workers at their workplaces; it implied that they did not earn an income for the days they did not go work.

The trauma had a financial implication on their social lives and their ability to provide for their families and for themselves:

"...and I do not have a lot of leave days, so I will have to take unpaid leave until I

feel better…" (P1)

The participant reported a loss in income due to the injury sustained. That affected the family's ability to make ends' meet. Therefore, the injury did not only affect the individual but the people who were financially dependent on him too.

Himmelstein, Warren, Thorne and Woolhandler (2005:66) conducted a study on the impact of injury on the economic status of individuals or victims of injury. They discovered that people who were injured had increased medical costs. Some participants went without water

or food, even had to move residences because of financial difficulties caused by an inability to work.

A participant reported going to work while he was still not well, since he could not afford to stay away from work. That influenced his productivity at work because he worked as a cleaner and could not clean properly due to his hand injury:

> *"...even the sick note I got is for two days and I can still not mop with this hand,*
>
> *but I need to go to work because I will not be paid if I do not have a sick letter*
>
> *(cleaner)..." (P4)*

It appeared that the participant was not even sure about how long it was going to take for him to return to a complete state of wellbeing that would enable him to work and provide properly for his family. Due to a sick note that only covered two days, the patient had to go to work before full recovery, since he could not be remunerated for days that he could not provide sick notes for.
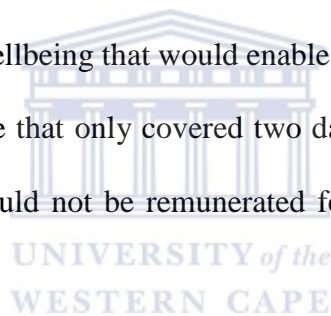
Stewart, Ricci, Chee, Hahn and Morganstein (2003:3116) conducted a study on the productivity of patients who suffered from depression. They found that productivity was negatively influenced, since the workers worked slower than usual, felt fatigued at work, and completed much less tasks on the days that they were not feeling well.

3.3.2   Applied defensive coping strategies to deal with the trauma

Theme 2 comprises the following categories: Denial, rationalisation, and blame. The defence mechanisms are the spontaneous psychological processes that protect the individual against anxiety and from the consciousness of the inner dangers and stressors. Lazarus (2003:95) defines coping mechanisms as "the cognitive and behavioural efforts made to master, tolerate, or reduce external and internal demands and conflicts within one's self". Through

the coping process, an individual makes an effort to handle conditions that evoke hostile emotions by managing those emotions on their own (Riolli & Savicki, 2010:97).

The individuals are not usually aware of this reaction while it is happening. Coping is critical to a full understanding of the effects of stress on youth members because not only does it describe the individual's role in dealing with the demands of danger situations they have encountered, but also has the potential to reflect on how they would deal with future adverse situations (Skinner & Zimmer-Gembeck, 2007:119).

When these participants were faced with a violent ordeal, they projected certain feelings towards the perpetrators and also towards the nursing staff who cared for them.

3.3.2.1   Denial as a coping mechanism

Zimmerman (2007:297) defines denial as a natural defence to repress an unpleasant reality both on an individual and on a societal level. Denial is avoiding the awareness of some painful reality or existence of a severe problem. It is when the person escapes from the reality of adversity he or she has experienced.

Participants shared how they blocked their feelings of fear and stopped feeling the pain that was inflicted on them while the victimisation was happening:

>*"I was scared at first, but I stopped feeling fearful because after the first knock,*
>
>*it's painful, but the second time, you can't feel anything." (P1)*

>*"I did not feel anything; I was just scared when they came…" (P2)*

The patients became "used to" to the pain that they felt during the attack. This was the psychophysiological response to the trauma that they experienced. They described their

experiences as the pain disappearing while they were being assaulted. That is how their psyche and bodies dealt with the victimisation at the time it occurred.

In a study conducted by Lindgren and Renck (2008:222) on women who had experienced violent relationships, the participants mentioned that at the time of the violent incidents, the victims felt a lot of fear and uncertainty and that they desired change. Particularly the women in this study mentioned that when the violent attack happened for the first time, they were in shock and disbelief.

According to Walter, Leibner, Jerg-Bretzke, Hrabal and Traue (2010:466), the traumatic experiences cannot be cognitively or behaviourally coped with in the same manner we deal with everyday stress. During extreme stress, the brain tries to avoid acute stress through central nervous system and psychophysiological activity. However, the memory trace of the event remains retrievable.

These authors also mention that during an attack, one of the survival mechanisms of the brain allows the victims to dissociate the extreme insufferable feelings of fear and anxiety from their consciousness at that time.

3.3.2.2   Rationalisation as a coping mechanism

Rationalisation is the defence mechanism in which a person attempts to justify (behaviour or attitude) by logically justifying the reasons. Palmer (2009:1) suggests that when an individual becomes fearful in a traumatic event, from which there is no escape, his or her feelings of helplessness and total loss of power and control form a script that becomes engraved in the neurological pathway of the central nervous system. A participant stated:

> *"…I was scared at first but, I stopped feeling fearful because after the first knock,*
>
> *it's painful, but the second time, you can't feel anything…" (P1)*

The participant rationalised the pain because after the first hit, his justification enabled him to tolerate the pain that was inflicted on him.

