

**SOCIAL SUPPORT AS A MODERATOR OF POST TRAUMATIC STRESS
DISORDER AMONG SEXUAL ASSAULT SURVIVORS IN NGAKA MODIRI
MOLEMA DISTRICT, NORTH-WEST PROVINCE**

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Declaration

I the undersigned declare that, “*Social support as a moderator of posttraumatic stress disorder among sexual assault survivors in Ngaka Modiri Molema District, North-West province*”, is my original work and that all the sources that I have used or cited have been indicated and acknowledged by means of complete references.

Signature: _____ Date: _____

Acknowledgement

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Abstract

Statistics of sexual assault, which are the underestimations, suggest that it is a global problem with various serious negative implications on the individuals, communities and nations and is highly prevalent in the Republic of South Africa. It impacts on the physical, social, occupational and psychological wellbeing of the aggrieved as well as those who provide informal and professional care to them. The most common sequel of this traumatic event is another serious mental condition called Posttraumatic Stress Disorder (PTSD). PTSD is said to be very difficult to successfully permanently treat and often leaps back in the individual after some time post-therapy. Yet social support can prevent this condition and/or enhance the efficiency of therapies employed against it. But all this is based on the international scholarly work and is inadequately addressed in the Republic of South Africa which is said to top the world with the prevalence of sexual assault. The purpose of the study was to investigate the impact of social support on PTSD among sexual assault survivors in the Ngaka Modiri Molema district of North-West Province.

A quantitative cross-sectional ex post facto study was undertaken with the sample of 115 women who were sexually assaulted and met the selection criteria for participation. The method of data collection was the use of structured interviews (guided by the interview guide) in the setting/venue and time selected by the participant. The interview guide was comprised of four sections which are demographics, social support grid, PTSD Checklist – Specific Version symptoms scale, and rape myth scale. The frequency statistical test to determine the incidence of PTSD, correlational and ANOVA statistical tests to determine the relationship between PTSD and social support were run using the Statistical Package for Social Sciences version 21.

The majority of participants were of the age range of 18 to 25 years, with low or no formal education, low income and unemployed. Almost all the participants reported receiving adequate social support, very little of social undermining and very little negative social reactions. About 71.3% of participants met the DSM-IV-TR Diagnostic criteria for PTSD based on the three symptom clusters. No statistically significance, neither positive nor negative, association between PTSD and social support was found. The results are discussed based on the three objectives of the study and are applied the conceptual model that guided

the study. Limitations of the study and recommendations for practice, nursing education and further research are also discussed.



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List of Acronyms

AIDS	: Acquired Immunodeficiency Syndrome
CBT	: Cognitive Behaviour Therapy
CITI	: Collaborative Institutional Training Initiative
DoH	: Department of Health
DRC	: Democratic Republic of Congo
DSM-IV-TR	: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition- Text Revised
FBI	: Federal Bureau of Investigations
HIPAA	: Health Insurance Portability and Accountability Act of 1996
HIV	: Human Immunodeficiency Virus
IRB	: Institutional Review Board
NWP	: North West Province
PEP	: Post Exposure Prophylaxis for HIV Infection
PTSD	: Posttraumatic Stress Disorder
RSA	: Republic of South Africa
SAPS	: South African Police Service
TCC	: Thuthuzela Care Centre
UCLA	: University of California, Los Angeles
UNICEF	: United Nations Children’s Fund
UNODC	: United Nations Office on Drugs and Crime
USA	: United States of America

CHAPTER ONE

OVERVIEW OF THE STUDY

1.1 Introduction

This chapter introduces the problem and shows the extent as well as the impact of the problem. The focus of the study is sexual assault and most common mental health sequel, Posttraumatic Stress Disorder (PTSD). Social support is analysed as this remains one of the mitigating factors of PTSD. Thus, this study seeks to investigate if social support can be employed as cost-effective therapy for PTSD among sexually assaulted women.

1.2 1.2 Background

Sexual assault appears to be a worldwide phenomenon. The report from the Seventh United Nations Survey of Crime Trends and Operations of Criminal Justice Systems by the United Nations Office on Drugs and Crime (UNODC), covering the period 1998 – 2000, ranked Australia the third, the United States of America ninth and Canada fifth in the world in the prevalence of rape (UNODC, 2010: 25). The Republic of South Africa (RSA) is the leading country in the world followed by the Seychelles. The latter two countries are both African countries and as such suggesting a high prevalence of sexual assault in the continent. Zimbabwe is the fifth highest country in Africa. On the other hand, Europe appears to have the least number of sexual assaults as three of its countries, United Kingdom, Spain and France, are ranked the lowest with France being the lowest in the world rank. Figure 1.1 illustrates the statistics from the United Nations Survey (UNODC, 2010: 25).

Although there is no recent statistics that provides a comprehensive magnitude of sexual assault globally, individual national statistics implies that this is still a problem. Holt (2002:91) found that as much as 70% of female adolescents were sexually harassed in a study carried out in a medium-sized school in the USA. It is reported, by the Federal Bureau of Investigations, that rape statistics in the USA were 92,427 in 2007 and 89,000 in 2008 (FBI, 2009). Furthermore in 1996, the rape offences were estimated to cause U.S.A. about \$127 billion per year (Miller, Cohen & Wiersema, 1996: 17).

The majority of available statistics on the magnitude of rape is deducted from police reports based on the reported cases. Similarly, Elwood, Smith, Resnick, Gudmundsdttir, Amstadter, Hanson, Saunders and Kilpatrick (2011:170) found that 12.5% of female adolescents experienced sexual assault which led to the estimation of more than 1.3 million female adolescents who were sexually assaulted between 1995 and 2003 in the USA.

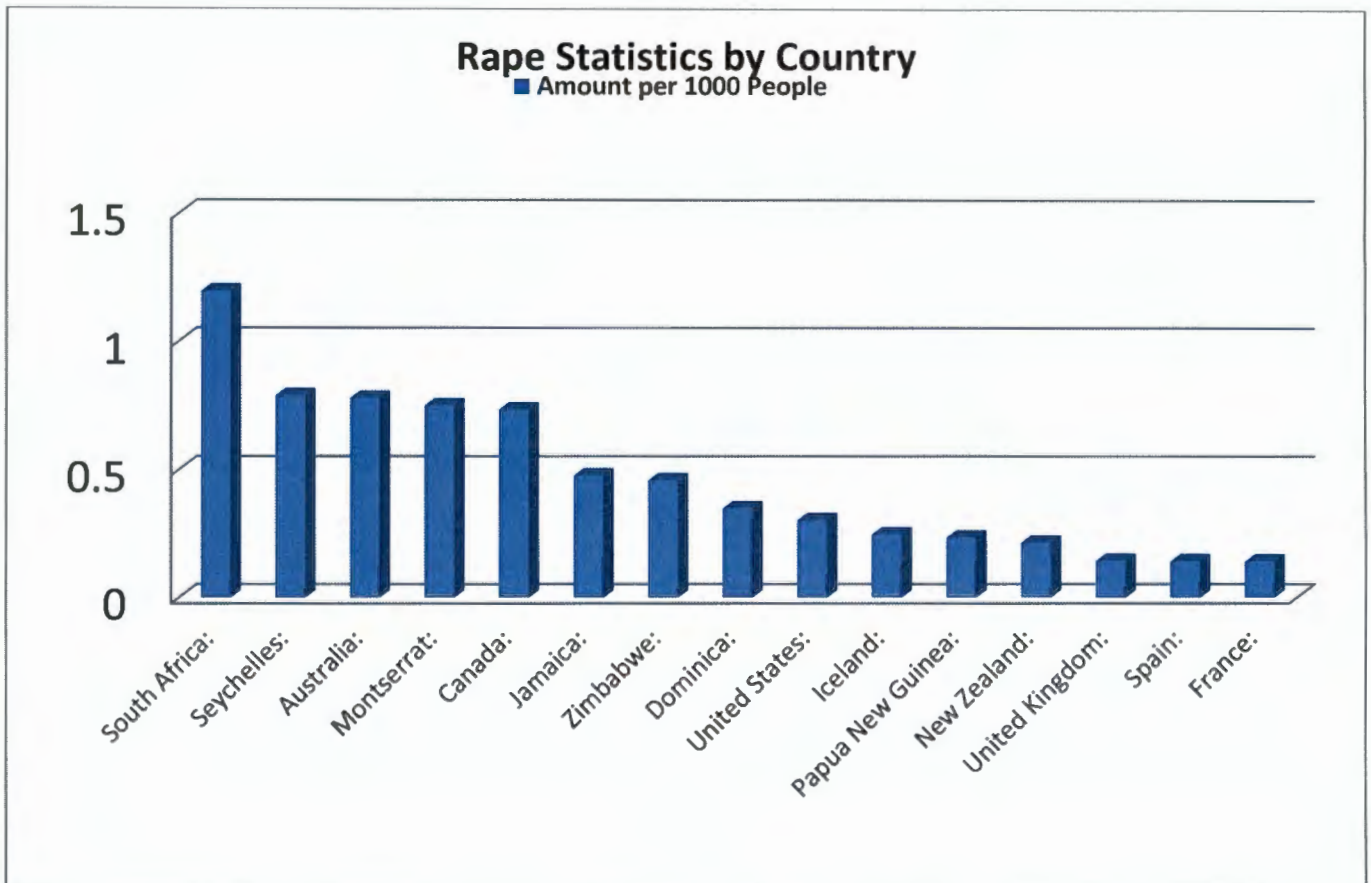


Figure 1.1 Global statistics of the prevalence of rape (UNODC, 2010: 25)

The South African Police Service (SAPS, 2011: 6) crime report suggests that the country is still having a paramount problem with sexual assault as it is still among the highest reported crimes in the country. These statistics show that sexual offences increased with 10.1% (from 133.4 to 146.9) from 2007/2008 to 2008/2009 but decreased with only 4.4% (from 146.9 to 138.5) from 2008/2009 to 2009/2010. The SAPS classify crimes into different categories and sexual offences fall under a category called contact crimes (crimes on a person) which account for 31.9% of all crimes. This is 5.8% higher than the second highest type of crime.