One of the participants defended the behaviour of the criminals that violated him by understanding that they were doing it because they wanted to buy drugs with the money that they stole from him:

"…And that I was going to have this 4cm scar in my face, because of the

gangsters that crave for tik." (P8)

When something transpires that a victim find challenging to accept, that person would usually concoct a logical reason why it has happened. Bullies also rationalise by proclaiming that their victims 'deserved' the violence inflicted on them.

When decision makers make use of their defence mechanisms, they start blocking out vital information and the capacity to evaluate their situation effectively. Critical details are rationalised away or pushed out of consciousness. The ones with different points of view are turned upon or they simply decide to keep quiet (Chapman, 2006:1400). That was evident in this study because some of the participants did not open a case against the perpetrators because they attempted to understand why they were assaulted; they started justifying the perpetrators' actions.

3.3.2.3   Blame as a coping mechanism

According to O'Connor, Kotze and Wright (2011:115), a phase of blame is a common phenomenon that arises after an initial state of shock once an individual grasps the magnitude of the incident and feels that the universe is no longer a rational and orderly system.

The participants blamed the nurses for their bad experience at the day hospital for their "non-caring" attitude. That was a psychological response that allowed the patients to shift the adverse feelings caused by the perpetrator to feeling that the nurses made it worse by not attending to them immediately. Their personal experiences eclipsed the fact that the trauma unit inundated with many patients who were either injured or medical emergencies.

The feelings of neglect led the participants to project their anger and disappointment to the nursing staff at the day hospital:

"…and I felt neglected somehow…" (P3)

"…the staff… I got no support, I was sitting here… I could have bled to death
because they let you wait the whole time…" (P4)

According to O'Connor *et al*., (2011:1155), blaming provides an early, simple, and non-reasonable solution to multifaceted inter-personal or situational problems. It is the process of identifying the problem as a result of another person's actions. In a trauma setting, this generates fear, as well as destroys trust in the medical and nursing team in the unit.

3.3.3   Diverse experiences of care and support

According to McAlpine and Amundsen (2011:173), diversity of experiences means the way different participants would understand the care and support; this includes openness to differences among people, values, cultures, and perspectives.
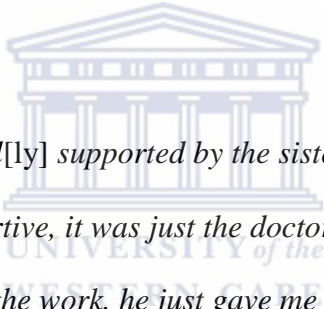
In most cases, the trauma unit is the first point of contact after the patient has experienced a violent attack in a community. The Mitchells Plain Day Hospital is open for 24 hours, 7 days a week. This enables the victims of physical trauma to seek assistance at any time of the day. The participants articulated that they experienced lack of support, whether it was either

interpersonal or external support, or both. However, some of the participants had positive experiences with the care and holistic support they had received at the community health centre.

3.3.3.1   Positive experiences

Some patients reported positive experiences in respect of the treatment they received from staff members. They reported that the support assisted them to cope better with the trauma that they experienced and restored their positive outlook on life.

Participants felt cared for and emotionally supported when they were probed about what had happened to them. One participant experienced the support as a sign of concern that the nurses displayed:

> *"I can say I was emotional*[ly] *supported by the sister that did my dressing, she was very helpful and supportive, it was just the doctor that didn't seem to care, he just told the sister to do all the work, he just gave me pain tablets. …it felt like she wanted to know what was wrong with me and was interested in knowing what had happened. For me it was a sign of showing concern so that made me feel better…" (P3)*

A participant indicated that information provided left them feeling more confident:

> *"The sister told me it was going to be okay, I was alright after that. I felt better…" (P4)*

Another patient pointed out that psychosocial care provided was essential to him:

> *"…they gave me emotional support, they told me to be strong. I felt better afterwards because of the support that I got from them." (P7)*

According to the participants' recollection, the support that they received from the nurses in the form of asking what had happened, giving advice on how they could recover sooner, and giving health education with regard to their injuries and how to care for the wounds. That on its own made a huge difference to the manner in which the participants perceived the care that they received from the nurses and the hospital staff in general.

In their study about patients and their families Boti, Endacott, Watts, Cairns, Lewis and Kenny (2006:309), recognise the provision of psychosocial care as a multi-professional process and when it is provided to patients and their family, they are more confident to adhere to their treatment and they participate more actively in their treatment regime.

Auerbach, Kiesler, Wartella, Rausch, Ward and Ivatury (2005:203) also concur with the findings of this study by stating that the nurses as far as possible are to provide, clear, understandable, and honest information about the patients' condition.

Both the abovementioned studies specifically emphasise the importance of providing information and effective communication, not only to the patient but to the family members who accompany the patients to units.

A study conducted by Haskard, DiMatteo and Heritage (2009:22) evaluated patient-level variation in the communication pattern that predicted satisfaction. They found that positive nurse-patient communication led to a patient feeling that the nurse was empathetic, friendly, and had a caring attitude towards them.

3.3.3.2   Negative experiences

Participants experienced that they were not supported emotionally when they approached the health services for treatment. Some described their experience as painful and viewed the nursing staff as uncompassionate.