In this highest category of crimes, sexual offences contribute 10.1% (SAPS, 2011: 6). The report shows that between 2008/2009 and 2009/2010 sexual assault offences decreased with 4.4% from 70 514 to 68 332, between 2009/2010 and 2010/2011. A decrease of 4.4% from 68 332 to 66 196 was noted which is far below the national target reduction of 7% to 10% per contact crime set January 2004 (SAPS, 2011: 10).

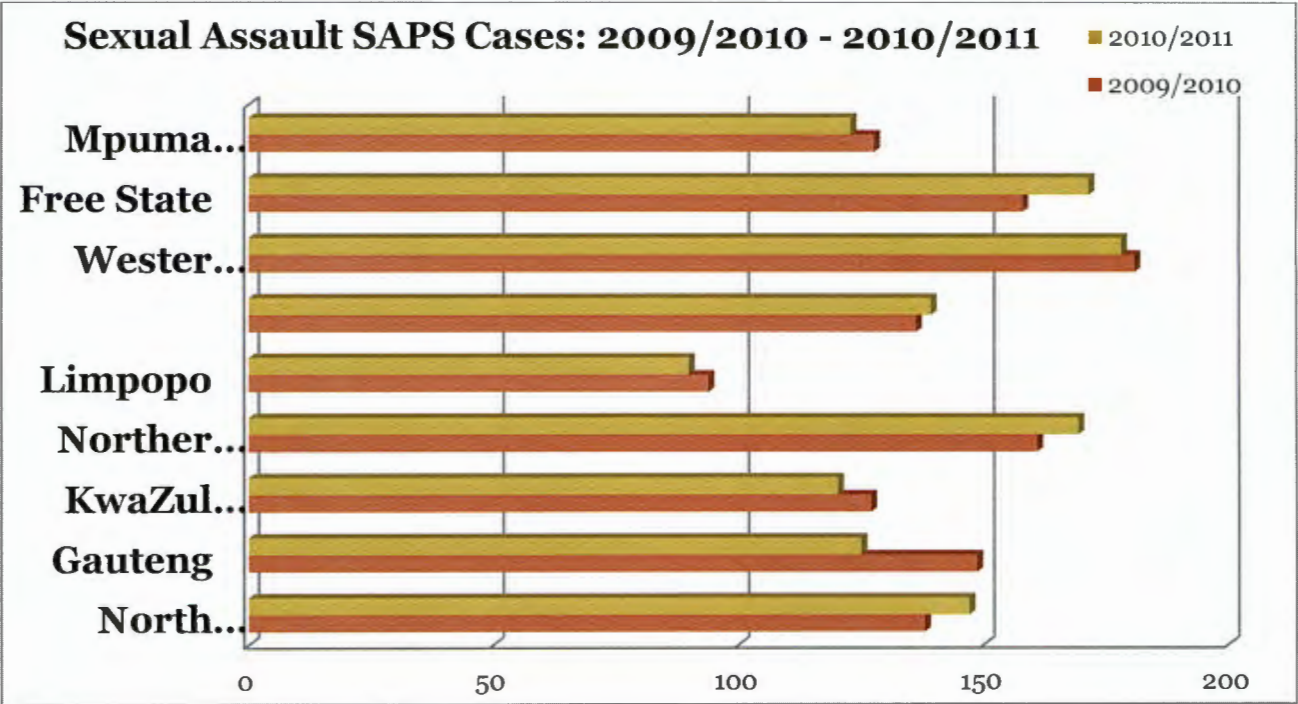


Figure 1.2. Comparison of the SAPS rape statistics of 2009/2010 and 2010/2011(SAPS, 2011)

The highest incidence was recorded in the Western Cape Province at 178.0 per 100 000 population showing a decrease of only 1.5% from the previous year. Limpopo Province was again the lowest in the incidence at 122.8 per 100 000 population with a decrease of 3.8%.

This report shows that four out of nine provinces experienced an increase and only one reached the national target reduction in the number of sexual offences. The highest increase was in the Free State Province with 8.6% and the highest decrease was in Gauteng Province with a 15.9% decrease (SAPS, 2011: 28). The North-West Province (NWP) featured as the fourth highest in the incidence of sexual offences, and recorded the second highest increase of 6.6% from 137.9 per 100 000 in 2009/2010 to 147.0 per 100 000 in 2010/2011 (SAPS, 2011: 28). The summary of the statistics from the SAPS 2010/2011 crime report is provided

in Figure 1.2. This implies that the province that served as the context of this study is doing extremely poor in a fight against sexual assault and this called for research studies in this field.

Despite these alarming high rates of sexual assaults presented by the SAPS literature suggests that we are not looking at the whole picture. A study conducted by Jewkes and Abrahams (2002: 1233) found that rape statistics based on cases reported to the police were significantly lower than those reported in community-based surveys. This implies that far more women than estimated are being raped in RSA.

Rape and sexual assault have a negative impact on victims, caregivers and society at large which can affect victims physically, emotionally, mentally, socially and economically (Department of Health, 2005: 5). Skhosana and Peu (2009: 128) indicate that both the victims of sexual assault and their caregivers suffer emotional trauma following the assault and consultation at the health care facilities. Physical injuries of sexual assault have also shown to play an important role in both physical and psychological wellbeing of rape survivors. Some rape survivors have reported serious physical injuries that sometimes require surgical interventions. Recovery from this trauma is also influenced by the psychosocial environment which survivors are exposed to. Mukamana and Brysiewicz (2008: 383) point out that rape survivors need not be only those who are close to them but also a community at large. They argue that the community has a powerful influence on the trauma resolution. One can reasonably say that this does affect the recovery of rape survivors. Case studies carried in Democratic Republic of Congo by Longombe, Claude and Ruminjo (2008: 139) have shown that some of the women who have been sexually assaulted suffered severe vesico-vaginal and recto-vaginal fistulae and other gynaecological injuries that had negative long-term effects on the rape survivors' psychosocial wellbeing. Some of those women underwent surgical interventions such as colostomies and urinary diversions in order to repair the fistulae (Longombe *et al*, 2008: 139). The researchers pointed out that those surgical interventions were also seen as taboo by the local societies. Consequently, those women were once again subjected to emotional and psychological trauma due to the interventions employed to help them.

It has also been documented that women with a history of sexual assault were more predisposed to sexually transmitted illnesses and HIV infection (Kalichman & Simbayi, 2004: 687). In addition to the physical or physiological negative effects of rape, mental ill-health has been identified by most researchers. The most commonly implicated mental disorder is Post Traumatic Stress Disorder (PTSD). The link between sexual assault and PTSD is well established by many studies locally and abroad (Kessler, 2000; Klump, 2006: 71; Breslau, 2009: 202; Masho & Ahmed, 2007: 266; Ullman, Filipas, Townsend & Starzynski, 2007:827b). Sexual assault, among all other types of trauma, is said to be a number one accurate predictor of PTSD development (Kessler, 2000; Klump, 2006: 71; Breslau, 2009: 202; Masho & Ahmed, 2007: 266; Ullman *et al*, 2007:827b).

Despite these unpleasant effects of rape, research dating as far back as 1975 to date, shows that people had and still have false beliefs that are used to justify sexual assault which include to belittle its impact on the victim (make as if rape does not affect the victim) and even blame the victims for the event (Lonsway & Fitzgerald, 1994: 137; Forbes, Adams-Curtis & White, 2004: 250). Many researchers describe these rape-supporting false beliefs as ‘rape myths’ and point out that perpetrators and victims of sexual coercion alike do hold such beliefs although in varying degree (Carmody & Washington, 2001: 432-434; Monto & Hotaling, 2001: 277; Forbes *et al*, 2004: 250). According to Peterson and Muehlenhard (2004: 140), some women who held rape myths and had sexual experiences that met the legal criteria or definition for rape did not label such experiences as rape.

The DoH (2005:1) points out that poor reporting to police is due to number of barriers such as fear of further trauma and stigmatization. Mukamana and Brysiewicz (2008: 382) found that Rwandan women who have been sexually assaulted were stigmatized and shamed by their communities when their experiences of rape became known. Stigmatization was also indicated by Abrahams and Jewkes (2010: 475) as one of the barriers to the completion of the Post Exposure Prophylaxis (PEP) for HIV infection among female rape survivors.

In addition to stigmatization, being blamed for rape and not receiving social support also decreased PEP compliance among these women (Abrahams & Jewkes, 2010: 475). Negative social reactions were also isolated as one of the predictors of more PTSD severity after sexual assault (Ullman & Filipas, 2001: 379). These concur with the DoH (2005: 5) which identifies

PTSD as one of the mental health problems common after rape. It was stated that family breakdowns, inability to cope by family members and partners of rape victims, are common consequences of PTSD suffering by the rape survivors (DoH, 2005: 5). This shows some association between PTSD and social support among sexually assaulted women, hence it was in the interest of the researcher to determine if this suggested association does exist in the South African context.