One participant described that the lack of communication had left him feeling neglected:

"…that day, the lady doctor was just consulting with the other doctor but had

minimal conversations with me, and I felt neglected somehow. This is my first time

being injured, but its hurtful and a painful experience…" (P1)

Another participant felt that the long waiting hours would have caused his death if he had sustained the wound elsewhere:

"It's like the people here are not interested, because if I had a wound somewhere

else, I could have bled to death because they let you wait the whole time…" (P2)

The participant felt that the information requested from him was insufficient:

"...they just asked me with what was I stabbed and asked me to show him the

wound that was all..." (P2)
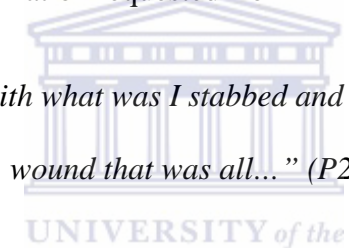
Those participants felt like they were treated as objects, and their interaction with the nurses and doctors was dissatisfactory.

Muntlin, Carlsson, Gunningberg and Sweden (2010:319) asked their participants (nurses and doctors in the emergency units) what they viewed as barriers to the quality of care that they provided. They mentioned three main barriers:

1.   The patient is viewed as an object or a problem.
2.   The physicians and nurses had different cultural backgrounds
3.   The hospital organisation that hinders the optimal flow of patients and improvements to quality.

The first barrier was evident in this study, since the participants confirmed that they were treated like objects.

Some participants felt that the nurses were not empathetic towards them:

"I felt bad, I thought these people don't want to help me and I don't know why...

It was sad..." (P2)

According to Dinkins (2011), empathy is one of the basic building blocks of ethics and ethical conduct toward fellow human beings. Without empathy, it is challenging for any of us to recognise the needs and wants of other people to enable us to know how to treat them kindly and generously, or to practise nursing effectively in our day-to-day interaction with them.

A patient also felt that the nurses were just rushing to finish with her and it felt like she was treated like an object instead of an individual:

"...for me it really felt like she was rushing and wanted to get off me... I believe

each person is unique and should be treated with care." (P7)

One of the patients felt that they were ignored by the nurses and that the nurse was not there for her:

"The nurse that stitched me just cut my weave off... he did not listen to me when I

asked her not to cut it off and to try be careful. She ignored me... I was so sad.

She had no empathy at all..." (P7)

A participant reported that he was not supported in terms of proper communication. He did not get adequate information and the communication was not clear. That made him feel sad:

"...most of the people were sick, but there was one guy that was stabbed in the

finger, and he came for stitches. He just came; he came three hours after me. He

just came, got his folder, waited for about ten minutes and was helped and left... I

did not understand because they helped people that came after me first, I don't

know why, but I just kept quiet. But there was a thing on the wall that read, a

patient will be helped by the colour code and mine was red, so ((lifting

shoulders))... I also thought is my name on there, is my folder there? Because

they had not called my folder yet. I got a bit worried, then I went again to check

my folder and they just told me to wait... they did not even check my folder... it

was sad..." (P2)

Another participant stated:

"I was not given the proper information on when I would be able to work." (P3)

Pytel, Fielden, Meyer and Albert (2009:406) are confident that communication amongst nurses, patients, and patients' family members play an important role in the the recovery of patients after an experience of illness. Their quantitative study was conducted in an emergency department with patients about their satisfaction with the communication between them and personnel of the emergency department. The youth patients of this study assisted the researcher to identify three main communication needs, which were explanation of the procedures done on them, education about their injuries or illness, and circumstances that may require them to return to the emergency unit.

Some of the participants were concerned about the fact that the triage system was not clear to them. They waited for hours without knowing what had happened to their folders, whether they were still in the system, or whether their folders had been thrown out.

Emergency unit triage is the process of filtering patients based on their medical urgencies (Twomey, Wallis, Thompson & Meyers, 2011:4). Its main aim is to determine the patient's need for urgent care, in order to facilitate care before their condition worsens. This information is displayed in the waiting area of the trauma units. Although this system is implemented, patients still wait longer that what the triage score suggests. This is usually due to the high turnover of patients in the emergency unit.

The participants were scared to ask the nurses how far their folders where and what the reasons were why they had to wait for such a long time. They also witnessed how the some of the other patients who asked were told to "just" wait:

> *"We were just sitting there waiting for my name to be next, but it didn't seem to happen..." (P5)*

> *"...after the looong wait, I was called in, by that time I had even lost hope that they had my folder or while I was in toilet. I wanted to ask but I observed how people that were asking were just told to wait." (P7)*

A participant felt that if she could afford private care she would have, since she would not have waited such a long time to get treatment:

> *"I arrived here at the hospital at around 7:30 pm on a Friday night and I was only seen on Saturday at 4:00 am. So, it was a nine hours wait. It must have been the longest wait of my life. I never thought that I a person* [sic] *can wait this long for medical assistance. I felt like if I had money or medical aid, I would have received better and quicker medical care..." (P7)*

In the study conducted by Pich, Hazelton, Sundin and Kable (2010:270), they found that the long waiting hours frustrated the patients. According to the triage score, the patients who had

to be treated within an hour also had to wait for three to four hours. In the same study, they found that patients perceived emergency departments as a public entitlement, thus having unrealistically high expectations of the nurses.

The participants felt discouraged as a result of the long waiting hours and lack of communication. The trauma units at the community health centres – due to the increase in community violence and gang-related injuries in the communities – were usually under pressure to provide emergency medical treatment to the injured people.

Some people are either uninsured or underinsured. These people primarily relied on government emergency facilities for treatment (Hooper, Craig, Javrin, Wetsel, Reimels & Clemson, 2010:420). Everyone needs to be treated, but this frequently results in long waiting times, overworked personnel, and patients who are often not satisfied with the service provided (Nash, Zachariah, Nitschmann & Psenck, 2007:15).

However, personnel do not have any control over the types of patients that present and the pace at which they arrive; even more so when the hospital is full to capacity.

A participant felt frustrated that he got inadequate care, since he did not receive proof that he attended the day hospital:

> *"…made me feel frustrated and useless, because, because I do not understand*
> *why I did come here and I didn't get nothing, I cannot even produce a sick note at*
> *work or even knowledge of how long this was gonna take for me to heal…" (P3)*

Patients in the emergency unit of the day hospital usually have injuries that require a period of absence from work; due to their injuries, they are unable to perform their normal work activities. A doctor who treats and diagnoses a patient initially is better equipped to estimate

the time off work that is required for proper recovery (Walker, Gregori, O'Connor, Jaques & Joseph, 2007:31).

3.4 CONCLUSION

This study explored and described the lived experiences of youth victims of physical violence about the support at the community health centre in the Cape Flats. Through data analysis, three main themes emerged, namely (i) violent incidents that impacted negatively on the participants' experiences, (ii) the use of defensive coping strategies to deal with the trauma, and (iii) diverse experiences of care and support. Some of the participants had a positive experience at the community health centre, while other participants had negative experiences. That indicated that some participants were resilient and had protective factors while some did not and experienced psychological distress due to the incident.
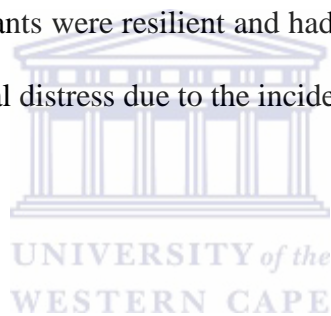
CHAPTER 4

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

4.1 INTRODUCTION

This chapter focuses on the conclusion of the study, proposes actions to the professional nurses at the community health centre, and recommends actions for practice, research, and nursing education. The research question required answers to: *How can nurses at a community health centre support the youth victims of physical violence after a violent incident?* The challenges and limitations of the study are also outlined.

4.2 CONCLUSIONS

Violent incidences affected the whole being of the participants. During a violent encounter, the participants experienced a range of physical injuries caused by the attack. Some of these were threatened loss of limbs and head injuries. Some of these injuries had long-term effects on the individual that might affect their quality of life later in life. The effects of community violence also had psychologically exhausting repercussions for the participants. Some of the participants were able to cope with these effects due to the support they had, while some experienced symptoms of psychological discomfort, such as aggression, anxiety, and depressive symptoms. According to Kelly (2010:62), youth who are exposed to these symptoms are likely to participate in gangs and gang activities. Post-traumatic stress disorder is another symptom that these youth is likely to develop.

Many of the participants lost their income due to absence from work while they were recovering from the injuries. Another concern of those participants was that they had part-time jobs, which meant that the 'no work, no pay' principle applied. So, even when they were issued with sick notes, they either did not use the entire period to recover from the ailment, or

they were not going to get paid for the days that they were absent. Some of the participants were worried that when they returned to work, their jobs would have been given to other people. This phenomenon did not only affect the individuals but their family too, since these participants had families who depended on them financially.

Some of these participants could not afford to stay away from work; therefore, they opted to go to work before their injuries healed properly. That increased the risk of infection to the wound; a particular participant was a cleaner and was exposed to unhygienic conditions.

Participants applied defensive coping strategies. Some of the participants used defence mechanisms to cope or make sense of what was happening. Some of the participants "got used to" the physical and psychological pain that they felt during the violent attack. Walter, *et al*. (2010:466) describes such an action as a temporary measure to escape from what has occurred but the memory trace of the event remains retrievable in the subconscious.

The participants presented signs of rationalisation as a defence mechanism. They tried to understand why the perpetrator had attacked them, which they mainly believed it could be attributed to their need for money to buy drugs, since some of the participants were attacked during a robbery. Some participants reported loss of sensation during the attack; at some point they did not feel any pain while they were attacked. In that manner, they managed to escape severity of the situation and were able to tolerate the pain inflicted upon them.

As a result of the injuries the participants sustained, they thought that they would be prioritised when they arrived at the emergency unit of the day hospital. When this expectation was not met, they started blaming the nurses for lack of care and they expressed feelings of neglect, based on their perceptions of the nurses' actions.

Diverse experiences of care and support were found. The participants had diverse experiences at the day hospital. Some participants expressed positive experiences with the care they received at the emergency unit of the day hospital, while other participants had negative experiences. Patients experienced emotional support from the nurses. That support they they derived from the way the nurses showed concern about their injuries. The patients mentioned that the nurses provided them with the information about their injuries and how to take care of the injuries. That boosted their confidence to follow the treatment regime given to them and increased their sense of responsibility. A positive nurse-patient communication could lead to a patient feeling the nurse is empathetic, friendly, and has a caring attitude.