1.3 Problem Statement

Despite alluded discussions, there are a number of rape-related issues that are not well catered for in South African research studies. Quite a number of studies have shown a possible link between PTSD and social support among female rape survivors (King, Taft, King, Hammond & Stone, 2006: 2987; Andrews, Brewin & Rose, 2003: 426; Schumm, Briggs-Phillips & Hobfoll, 2006: 833). Most of such studies indicate that social support can have a moderating effect on PTSD in rape survivors while some show that PTSD can erode social support (Littleton & Bretkopf, 2006: 113; King *et al*, 2006: 2987-2988; Guay, Beaulieu-Prevost, Beaudoin, Nachar, Marchand & O'Connor, 2011: 297). This possible link between PTSD and social support among sexually assaulted women is yet to be investigated or to be made precisely clear in RSA and particularly in the NWP. There was a clear need for study that will elicit how social support is linked to PTSD development in the context of NWP of the RSA. It was therefore the interest of the researcher to investigate whether social support has any impact on the level of PTSD.

1.4 Purpose of the study

The main aim of the study is to investigate the impact of social support on PTSD among sexual assault survivors. It is also intended to describe that impact of social support on PTSD.

1.5 Objectives of the study

The objectives of the study are:

- To determine the incidence of PTSD among sexually assaulted women;

- To determine whether social support reduces or increases the risk of developing PTSD among sexually assaulted women; and
- To determine whether sexually assaulted women who receive social support develop PTSD or not.
- To make recommendations for nursing research, nursing practice and nursing education in relation to social support and PTSD among sexual assault survivors.

1.6 Hypothesis

There are two hypotheses to the study:

H₀: Social support does not have a moderating effect on the development of PTSD.

H₁: Social support has a moderating effect on the development of PTSD.

1.7 Significance of the study

The results of this study may assist the policy developers to establish guidelines that entail the inclusion or exclusion of the sexual assault survivor's natural social support system in the therapies provided to them. The health care practitioners may benefit from these results as it may assist them to utilise a social support of the sexual assault survivors in providing care to those individuals. Sexual assault survivors generally may benefit from the improved services in terms of enhanced efficacy of therapies based on the possible inclusion or exclusion of the significant others.

1.8 Operationalization of terms

Moderator is a variable which systematically modifies either the form and/or strength of the relationship between a predictor and a criterion variable (Sharma, Durand & Gur-Aries, 1981:291). In this study this definition is used and the moderator variable is social support where the predictor is sexual assault and the criterion variable is Posttraumatic stress disorder.

Posttraumatic Stress Disorder is an anxiety mental condition that can result from any kind of traumatic experience such as war, rape, natural and accidental disasters (Voges & Romney, 2003: 3; Klump, 2006: 69). In this study PTSD is only related to sexual assault.

Rape is an unlawfully and intentionally commits a sexual penetration by the genital organ, any part of the body or animal and any object into the complainant's genital, anus, mouth or beyond without the consent of complainant (RSA, 2007). In this study rape and sexual assault refers to the actual commitment of rape as defined here as well as the attempt to commit it.

Sexual assault is when a person unlawfully and intentionally sexually violates another person or inspire the belief in that person that they will be sexually violated (RSA, 2007). In this study, both terms of rape and sexual assault are used interchangeably and their contextual meaning is the commission as well as the attempt of committing rape as defined by the law.

Sexual Assault Survivors is any female aged from 18 years to 55 years of age who have been sexually assaulted and thereafter consulted at local Thuthuzela Care Centre (TCC).

Social support is the quality of the interactions within an individual's social network (Guay *et al*, 2011: 282). In this study social support refers to the quality and quantity of interactions between a sexual assault survivor and her significant others before and after sexual assault.

1.9 Arrangement of chapters



The dissertation is arranged in the following manner:

Chapter 1: An overview of the study.

Chapter 2: Literature review.

Chapter 3: Research design and methods.

Chapter 4: Results.

Chapter 5: Discussions, conclusions, limitations and recommendations.

1.10 Summary

The study is based on the relationship between social support and PTSD development among sexual assault survivors. The background of the problem, problem statement, main purpose of the study, objectives of the problem, and hypotheses of the study were indicated in this chapter.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter provides an in-depth discussion of the research variables which will include sexual assault of women, social support and PTSD with special focus on the previous scholarly work on these three variables.

2.2 Sexual assault

Sexual assault can be viewed as global problem as quite a number of countries in the world is experiencing it. The problem with these statistics is that they are mostly based on the cases reported to the police. Jewkes and Abrahams (2002: 1233) have shown that this is just a mere fraction of what is actually happening. They argue that true statistics of sexual assault is like an ice-berg whereby we only see a tip while the majority of the problem is hidden under “water” (Jewkes & Abrahams, 2002: 1233). According to this “theory of an ice-berg” we see the smallest fraction of the problem, thus, just a tip of an ice-berg, which is reported to the police.

A larger fraction than what we see, the middle portion, is hidden just under the “surface water”, and this is the assault reported to the researchers where the victims’ and perpetrators’ identities are protected by research ethical standards.

The largest portion, base of the ice-berg, is not even disclosed to the researchers. It is kept secret due to many indicators such as shame and fear of being blamed for being sexually assaulted. It occurs due to economical vulnerability, blackmailing and threats among others and in the context of marriage and dating.

This theory is well-explained in a form of a diagram in figure 2.1.

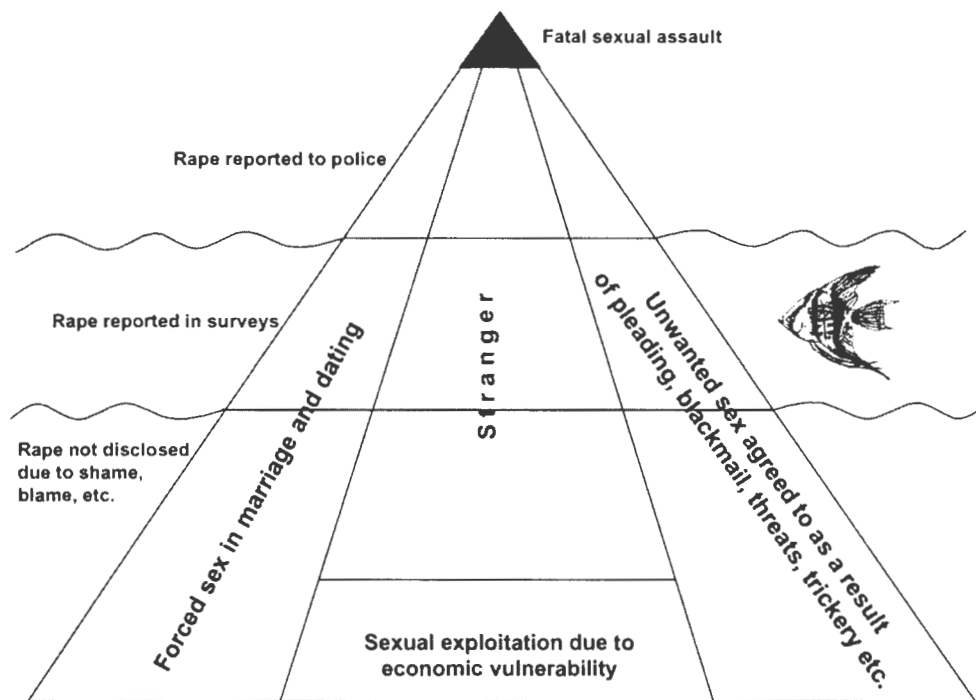


Figure 2.1 The tip of an ice-berg of sexual coercion (from Jewkes & Abrahams, 2002: 1233)

Sexual assault has very devastating effects on individual victims, their loved ones, their caregivers and the society at large. Its effects can manifest physically, emotionally, psychologically, socially and economically (DoH, 2005: 5; Skhosana & Peu, 2009: 128).

It is surpassed only by homicide in violation to a person because of force, domination and humiliation involved (Kniesl & Trigoboff, 2009: 639). The issue of sex is said to be of little importance, as sexuality is used to cater for nonsexual needs which are related to the issues of power and anger (Sadock & Sadock, 2007: 882; Kniesl & Trigoboff, 2009: 640). This in a way explains why women who have been sexually assaulted by their partners or husbands, whom they have been sexually involved with before, are also devastated.

2.3 Types of rape

When one looks at the negative impact sexual assault and its prevalence, it is not surprising that a number of scholars aim to find out the predictors of sexual assault. Elwood *et al*

(2011:170) found that prior sexual assault, family drug problems, PTSD and race are accurate predictors of sexual assault and that PTSD is the strongest predictor.

According to McCabe and Wauchope (2005: 250) there are four types of rape which are anger rape, power exploitative, power reassurance and sadistic which are based on the characteristics of the perpetrators. Generally, researchers indicates five types of rape which are anger rape, power rape, sadistic rape, date or acquaintance rape and gang rape and these types are influenced by the perpetrator's intrapersonal turmoil (Sadock & Sadock, 2007: 882; Kniesl & Trigoboff, 2009: 640). Some types are based on the victim-perpetrator relationship and include strangers, a date, an acquaintance, and partner or husband rapes (Cowan, 2000: 819). These types are described in detail as follows:

2.3.1 Anger rape

The perpetrator believes that they have been somehow unjustly treated by the society and are taking revenge by raping and often use physical violence and cruelty in the process (Sadock & Sadock, 2007: 882; Kniesl & Trigoboff, 2009: 641; McCabe & Wauchope, 2005: 244). The anger rapist is said to have use a weapon, especially a knife during the assault, use force especially when there is resistance, forced entry in the victim's home, have macho image and overwhelming anger (McCabe & Wauchope, 2005: 244). An angry perpetrator usually commits episodes of sexual assaults because shaming, traumatising and injuring their victim, temporarily relieves them of their internal agony which will build-up again (Kniesl & Trigoboff, 2009: 641).

2.3.2 Power rape

The perpetrator use sexual assault as a vehicle to express power and strength and use the victims for the gratification in an impulsive manner (Sadock & Sadock, 2007: 882; Kniesl & Trigoboff, 2009: 641). This type is also referred to as power exploitive rape and the perpetrators as exploitive predators (Sadock & Sadock, 2007: 882; McCabe & Wauchope, 2005: 245). The characteristics are moderate and immediate force, sexual dysfunction on the

perpetrator, demeaning demeanour, selection of blitz victims, takes place in the public areas, and display of some anger (McCabe & Wauchope, 2005: 245).

2.3.3 Power reassurance rape

The perpetrators in this type of sexual assault are described as inadequate men who have sexual fantasies but believe that no woman would sleep with them (Sadock & Sadock, 2007: 882). This type is said to be characterised by apologetic and/or complimentary attitude, some negotiation and/or cease on resistance, sexual dysfunction and complimentary demeanour (McCabe & Wauchope, 2005: 245).

2.3.4 Sadistic rape

In this type of rape, the perpetrator draws their sexual arousal and excitement from the pain, torture, bondage and brutality on the victim (Sadock & Sadock, 2007: 882; Kniesl & Trigoboff, 2009: 641; McCabe & Wauchope, 2005: 244). The elements of this type are usually planned victim selection, use of a weapon, a directive attitude, sex related collections, force during sex, using of gags, blindfold and excessive restraints, demeaning demeanour, ritualised process, and murder of the victim (Sadock & Sadock, 2007: 882; Kniesl & Trigoboff, 2009: 641; McCabe & Wauchope, 2005: 244).

2.3.5 Date or acquaintance rape

A type based on the degree to which the victim knows the perpetrator and the relationship. This type of sexual assault is characterised by more deception and less coercion (Kniesl & Trigoboff, 2009: 641; Cowan, 2000: 819). This type is said to be the most serious, the most prevalent and the most under-reported and leads to mental and physical illnesses in the victims (Dutton, Green, Kaltman, Roesch, Zeifiro & Krause, 2006: 962; Bradley, Schwartz & Kaslow, 2005: 693). It is reported that in the RSA, 75% of rape cases involved a known perpetrator (SAPS, 2011: 6).

2.3.6 Gang rape

The last type is gang rape. It involves a number of perpetrators usually of the same age and typically adolescents, age range from 10 to 30 years (Kniesl & Trigoboff, 2009: 641). The victims are usually of the same age as the perpetrators. This type may be carried out as part of group rituals to confirm the power, masculinity and authority held the gang members (Kniesl & Trigoboff, 2009: 641).

It has been found that one's social network can play an integral part after a stressful event such as sexual assault. Furthermore, the involvement of a partner in a therapeutic milieu such as Cognitive Behaviour Therapy enhances the possibility of positive outcomes. On the other hand most people tend to think that rapists are strangers and even the victims sometimes do not consider sexual coercion by a partner as rape. Therefore, some types of rape such as sadistic and gang rapes, rather than acquaintance rape, are the ones to be mostly regarded as rape, while it has been shown that acquaintance rape is one of the most devastating and the most common types. Looking at social support for sexual assault survivors and these types of rape, one should envisage how many survivors may be forced to go without such support and, more disturbing, be exposed to stigmatization in their time of dire need for such support. This may result in non-disclosure due to shame and fear of being blamed. Therefore, one can say the type of sexual assault one suffers can influence the type of social support one will receive and ultimately their psychological outcomes such as PTSD.

2.4 Rape myths

The concept of rape myth was introduced in 1970's by Brownmiller. Many researchers point out that rape myths are culture-embedded in some way (Franiuk, Seefelt, Capress & Vandello, 2008: 290; Carmody & Washington, 2001:434; Johnson, Kuck & Schander, 1997: 701; Payne, Lonsway & Fitzgerald, 1999: 29). This implies the socialisation or a common practices or beliefs within a particular community. Literature pin-point three elements in the construct: Rape Myth. These are (1) false or unfounded, (2) commonly/ generally/widely held/used, and (3) work to justify/ negate/ diminish the effect or seriousness of the sexual

coercion or blame the victim for the coercion (Payne *et al*, 1999: 29; Lonsway & Fitzgerald, 1994: 134; Franiuk *et al*, 2008: 295).

In 2008, Franiuk and colleagues published two articles that showed how widely-held the rape myths are by investigating their prevalence in the media. They found that in one case involving a well-known defendant, 65.4% of media articles contained at least one rape myth-endorsing statement (Franiuk *et al*, 2008: 293). They also discovered that 10% of headline, despite their brevity, comprised of rape myths and used the word “accuser” frequently than the word “alleged victim” to describe the complainant (Franiuk *et al*, 2008: 297). With the presence of variations, both genders are said to conform to rape myths (Johnson *et al*, 1997:706) and even in those who were once victims (Peterson & Muehlenhard, 2004: 140; Carmody & Washington, 2001: 434). These false beliefs are sometimes deeply-rooted in individuals that some individuals who were sexually victimised did not label such experiences as rape even though it met the legal definition of rape (Peterson & Muehlenhard, 2004: 140).

Rape myths functions to falsify the effects of sexual assaults and protect the perpetrator (Franiuk *et al*, 2008: 298). Furthermore, rape myths have been shown to infuse negative attitude towards sexual assaults survivors (Lonsway & Fitzgerald, 1994: 155). It is quite clear that this can discourage the sexual assault survivors from reporting (Franiuk *et al*, 2008: 305; Peterson & Muehlenhard, 2004: 142). Furthermore, people who held these false beliefs reported that they are likely to rape or force a woman to sex (Lonsway & Fitzgerald, 1994: 155). The other impact of rape myths is that they influence how the survivor is treated by personnel of the health care and the justice or law enforcement systems which inflicts a secondary trauma to them (Franiuk, 2008: 305). The rape myths are said to create a vicious circle where they cause people to deem the true rape cases untrue and thereby causing other people, who did not have such beliefs before, to have them, e.g. women, believe to have sex and then lie about being raped (Franiuk *et al*, 2008: 305; Peterson & Muehlenhard, 2004: 142).

There are many different types of rape myths. Johnson *et al* (1997: 697) divided the most common ones under three categories: (1) Blaming the victim, (2) excusing the perpetrator, and (3) justifying acquaintance rape. On the other hand, a bit more comprehensive

uncategorised list of myths was provided by Payne *et al* (1999: 50) the following are those provided by Johnson *et al* (1997: 697):

1. Blaming the victim

These include myths such as:

- Women provoke rapes;
- Women secretly want to be raped;
- Woman's reputation should be an issue;
- Women can't be raped without a weapon; and
- Healthy women can resist rape.

2. Excusing the perpetrator

These include myths such as:

- Most men are capable of rape;
- Men have sexual urges they can't control;
- Men who rape are sick and emotionally disturbed; and
- Men who rape hate women.

3. Justifications for acquaintance rape

Myths that exist are:

- Rapists are almost always strangers;
- A man has the right to assume a woman wants to have sexual intercourse with him if:
 - She allows him to touch her in a sexual way;
 - She touches him in a sexual way;
 - She has an oral sexual encounter with him;
- If a woman has had previous sex with a man, she cannot claim that she was raped if the same man has sex with her again; and
- If a man pays for everything on a date, a woman is obligated to have sex with him.

Given the prevalence and impact of rape myths it is clear that they may negatively influence the social support a sexual assault survivor may receive and perceive after an experience.

2.5 Social Support

Social support is the quality and quantity of interactions between an individual and their social network (Guay *et al*, 2011: 282). Social support has long been shown to play an integral role in the physical and psychological well-being of individuals (Cohen, 1988: 281; Cohen & Wills, 1985: 387; Guay *et al*, 2011: 284-285).

Perceived social support and received social support are the two types of social support generally recognized in literature (Guay *et al*, 2011: 282-283; Borja, Callahan & Long, 2006: 911). Perceived social support is the individual's belief that they will get social support when they need it. On the other hand, the received social support refers to the frequency of interactions of an individual and their social network (Guay *et al*, 2011: 283). Surprisingly, literature shows that the perceived social support is more related to mental health than the received social support (Guay *et al*, 2011: 282).

The social network of a person has great impact which can be both positive and negative in the mental health of a person after experiencing sexual assault. Research has shown that social reaction to an individual who have been sexually assaulted can be negative or positive (Forbes *et al*, 2004: 252; Schumm, *et al*, 2006: 833; Ullman & Filipas, 2001:383; Ullman *et al*, 2007:33a). The positive social reactions, which is positive social support, impacts positively on an individual's health (Schumm *et al*, 2006: 833; Billette, Guay & Marchand, 2008: 891). Conversely, the negative social reactions, usually termed counter supportive social support, is proven to be detrimental to an individual's psychological well-being (Billette *et al*, 2008: 877, Guay *et al*, 2011: 283).

Researchers point out that social support system that is characterized by blaming, stigmatization, avoiding and criticizing is negative or counter-supportive social support (Borja *et al*, 2006: 106; Lincoln, 2000: 240, Guay *et al*, 2011: 283). From literature, these attributes seems to be common after sexual assault. This is evidenced in the concept called

“rape myth” coined by Burt in 1980 (Lonsway & Fitzgerald, 1994: 134). Lonsway and Fitzgerald (1994: 134) defined rape myth as an “attitudes and beliefs that are generally false but are widely and persistently held, and that serve to deny and justify sexual aggression against women”.

These myths are usually embedded in the socio-cultural factors such as tradition, religion and gender role expectations and they can lead societal members to hold or believe them (Johnson *et al*, 1997: 698). Lonsway and Fitzgerald (1994: 135) indicated that rape myths tend to be generally applied in public policy decisions and personal reactions to sexual assault survivors, and this implies that they are usually held by majority of the community.