Some of the participant had an unfortunate experience at the day hospital. Some of the factors that led to their dissatisfaction were lack of communication. They felt that the staff members were merely interested in their wounds and they did not receive holistic care. They were simply requested to show their injuries, injuries were treated, and no other information was given to them. Another cause of dissatisfaction was long waiting hours; the patients did not seem to understand the triage system at the emergency unit of the day hospital. Therefore, that made them anxious about when they were going to be seen, since some of the patients waited over eight hours in the waiting room without knowing whether their folders were available or not. Those patients who attempted to ask were told to wait. Some patients were given sick notes for the day although they felt that their injuries were going to take more than one day to heal. They experience it as incompetent staff behaviour.

4.3 ACTIONS TO BE TAKEN BY THE PROFESSIONAL NURSES AT A COMMUNITY HEALTH CENTRE TO SUPPORT THE YOUTH VICTIMS OF PHYSICAL VIOLENCE

The nurses at the day hospital can aim at providing quality holistic care to the patients who present at the emergency unit of the day hospital. This means that every dimension of the patient as a person should be explored and where needed health education and advice should be given to the patient. When they leave the emergency room, they do not only feeling better physically, but they are confident to deal with the effects of the ordeal.

Providing holistic care of the patient includes physical, psychosocial, occupational, and emotional support by making use of effective communication.

4.3.1 Physical support

Patients need immediate support when they arrive at an emergency unit at the community health centre. This is done in triage where the nurses triage the patient to determine the extent of their injuries using a Triage Early Warning Score (TEWS). Those who are bleeding should be bandaged to stop the bleeding and patients should be comfortable.

4.3.2 Psychosocial support

According to Barry (2009:509), nurses spend quite a significant time with the patients and more than two thirds of this time is used for interpersonal interaction. Nurses should increase their communication with the patients in the emergency room. Every hour there needs to be a nurse who explains the procedure in the emergency room and answers any questions that the patients might have. A patient-centred communication style could have a positive effect on the patient-nurse relationship. This study proved that patients desired proper communication, especially the ones who were victims of physical abuse.

The operational manager of the trauma unit at the day hospital should ensure that the nursing staff has the ability to comfort, educate, and listen to patients and families in a caring and non-judgemental manner.

4.3.3   Occupational support

From a nurse's perspective, health education remains a primary function even in the emergency unit in terms of teaching patients how to treat their injuries at home with the aim of enabling them to return to work as soon as possible. The patients need this information in order to inform their employers how long they might have to stay away from work; also to make necessary arrangements to cope with their loss of income due to the injuries they have sustained. The nurse should also assist patients timely when their employers insist on receiving a medical report.

4.3.4   Emotional support

Being involved in a physical ordeal can be emotionally incomprehensible, thus the victims of physical violence need emotional care and assistance. The nurses should allow time for interviewing and counselling the patients to provide them with emotional stability before they allow them to go home. As small an intervention it may be, it is incredibly valuable to the patient. This should be routine practice in the unit, since patients who present are in distress. This can be incorporated in the care the nurse provides. While bandaging a wound or suturing the patient's wound the nurse's engagement with the patient would give one an indication of the patient's emotional status. This will definitely have a huge impact on the emotional outcomes of the youth victims of violence. Manton (nd:24) identifies two important attributes an emergency nurse should have and these attributes include compassion and humour. That would really help to improve the emotional status of the patients in emotional distress who visit the trauma unit.
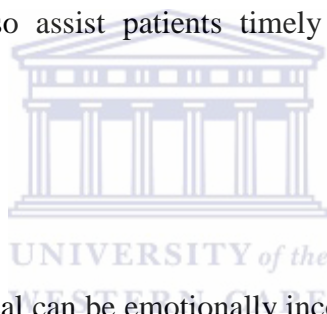
4.3.5   Effective communication

It is clear and evident that many patients have difficulties with understanding the South African Triage Score (SATS) used in nursing practice. Triage is the process of sorting patients based on the level of acuity of their medical needs to ensure that the most severely injured and ill patients receive timely care before their conditions worsen. The SATS scale has been developed out of a need for an accurate and objective measure of urgency based on physiological parameters and clinical conditions and for easy implementation at low resource settings (Rominski, Bell, Oduro, Ampong, Oteng & Donkor, 2014:2). However, a need exists for regular information sessions on the triage score for patients to understand how the scoring works and why they would wait longer than the time reflected on the triage score chart (Figure 4.1).