Carmody and Washington (2001: 429) identified the common rape myths. These myths are: women who go to a man’s house (residing place) on their first date implies that she is willing to have sex, women falsely report to be raped because they need attention; any healthy woman can successfully resist rape; women who engages in intimate activities, such as petting, and let things get out of hand and then raped, it is their fault; women who got raped while hitchhiking get what they deserve; when woman goes around wearing tight tops and short skirts they are asking for rape; the victims of rape are often promiscuous, drunkards and has a bad reputation; women may set up a situation in which they are likely to be raped because they have an unconscious wish to be raped.

These show what a vital role the society may play in encouraging rape and victimizing the rape survivors. Negative social support is also shown to play an important role in mental health prior and post a traumatic experience such as rape. Victimization, one characteristic of negative social support, has been shown to be pre-trauma risk factor in the development of PTSD which is a anxiety disorder (Breslau, 2009: 205). One study that investigated the factors affecting PTSD (Voges & Romney, 2003: 5) found that having someone to talk to can decrease the odds of developing PTSD. The same study indicates that people without support tended to use emotion-oriented coping in dealing with stressful life events. These researchers pointed out that this type of coping also increases the possibility of PTSD development. This shows how detrimental lack of social support or negative social support can be to a person’s psychological wellbeing.

2.6 Posttraumatic Stress Disorder

Apart from a link between PTSD and social support as previously discussed, this mental illness has been strongly linked to rape. Rape was found to be the number one accurate predictor of PTSD development (Klump, 2006:71). According to the USA's National Center for Victims of Crime (2011) four most common symptoms of PTSD in rape survivors are (1) re-experiencing the trauma, (2) Social Withdrawal, (3) Avoidance behaviours or actions, and (4) Increased physiological arousal. This supports Voges and Romney (2003: 1) when they indicate that hyper arousal, avoidance and re-experience are the three major symptom clusters and that sexual assault is one of the common causes of PTSD. These symptoms are generally indicated by a number of studies in this field (King *et al*, 2006: 2983; Guay *et al*,2011: 285; Klump, 2006: 69) The South African National Department of Health (2005: 5) indicates that PTSD may result in maladaptive behaviours such as substance abuse and unsafe sexual behaviour. PTSD was found to be the strongest predictor of sexual assault in a national survey carried out in the USA (Elwood *et al*, 2011:170). PTSD is also associated with development of other mental conditions such as major depressive disorder, some physical illnesses such as hypertension and arterosclerosis which are attributed mainly to increased reactivity of the sympathetic nervous system observed under the hyper-arousal symptom cluster (Dutton *et al*, 2006: 962).

The fact that literature shows that PTSD can accurately predict sexual assault, and sexual assault does the same for PTSD, indicate a clear relationship among these constructs. On the other hand, social support that an individual who have been sexually assaulted receives has been shown to reduce the impact of PTSD and that PTSD can erode social support shows another relationship. This shows that sexual assault, PTSD and social support are inter-related.

2.7 Conceptual Framework

The study was guided by stress-buffering model developed by Cohen and Wills (1985). According to Cohen and Wills' model (1985: 313), social support can work immediately after the stressful event, at appraisal phase, or after the event was appraised as stressful of the

situation to correct the maladaptive behaviour, emotional disturbance and/or physiological response, Cohen and Wills (1985: 313) call this “reappraisal”.

This model shows how social support can prevent appraisal of stressful event, which is sexual assault in the intended study, as stressful. Firstly, the person may see the event as an everyday problem because they know that they will be helped by their social network, which is perceived social support, and hence they will be able to cope. This is supported by Ullman *et al* (2007: 33a) when they say that avoidance coping and negative social reactions have a pivotal role in PTSD development. On the other hand, if sexual assault was over whelming and it was appraised as stressful, perceived and received social support can inhibit the negative psychological response, which is posttraumatic stress disorder in this study.

In summary, this model implies that social support can moderate the development of PTSD in rape survivors by altering the appraisal of rape as stressful or by inhibiting the development of PTSD symptoms. See Figure 2.1 for diagrammatic illustration of the model.

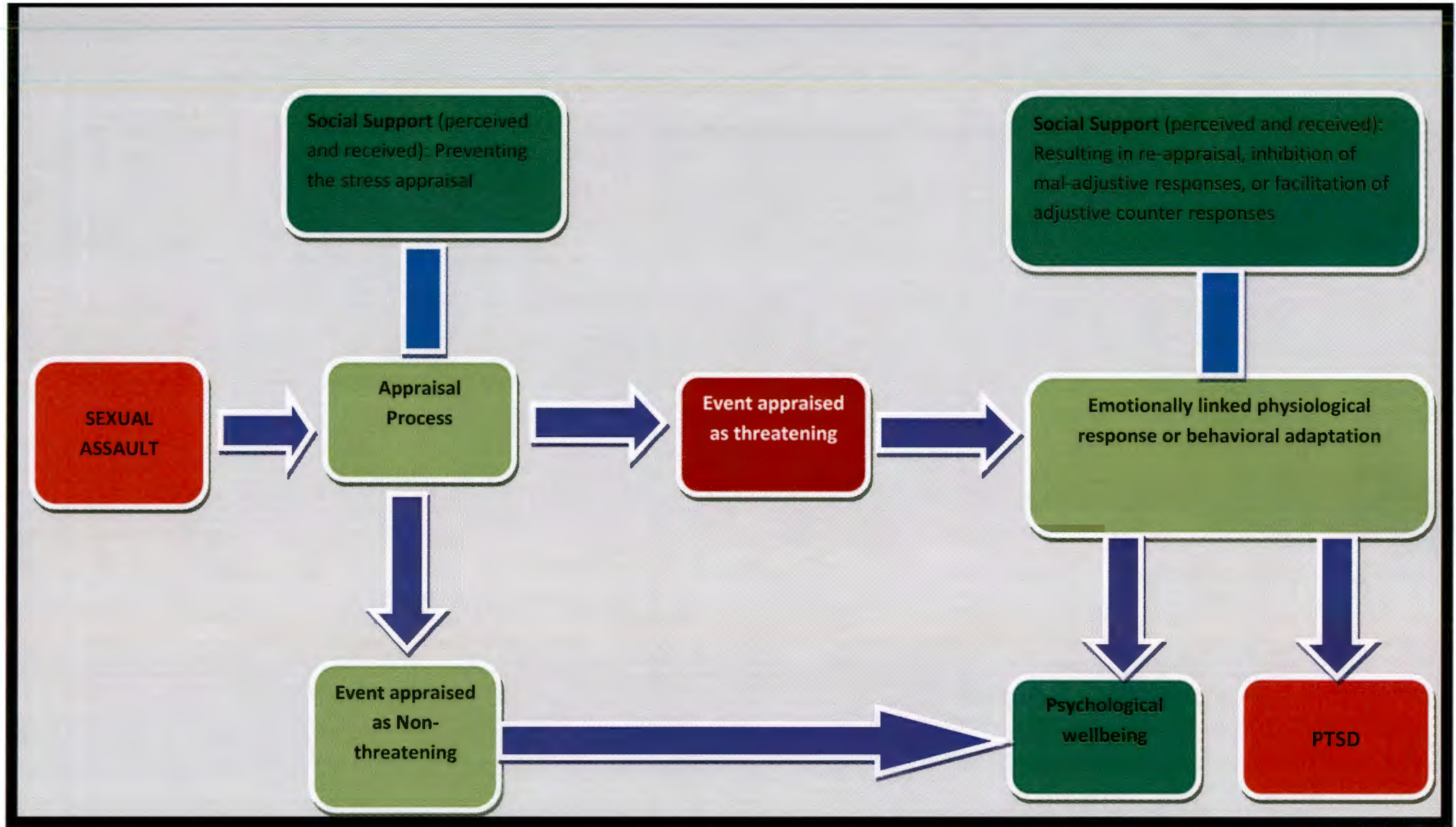


Figure 2.2. The adapted Stress Buffering model (from Cohen & Wills, 1985)

2.8 Summary

This section covered the literature related to sexual assault and social support. It has been discussed that sexual assault is a serious and one of the highest crimes especially in RSA and that it is under-reported. It usually results in problems that affect different spheres of human being - one being the psychological dimension in the form of PTSD. PTSD is a serious mental health condition and its effect can be decreased by social support especially perceived social support. On the other hand, PTSD can erode social support. Social support is also related to rape myths which can influence support towards sexual assault survivor. Stress buffering model which is adapted to guide the study was also discussed.

CHAPTER THREE

RESEARCH DESIGN AND METHODS

3.1 Introduction

This chapter outlines the research design and methods used in the study. It encompasses eight sections which are: research approach, population targeted, study design, sampling techniques, sample size, data collection, data analysis and interpretation, and ethical considerations followed while conducting the study.

3.2 Research Approach and design

The study was a quantitative research and its context was Ngaka Modiri Molema district in the NWP of the RSA. The design of the study was the descriptive cross-sectional ex post facto design. A cross-sectional study is a study in which data is collected at a single point in time and the ex post facto design, also called correlational, is a design used to investigate how a specific event or independent variable affect the dependent variable after (Brink, 2006: 105; de Vos, Strydom, Fouche & Delport, 2011: 148). In the ex post facto (“after the effect”) design, the researcher identifies the event that has already occurred and examines the subsequent characteristics to determine possible relationships between variables rather than cause-and-effect. These designs are useful in obtaining a descriptive data regarding the prevalence and interrelationships, cause and effect, of variables within a population and allow the use of questionnaires, structured interviews and observation as the means of data collection (de Vos *et al*, 2011: 148; Brink, 2006: 106). The study aimed to describe the possible relationship between social support and PTSD development among women who have been sexually assaulted and it used structured interview (guiding the participant through the questionnaire) and unstructured observations as data collection techniques. The study was part of a major study which was a longitudinal design to follow sexually assaulted women six weeks, six months and 12 months after the event of sexual assault. This study only focused on the base-line, six weeks, and related data making it cross-sectional in nature.