ADULT TRIAGE SCORE	3	2	1	0	1	2	3	© South African Triage Group 2008
Mobility				Walking	With Help	Stretcher/Immobile		Mobility
RR		less than 9		9-14	15-20	21-29	more than 29	RR
HR		less than 41	41-50	51-100	101-110	111-129	more than 129	HR
SBP	less than 71	71-80	81-100	101-199		more than 199		SBP
Temp		Cold OR Under 35		35-38.4		Hot OR Over 38.4		Temp
AVPU		Confused		Alert	Reacts to Voice	Reacts to Pain	Unresponsive	AVPU
Trauma				No	Yes			Trauma

over 12 years / taller than 150cm

Colour	RED	ORANGE	YELLOW	GREEN	BLUE
TEWS	7 or more	5-6	3-4	0-2	DEAD
Target time to treat	Immediate	less than 10 mins	less than 60 mins	less than 240 mins	DEAD
Mechanism of injury		High energy transfer			
Presentation		Shortness of breath - acute			
		Coughing blood			
		Chest pain			
		Haemorrhage - uncontrolled	Haemorrhage - controlled		
	Seizure - current	Seizure - post ictal			
		Focal neurology - acute			
		Level of consciousness reduced			
		Psychosis / Aggression			
		Threatened limb			
		Dislocation - other joint	Dislocation - finger or toe	ALL OTHER PATIENTS	
		Fracture - compound	Fracture - closed		
	Burn - face / inhalation	Burn over 20%			
		Burn - electrical	Burn - other		
		Burn - circumferential			
		Burn - chemical			
		Poisoning / Overdose	Abdominal pain		
	Hypoglycaemia - glucose less than 3	Diabetic - glucose over 11 & ketonuria	Diabetic - glucose over 17 (no ketonuria)		
		Vomiting - fresh blood	Vomiting - persistent		
		Pregnancy & abdominal trauma or pain	Pregnancy & trauma		
			Pregnancy & PV bleed		
Pain		Severe	Moderate	Mild	
	Senior Healthcare Professional's Discretion				

Figure 4.1:   The South African Triage Scale

This scale is used daily in the triaging of patients and is readily available in trauma units at the community health facilities and at the hospitals. The nurses should also display a caring attitude and willingness to assist patients with their queries.

Beyond the immediate medical attention that is provided at the emergency unit of the community health centre, victims and survivors of physical violence may need psychological

support and legal or housing assistance (Feldman-Jacobs, Guedes, Rege & Gribble; n.d:2). Therefore, nurses should always be vigilant enough to refer patients when it is necessary.

4.4   RECOMMENDATIONS

4.4.1   Nursing education

At the day hospital, the researcher identified a need for continual skills development, especially with regard to the health problems in that community. This study has confirmed that the Mitchells Plain community experiences a high rate of violent incidences. This leaves the community members in fear and most of them end up being victims of drug-related crimes. It remains the duty and responsibility of the hospital staff to be equipped and able to deal with these increasing incidents of caring for victims of physical violence.

The researcher recommends regular continual in-service training interventions need to be held quarterly for the nurses and doctors who treat these victims to equip and enable them to treat the patients holistically and not only the physical injuries of the youth victim of violence. All staff members – especially in the emergency unit of the community health centre – need to attend these training interventions. The training needs to be very practical to enable all personnel involved in the wellbeing of patients who are victims of physical violence to implement necessary support measures for these patients who arrive at the unit on a daily basis.

4.4.2   Research

The researcher recommends that further research be done on the prevalence rate in relation to victims of physical violence who seek medical assistance at the trauma unit of the community health centre. This will assist to quantify the problem and to effectively implement measures support these victims of physical violence.

The researcher also recommends that the study be done on the patients in the waiting areas of the emergency unit to identify whether they do understand the triage system and their experiences thereof. This has been identified as one of the problems, especially with regard to communication with the nurses while they are waiting to be attended to.

Another recommendation requires that the experiences of nurses who care for patients who are victims of physical violence in a trauma unit need to be explored. The nurses too might need some form of support to effectively care for these patients.

4.5   CHALLENGES AND LIMITATIONS OF THE STUDY

The results of this study were limited to the experiences of youth patients who had been victims of physical violence and who have attended the emergency unit of a community health centre where the research interviews took place. Therefore, these find findings cannot be generalised to an emergency unit at another community health centre. Furthermore, the findings of this study are only applicable to the population that was studied and not the entire population of patients who arrive at the emergency unit post physical victimisation. The researcher chose participants older than 18 years, as since for teenagers younger than 18, legally required their parents' would have to provide consent before they could be interviewed for research purposes.

A challenge and potential weakness of this study comprises a small sample size. Quantitative researchers sometimes criticise a small sample size of qualitative studies as unscientific and unrepresentative of the population. However, the principle in qualitative research is data richness, not quantity.

Another possible limitation might be that the sample consisted mostly of males; six of the eight participants were males. Although the inclusion criteria made provision for male and

female participants who were victims of physical violence, the majority of victims visiting the community health centre who were willing to participate in the study were male.

The researcher noticed that some participants needed a lot of probing. Nonetheless, the researcher attempted to ensure scientific rigor in the study (Chapter 2).

4.6   CONCLUSION OF THE STUDY

This study explored and described how youth participants who were victims of physical violence in the community experienced care and support from the professional nurses when they visited the trauma unit. Their experiences were diverse; some had positive experiences, while other participants had negative experiences.

The participants felt that they needed support in terms of correct information about caring for their injuries in order for them to return to work as soon as possible. Some patients mentioned that they almost wanted to go home because they did not know where they were in the queue of waiting patients and were afraid to ask, since they observed how those who asked were simply told to wait their turn.

All participants mentioned the need for effective communication, since they were in distress when they arrived at the emergency unit.