3.3 Population

The population was all the women who have been sexually assaulted or raped and thereafter consulted at a local TCC in Ngaka Modiri Molema District in the NWP. In this study a woman referred to any adult female person with the age ranging from, and including, 18 years to, and including, 55 years.

3.4 Study context

The context of the study was a local TCC in Ngaka Modiri Molema District in the NWP of RSA. The TCC is situated in the Mafikeng Provincial Hospital. Its area of jurisdiction covers the local municipalities of Ditsobotla, Mafikeng, Ramotshere Moiloa, Ratlou and Tswaing. The principal towns in the district are Mafikeng/Mmabatho, Zeerust and Lichtenburg. TCC's were established as a South African anti-sexual assault intervention (Unicef, 2009). These centres are aimed at preventing emotional trauma and secondary victimization of sexual assault survivors (Artz, Smythe & Legget, 2003).

3.5 Sampling

The sampling technique that was used in the study was purposive non-probability sampling as the researcher was selecting the participants purposefully based on the characteristics of interest (de Vos *et al*, 2011: 232; Brink, 2006). The characteristics that were sought by the researcher and hence serve as inclusive criteria were:

1. Females aged 18 years to 55 years.
2. Have experienced an event that can be labelled as sexual assault and rape as defined in chapter three (3) of the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007 of the RSA.
3. The event took place within the last six months from the date of data collection.

The researcher chose sexual assault survivors who met the above criteria from the examination register(s) of the local TCC.

3.6 Sample Size

The sample size was computed with the use of web survey software: Raosoft Sample size calculator from Raosoft, Inc. The total number of participants (sample) was calculated at a confidence level of 95% and a margin of error at 5% by using the following formula:

$$n = \frac{XNP(1 - P)}{2[ME(N - 1)] + [XP(1 - P)]}$$

Where:

n = Sample size

X= Chi-square for the specified confidence level at 1 degree of freedom

N= Population Size

P= population proportion

ME= desired margin of error (expressed as a proportion).

3.7 Data Collection

The method of data collection was the use of structured interviews (guided by the interview guide/questionnaire) in the setting/venue and time selected by the participant (Brink 2006: 152). The interview guide comprised of four sections which are demographics, social support grid, PTSD Checklist – Specific Version (PCL-S), and rape myth scale. This tool was developed by the principal investigators of the major study.

PTSD Checklist – Specific Version (PCL-S) to assess the level of anxiety

PTSD Checklist – Specific Version (PCL-S) (Blanchard, Jones-Alexander, Buckley & Forneris, 1996:670) was used to assess PTSD symptoms by asking participants to report on how much they were troubled in the month after they had been sexually/physically assaulted. The PTSD Checklist consisted of 17 items which were rated on a 5-point Likert scale (1-5) for degree of bother for each symptom in the last month (1 = not at all, 2=a little bit, 3 =

moderately, 4=quite a bit, 5 = extremely). Cronbach's test for reliability for PTSD was found to be reliable with Cronbach's Alpha values exceeding .70, which is the widely accepted reliability limit. Cronbach's Alpha values were .740 with 17 items. McDonald and Calhoun (2010: 978) delicately describes that the validity and reliability of PCL-S have been tested by various researchers. It is also reported that the PCL -S has been found to elicit accurate results than other scales (McDonald & Calhoun, 2010: 984). Various researchers have used this 17-itemed tool to measure PTSD accurately and found the Cronbach's alpha to be as high as .95 (Jacques-Tiura, Tkatch, Abbey & Wegner, 2010: 181).

Social support grid

The social support grid used was a tool of 19 items comprised of four subsections, viz: important person, social support, social undermining, and social reactions. The first part investigated the interaction with the social network and consisted of 6 items in a form of questions. The social support, 5 items, and social undermining, 3 items, are arranged in a form of Likert scale with three options from "Not At All or A Little" (1) to "Quite A Lot" (3). The last subsection, social reactions consist of 8 items arranged in a Likert scale ranging from "Never" (1) to "All the Time" (5). The items in this grid have been frequently used in research to assess the level of social support (Guay *et al*, 2011: 282).

Rape myth scale

The rape myth scale is made-up of 19 items to which the responses are arranged in the Likert scale format of five options from strongly disagree (1) to strongly agree (5). The rape myth scale used in the is made up of questions that have been used throughout the studies that sought to investigate rape myths since Brownmiller came up with the construct (Franiuk *et al*, 2008: 290; Carmody & Washington, 2001:434; Johnson *et al*, 1997: 701; Payne *et al*, 1999: 29). These questions have thus been found to be reliable and valid to elicit the level to which the rape myths are held.

3.8 Data Analysis And Interpretation

The data was collected in the language preferred by the participant and also understood/known by the researcher. The data base was developed and captured at North-

West University (Mafikeng Campus) using Statistical Package for Social Sciences (SPSS) version 21. Screening and decoding of data was done on daily basis. Dependent and independent variables were analysed using t-test, frequency distribution, correlational and ANOVA analysis.

3.9 Ethical Considerations

The study underwent all the required processes of ethical approval (Brink 2006: 44; de Vos *et al*, 2011:10). The study proposal was first presented in Department of Nursing Sciences' Research Committee (North-West University, Mafikeng Campus). The proposal was later presented to the institutional committee, the North-West University Ethics Committee for institutional ethical clearance which was granted. The study was carried under the major longitudinal study, headed by Professor Davhana-Maselesele (RSA) and Professor Wyatt (USA), called "The Aftermath of Rape on Mental Health of Survivors in North-West and Limpopo Provinces". This major study received an Institutional Review Board ethical clearance from the University of California, Los Angeles (USA), North-West University Ethics Committee (RSA), the Provincial Department of Health of NWP and Limpopo Province. The researcher was trained through workshops on data collection and underwent an online Collaborative Institutional Training Initiative (CITI), IRB training provided by the University of California, Los Angeles. The three courses taken were Human Research - Social & Behavioral Researchers & Staff; Social and Behavioral Responsible Conduct of Research, and UCLA HIPAA (see Appendices 4, 5 and 6). This was done to ensure that the researcher collected the data in an ethical manner.

The participants were requested in writing for participation through the use of informed consent form where all their rights and necessary information was clearly explained (Brink 2006: 37; de Vos *et al*, 2011). The participants were informed about their rights such a right to choose to participate, terminate their participation, privacy and anonymity, and protection against coercion of any sort. The consent form also provided the participants with information regarding the study. This information included the topic, purpose, objectives and methods of the study as well the as the identity, contact details and qualifications of the researcher. The time and place for data collection was chosen by the participants and each

participant was provided with a R100 voucher for transport after each interview and the interviews were paused or stopped depending on the preferences of the participant.

Bearing in mind that although this cross-sectional study was part of an on-going longitudinal study that followed the same participants on a number of times, the questionnaires (interview guides) were coded to ease the process of follow up. These coded questionnaires were kept in a locked cupboard in an access-controlled office of the supervisor of this study who was one of the principal investigators of the major longitudinal study, Professor M. Davhana-Maselesele. The consent forms from the participants were kept in a different cupboard with the same security measures. For follow-up purposes the participants were only identifiable to the researcher and the supervisor to protect their anonymity. The participants' privacy was ensured at all times during data collection.

The participants were those women who were attending the post sexual assault services offered at the TCC. These centres are equipped with multi-disciplinary team of Health and Law and Justice Professionals who provides comprehensive care to the sexual assault survivors. Hence, when the researcher identified a particular problem during the interview the participant was referred to a relevant professional, e.g. medical officer for a medical problem, psychologist for counselling with the assistance of the professional nurse. The means debriefing were provided for the participants by the health care professionals at TCC. The researcher sought professional help as the need arose.

3.10 Summary

This chapter described how the study was conducted. It indicated that the study was a quantitative descriptive cross sectional ex post facto and other related issues such as population and sampling. The ethical considerations were also elicited because sexual assault is one of the sensitive and traumatic subjects and require the researcher to be very cautious in safe-guarding the interests of the participants while ensuring reliable and valid study.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter describes the results of the study in raw details. The results are presented in relation to the manner in which data was analysed and in relation to the hypotheses and objectives of the study.

4.2 Data description

One hundred and fifteen (115), questionnaires were analysed and from these 115 questionnaires there were no missing values. All 115 participants were women who have been sexually assaulted. The variables used in the analysis are summarised in Table 4.1. The other variables were left out because they were incomparable in terms of difference in their quantity.

Table 4.1 Statistics of Variables of Interest

	<i>n</i>	Missing	
		Count	Percent
Level of Education	115	0	.0
Relationship Status	115	0	.0
Number of Dependants	115	0	.0
Community Standing	115	0	.0
Level of PTSD	115	0	.0
Level Of Social Support	115	0	.0
Number of Children	115	0	.0
Rape Myth Scale	115	0	.0

The independent variable was Social Support and contained three aspects. These three aspects were positive social support termed Social Support, and two negative forms of social support termed Social Undermining and Social Reactions. The other variable of interest was PTSD. The other variables appearing in Table 4.1 were looked at in conjunction to these two variables. The participants' demographics will be elicited to provide the background or context of the study.

4.3 Demographic characteristics of participants

All 115 participants were women residing in the NWP of RSA at the time of data collection. Almost all the participants were Batswana (80.1%) and 91.3% were speaking Setswana at home, never resided anywhere else but in the NWP (91.3%), were never married (93.9%), and were Christians (94.8%).