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INFORMATION SHEET

Project Title: The support of professional nurses to youth victims of physical violence at a community health centre in the Cape Flats

What is this study about?

This is a research project being conducted by Melitah Selenga at the University of the Western Cape. I am inviting you to participate in this research project because you are a youth member residing in the Cape Flats who is a victim of physical violence and you are between 18 and 24 years old. The purpose of this research project is to explore the lived experiences of youth victims of physical violence in the Cape Flats.

What will I be asked to do if I agree to participate?

Should you agree to participate in this study, you will be asked to have a one-on-one interview with the researcher at the day hospital at a time and date that are convenient to you. The interview will take 30 to 45 minutes and the researcher might request more than one interview with you. You will be asked this question: "***How was it for you after the physical violence?***"

Would my participation in this study be kept confidential?

I will make every effort to keep your personal information confidential. To help protect your confidentiality, the researcher will not share the information you provide to anyone other than the supervisor and the independent coder. All information will be kept in a locked cabinet that only the researcher and the supervisor will have access to. Your name will not be used anywhere in the research report. Any information stored in a computer will be protected by a password for the researcher only. When I write a report or article about this research project, your identity will be protected to the maximum extent possible.

What are the risks of this research?

There may be some risks to participating in this research study. While the participants are sharing their experiences, some traumatic emotions may resurface. Should this happen to you, the researcher will refer you to the counselling services at the community health centre.

What are the benefits of this research?

This study is not designed to help you personally but the results will assist the researcher to understand the experiences of youth as victims of physical violence in the Cape Flats and to make recommendation to the community health centre how to assist the youth who deal with the implications of exposure to a violent incident. We hope that, in the future, other people might benefit from this study through an improved understanding of the experiences of youth members after a violent incident in the Cape Flats.

Do I have to participate in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalised or lose any benefits that you are entitled to.

What if I have questions?

This research is being conducted by Melitah Selenga in the School of Nursing at the University of the Western Cape. If you have any questions about the research study, please contact Melitah Selenga at:

Room 4 School of Nursing

Senate Building

University of the Western Cape

Tel: 021 959 2748 or 073 130 6317

Email: mselenga@uwc.ac.za / kjooste@uwc.ac.za

Should you have any questions about this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department: Prof Adejumo

Tel: 021 959 2271

Email: oadejumo@uwc.ac.za

Dean of the Faculty of Community and Health Sciences

Prof Hester Klopper

Tel: 021 959 2856

Email: hklopper@uwc.ac.za

University of the Western Cape

Private Bag X17

Bellville 7535

Supervisor: Professor K. Jooste

University of the Western Cape

Private Bag X17

Bellville 7535

Tel: 021 959 2274

Email: kjooste@uwc.ac.za

This research has been approved by the Senate Research Committee and Ethics Committee at the University of the Western Cape.

Melitah Selenga: …………………………………. Date: ....

Prof K. Jooste (Supervisor): …………………………. Date: ....

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WRITTEN INFORMED CONSENT

Letter of request to participate in the study

Title of Research Project: The support of professional nurses to youth victims of physical violence at a community health centre in the Cape Flats.

I, Melitah Selenga, has discussed the information sheet and ethical principles followed in this project with the participant. It is my opinion that the participant understands the risks, benefits, and obligations involved in participating in this project.

Signature of the researcher: ……………………….   Date: ………………

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name: ……………………………………

Participant's signature: ……………………………….

I further agree that the interview be voice recorded.

Participant's signature: ………………………………..   Date…………………

I further agree that the researcher takes field notes.

Participant's signature: ……………………………. Date…………………

Witness: ……………………………. Date…………………

Should I have any questions about this study or wish to report any problems I have experienced related to the study, I am allowed to contact the study supervisor:

Study supervisor: Prof Karien Jooste

University of the Western Cape

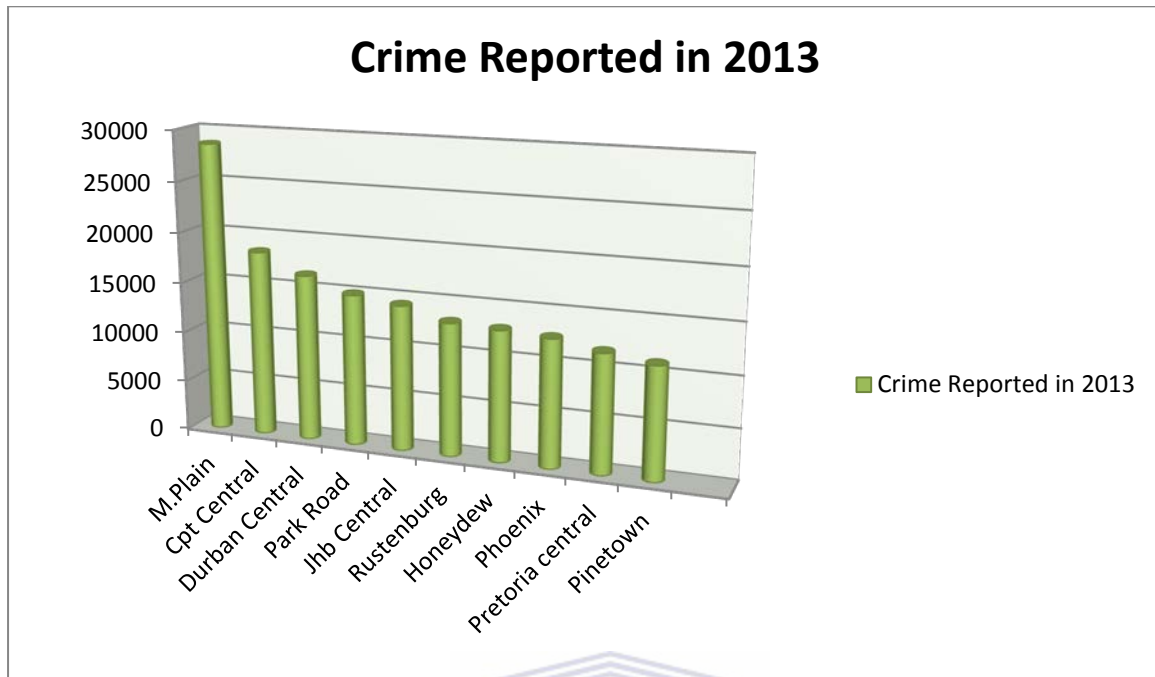Private Bag X17, Bellville 7535

Telephone: (021) 959 2274

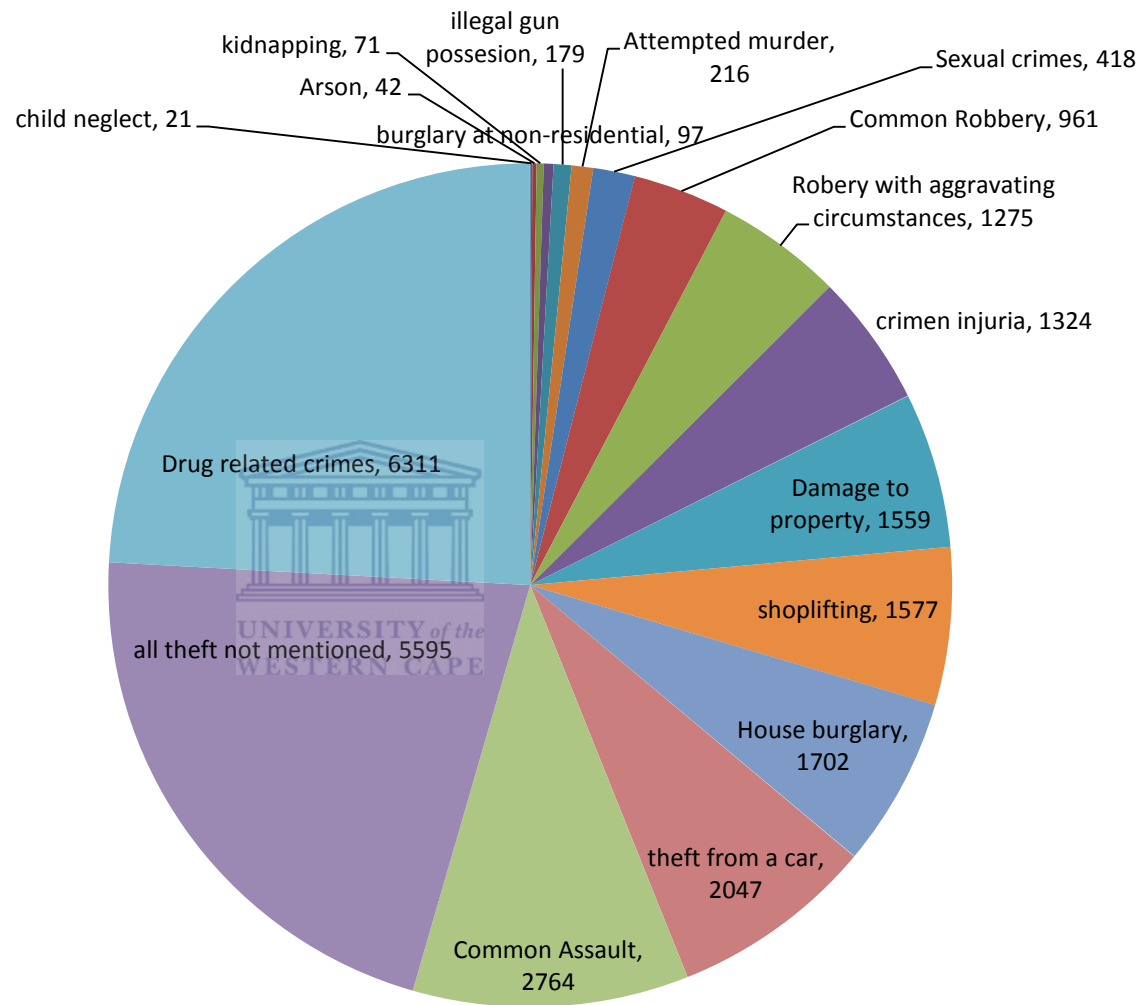Cell: 082 897 2228

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APPENDIX C: CRIME IN MITCHELLS PLAIN

Crime Reported in 2013

Graph 1:   South Africa's top 10 Crime hotspots 2013.

Source: www.crimestatssa.com

Graph 2:   Crimes reported in Mitchells Plain in 2013