The age range of participants was 18 years to 55 years where the majority (63.5%) fell in 18 to 25 year range, followed by 26 to 34 years with 24.3% and the remaining 12.2% being those of 35 to 50 years. Under relationship status, 27.8% participants had no relationship in the past three months at the time of data collection, 31.3% lived with their partners and 40.1% dated one or more people on a regular basis. Of all 115 participants, 43.5% had no children and 56.5% had one or more child.

Most of the participants, 53.9%, did not go to school at all or did not finish matric and the 46.1% indicated matric or above as their highest level of education. Only 28.7% were either working or attending school while the 71.3% was not working and 69.6% had an income of R0 to R499 while only 30.4% got R500 or more on a monthly basis. In summary, the majority of the participants had no or low level of education, were not working and had a no or low monthly income.

Table 4.2 Demographics of the participants

Ethnicity	n		Home Language	n		Residence		Religion		Importance of Religion		Age in Years		Marital Status						
	n	%		n	%	n	%	n	%	n	%	n	%	n	%					
Tswana	93	80.9	SeTswana	105	91.3	North West Province	105	91.3	Christian	109	91.3	Important	90	78.3	18 to 25	73	63.5	Never married	108	93.9
Other	22	19.1	Other	10	8.7	Other	10	8.7	Other	6	5.2	Not important	25	21.7	26 and Above	42	36.5	Other	7	6.1

1. Relationship Status	n		Highest Level of Education		Employment Status		Monthly Income		Number of Children		Number of Dependents		Community standing ladder							
	n	%	n	%	n	%	n	%	n	%	n	%	n	%						
No Relationship in the past 3 months	32	27.8	Less than matric	62	53.9	unemployed	82	71.3	R0 to R499	80	69.6	No Children	50	43.5	1 to 4 dependents	75	57.4	Rung 1 to 4	66	57.4
Live with one partner	36	31.3	Matric and above	53	46.1	Employed or attending school	33	28.7	R500 or More	35	30.4	One or more children	65	56.5	5 or more dependents	40	42.6	Rung 5 to 10	49	42.6
Date one or more persons regularly	47	40.1																		

4.4 The frequency of PTSD

The diagnosis for PTSD was based solely on the three core cluster symptoms of PTSD which are re-experiencing, avoidance and hyper-arousal. The majority, 71.3, of participants met the DSM-IV-TR symptomatic criteria of PTSD and only 28.7% had no PTSD.

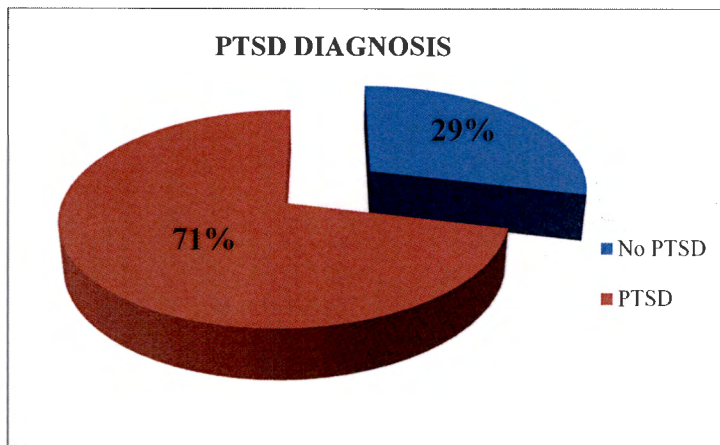


Figure 4.1 frequency of PTSD among Participants

Sixty-seven or 58.3%, indicated being sexually assaulted by someone known to them as the traumatic event that bothered them the most. The remaining 48, 41.7%, were most bothered by sexual assault by the stranger. This implies that most of the participants were sexually assaulted by someone known to them. The incident of sexual assault took place in less than a month ago for 13% of participants, one to three months for 65.2%, 4 to 6 months for 15.7% and more than six months for 6% of the participants.

The majority, 72.2%, of participants were not injured during the assault whilst only 27.8% indicated that they were injured during the assault. Similarly the majority, 89.6%, of participants indicated that no one-else was injured during the assault and only 10.4% indicated that someone else was injured. Unexpectedly about a half, 43.5%, of the participants pointed out that they thought that their lives were in danger at the time of sexual assault and 56.5% did not think that that their lives were in danger during the assault. On the contrary, most (88.7%) of the participants did not think that someone else's life was in danger and 11.3% thought that some else's life was in danger during the incident.

It is important to note that most (79.1%) of participants felt helpless and 87.8% were terrified during the incident of sexual assault. Only 20.9% did not feel helpless and 12.2% of the participants were not terrified.

Table 4.3 Characteristics of a traumatic event to Participants

Characteristics	Frequency	Percentage
Most Bothersome Traumatic Event		
Sexual assault by someone known to the participant	67	58.3
Sexual assault by a stranger	48	41.7
How Long Did The Traumatic Event Take Place		
Less than 1 month	15	13.1
1 to 3 months	75	65.2
3 to 6 months	18	15.7
More than 6 months	7	6
Physical Injury To The Participant During Sexual Assault		
Yes	32	27.8
No	83	72.2
Physical Injury To Someone Else During Sexual Assault		
Yes	12	10.4
No	103	89.6
The Participant Thought Their Life Was In Danger During Sexual Assault		
Yes	50	43.5
No	65	56.5
The Participant Thought Someone Else's Life Was In Danger During Sexual Assault		
Yes	13	11.3
No	102	88.7
The Participant Felt Helpless During Sexual Assault		
Yes	91	79.1
No	24	20.9
The Participant Felt Terrified During Sexual Assault		
Yes	101	87.8
No	14	12.2

4.5 The frequency of types of social support

The social support grid assessed three types of social support which were social support, social reactions and social undermining. Social support was regarded as positive social

support and the two, social reactions and social undermining, were regarded as negative social support. It is important to note that the type of support that was evaluated was perceived as social support rather than received social support, i.e. the manner in which the participants perceived their interaction with their social network was assessed and not the actual interaction of the participants and their social network.

Table 4.4 Characteristics of social support

Characteristic	Frequency	Percentage
Level of Social Support		
Moderate	6	5.2
Quite a lot	109	94.8
Social Undermining		
Never	3	2.6
Rarely	71	61.7
Sometimes	33	28.7
Frequently	6	5.2
All the time	2	1.7
Social Undermining		
Not at all	85	73.9
Moderate	27	23.5
Quite a lot	3	2.6

Positive social support was found to be very high among the participants as most of them, 94.8%, reported receiving quite a lot of support. Only six, 5.2%, participants reported receiving moderate support. This implies that all 115 participants believed that they were given support but only six of them were not satisfied by the amount of support they were given.

Also, the minority (7%,) of participants felt that their social network reacted negatively to them after the incident of sexual assault. The majority, 64.3%, never or rarely received the negative social reactions and 28.7% indicated that sometime the social reaction was negative towards them. Similarly, 73.9% of the participants indicated that no social undermining was ever directed to them and 26.1% were victims of moderate and quite a lot of social undermining. The two latter trends of negative social support might explain the high levels of the positive social support indicated by the participants.

4.6 The frequency of rape myths

The participants were found no to support the rape myths. The rape myth scale was in a form of Likert scale and arranged in five options from strongly disagree to strongly agree. It consisted of 19 questions. The option of strongly disagree got the highest percentage in all the 19 questions and strongly disagree the least percentages.

The highest percentage under strongly disagree 91.3% (*Question 9: A rape probably did not happen if a woman has no bruises or marks*) and the least is 66.1% (*Question 13: When a man rapes, it is because of their strong desire for sex*) while the highest for strongly agree is 5.2%, Question 17, and the least is 0% for a number of questions. It is still important to note that 12.2% believe that men rape due to their strong desire for sex (*Question 13*), 9.5% of participants believe that “rape happens in the ‘bad’ side of town” (*Question 17*), 7.8% believe that “rapists are more likely to be black or coloured than white” (*Question 15*), 7.8% believe that “people who get raped are often promiscuous or has a bad reputation” (*Question 16*), and 6.9% believe that “when a woman talks or acts sexy she invites rape” (*Question 1*). Note that Question 13 scored the least (66.1%) for strongly agree and the third highest for strongly agree (2.6%), and the highest for agree (9.6%) and neutral (11.3%). See Table 4.5 which shows the scores of the rape myth scale in details.

4.7 The correlations of variables

This section of analysis focused on the correlations between the different variables. The existence of any relationship between variables and the nature as well as the strength of that relationship is also examined if it does exist.

Table 4.5 Scores of Rape Myth Scale

Questions	Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree	
1. When a woman talks and acts sexy, she is inviting rape	93	80.9%	11	9.6%	3	2.6%	6	5.2%	2	1.7%
2. When a woman is raped, she usually did something careless to put herself in that situation.	98	85.2%	10	8.7%	6	5.2%	0	0%	1	0.9%
3. Any woman who teases a man sexually and doesn't finish what she started realistically deserves anything she gets.	95	82.6%	10	8.7%	6	5.2%	4	3.5%	0	0%
4. Many rapes happen because women lead men on.	101	87.8%	7	6.1%	2	1.7%	3	2.6%	2	1.7%
5. Men don't usually intend to force sex on a woman, but sometimes they get too sexually carried away.	96	83.5%	5	4.3%	8	7.0%	4	3.5%	2	1.7%
6. In some rape cases, women actually wanted it to happen.	100	87.0%	10	8.7%	2	1.7%	2	1.7%	1	0.9%
7. Even though the woman may call it rape, she probably enjoyed it.	99	86.1%	9	7.8%	4	3.5%	2	1.7%	1	0.9%
8. If a woman doesn't fight back, you can't really say that it was rape.	103	89.6%	8	7.0%	1	0.9%	0	0%	3	2.6%
9. A rape probably didn't happen if the woman has no bruises or marks.	105	91.3%	5	4.3%	2	1.7%	1	0.9%	2	1.7%
10. When a woman allows petting to get to a certain point, she is implicitly agreeing to have sex.	93	80.9%	17	14.8%	5	4.3%	0	0%	0	0%
11. If a woman is raped, often it's because she didn't say "no" clearly enough.	104	90.4%	8	7.0%	3	2.6%	0	0%	0	0%
12. Women tend to exaggerate how much rape affects them.	93	80.9%	17	14.8%	5	4.3%	0	0%	0	0%
13. When men rape, it's because of their strong desire for sex	76	66.1%	12	10.4%	13	11.3%	11	9.6%	3	2.6%
14. It is just part of human nature for men to take sex from women who let their guard down.	91	79.1%	16	13.9%	2	1.7%	4	3.5%	2	1.7%
15. Rapist is more likely to be black or coloured than white	91	79.1%	14	12.2%	1	0.9%	5	4.3%	4	3.5%
16. In any rape case, one would have to question whether the victim is promiscuous or has a bad reputation.	84	73.0%	14	12.2%	8	7.0%	4	3.5%	5	4.3%
17. Rape mainly occurs on the "bad" side of town.	88	76.5%	11	9.6%	5	4.3%	5	4.3%	6	5.2%
18. Many so-called rape victims are actually women who had sex and "changed their minds" afterwards.	96	83.5%	11	9.6%	4	3.5%	1	0.9%	3	2.6%
19. If a man pays all the bills, he has the right to have sex with his partner whenever he wants.	103	89.6%	8	7.0%	2	1.7%	0	0%	2	1.7%

4.7.1 The correlations between PTSD, Traumatic event and demographic characteristics

PTSD is now going to be looked at in relation to traumatic event and the participants' demographics.

H_0 : there is no association between the level of PTSD and traumatic events that bothered the participants the most

H_1 : there is an association between the two variables

Level of PTSD * Most Bothersome Traumatic event

Cross tabulation

		Most bothersome traumatic event		Total	
		Sexual assault by someone you know	Sexual assault by a stranger		
Level of PTSD	NO PTSD	Count	15	18	33
		Expected Count	19.2	13.8	33.0
Level of PTSD	PTSD	Count	52	30	82
		Expected Count	47.8	34.2	82.0
Total		Count	67	48	115
		Expected Count	67.0	48.0	115.0

The expected count for the participants who had no PTSD and were assaulted by someone that they know is 19.2 and the actual count is 15. Thus, there are 4.2 fewer participants with no PTSD who were assaulted by someone that they know than would be expected by chance. There are also the same differences between the actual and expected counts in the other cells. It is important to note that of 67 participants assaulted by someone known to them, only fifteen had no PTSD and the rest, 52, had PTSD implying that 77.6% of participants assaulted by someone they know had PTSD. A similar trend is noticed in the forty-eight participants who reported assault by a stranger where only 18 had no PTSD and 30 had PTSD, which means that 62.5% of participants sexually assaulted a stranger had PTSD.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.121 ^a	1	.077		
Continuity Correction ^b	2.426	1	.119		
Likelihood Ratio	3.095	1	.079		
Fisher's Exact Test				.096	.060
Linear-by-Linear Association	3.094	1	.079		
N of Valid Cases	115				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 13.77.

b. Computed only for a 2x2 table

The significant value of 0.60

The p-value for the Pearson's chi square statistic (0.077) is greater than the significance level of 0.05 therefore the null hypothesis is not rejected concluding that there is no statistically significant association between the level of PTSD and whether the victim knew the perpetrator or not.

H_0 : the mean Level of PTSD is the same across all levels of education

H_1 : at least one mean is different

ANOVA

Level of PTSD

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.595	4	.149	.714	.584
Within Groups	22.935	110	.208		
Total	23.530	114			

The p-value of 0.584 is greater than the significance level of 0.05 therefore the null hypothesis that there is no statistically significant difference in the mean level of PTSD across all education levels is not rejected. This suggests that no particular level of education

can be regarded as a having a significant contribution to the change in the level of PTSD. All education levels contribute equally to the level of PTSD.

H_0 : the mean Level of PTSD is the same across all relationship status

H_1 : atleast one mean is different

ANOVA

Level of PTSD

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	.845	5	.169	.812	.544
Within Groups	22.685	109	.208		
Total	23.530	114			

The p-value of 0.544 is greater than the significance level of 0.05 therefore the null hypothesis that there is no statistically significant difference in the mean level of PTSD across all relationship statuses is not rejected.

H_0 : there is no correlation between Level of PTSD and number of children

H_1 : there is a correlation between the two variables

Correlations

		Level of PTSD	Number of Children
Level of PTSD	Pearson Correlation	1	.035
	Sig. (2-tailed)		.709
	N	115	115
Number of Children	Pearson Correlation	.035	1
	Sig. (2-tailed)	.709	
	N	115	115

The p-value of 0.709 is greater than the significance level of 0.05 therefore the null hypothesis that there is no statistically significant correlation between PTSD level and the number of children that one has is not rejected concluding that the Level of PTSD is not correlated with the number of children that one has.

H₀: there is no correlation between Level of PTSD and one's community standing

H₁: there is a correlation between the two variables

Correlations

		Level of PTSD	Community Standing
Level of PTSD	Pearson Correlation	1	.156
	Sig. (2-tailed)		.097
	N	115	115
Community Standing	Pearson Correlation	.156	1
	Sig. (2-tailed)	.097	
	N	115	115

The significance level of 0.05 is less than the p-value of 0.097 therefore the null hypothesis is not rejected leading to a conclusion that there is no statistically significant correlation between the two variables in question. This suggests that changing one's stand in the community does not necessarily lead to the change in that individual's PTSD levels.

4.7.2 The correlations between Social Support, Traumatic event and demographic characteristics

In this section all three subtypes of social support are looked at in relation to the characteristics of the demographics of the participants and the traumatic event.

H_0 : there is no association between the Social Support Level and whether the victim knew the perpetrator or not.

H_1 : there is association between the two variables

SOCIAL_SUPPORT * Most Bothersome Traumatic event

Cross tabulation

Count

		Most bothersome traumatic event		Total
		Sexual assault by someone you know	Sexual assault by a stranger	
SOCIAL_SUPPORT	MODERATE	6	0	6
	QUITE A LOT	61	48	109
Total		67	48	115

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.535 ^a	1	.033		
Continuity Correction ^b	2.905	1	.088		
Likelihood Ratio	6.718	1	.010		
Fisher's Exact Test				.040	.035
Linear-by-Linear Association	4.496	1	.034		
N of Valid Cases	115				

b. Computed only for a 2x2 table

The p-value for the Pearson's chi square statistic (0.033) is less than the significance level of 0.05 therefore the null hypothesis is rejected concluding that there is a statistically significant association between the level of Social Support and whether the victim knew the perpetrator or not.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	.199	.033
	Cramer's V	.199	.033
N of Valid Cases		115	

The Cramer's V and Phi coefficient are significant and their value (0.199) suggests that the association between the variables is weak.

H_0 : the mean level of social support is the same across all the levels of education

H_1 : at least one of the means of social support is different

ANOVA

SOCIAL_SUPPORT

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	.225	4	.056	1.135	.344
Within Groups	5.462	110	.050		
Total	5.687	114			

The p-value of 0.344 is greater than the significance level of 0.05 therefore the null hypothesis that there is no statistically significant difference in the mean level of Social Support across all levels of education is not rejected. This suggests that no particular level education can be regarded as having a significant contribution to the change in the level of Social support. All education levels contribute equally to the level of Social Support.

H_0 : the mean level of social support is the same across all relationship statuses

H_1 : at least one of the means of social support is different

ANOVA

SOCIAL_SUPPORT

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	.061	4	.015	.297	.879
Within Groups	5.626	110	.051		
Total	5.687	114			

The p-value of 0.879 is greater than the significance level of 0.05 therefore the null hypothesis that there is no statistically significant difference in the mean level of Social Support across all relationship statuses is not rejected. This suggests that no particular relationship status can be regarded as having a significant contribution to the change in the level of Social Support. All relationship statuses contribute equally to the level of Social Support.

H_0 : there is no correlation between the Social Support levels and the victim's community standing

H_1 : there is an association between these two variables

Correlations

		Please tell me where you think you stand at this time in your life, relative to other people in your community.	SOCIAL_SUPPORT
Please tell me where you think you stand at this time in your life, relative to other people in your community.	Pearson Correlation Sig. (2-tailed) N	1 115	.212* .023 115
SOCIAL_SUPPORT	Pearson Correlation Sig. (2-tailed) N	.212* .023 115	1 115

*. Correlation is significant at the 0.05 level (2-tailed).

The p-value of 0.023 is less than the significance level of 0.05 therefore the null hypothesis is rejected with a conclusion that there is a statistically significant correlation between the two variables. If there is any variation in the Social Support levels it does not necessarily mean that it resulted from the variation in the level of community standing.

Interpreting strength of relationship coefficients (De Vaus, 2002: 259)

0.0 no linear association

0.01-0.09 insubstantial

0.1-0.29 low

0.3-0.49 Moderate

0.5-0.69 Strong

0.7-0.89 Very strong

0.9+ near perfect

The Pearson's correlation value of 0.212 suggests that the correlation between the two variables is low. That is, there is a low, positive correlation between the level of social support and community standing.

H_0 : there is no association between the Social Reactions and whether the victim knew the perpetrator or not.

H_1 : there is association between the two variables

SOCIAL_REACTIONS * Most Bothersome Traumatic event

Cross tabulation

Count

		Most bothersome traumatic event		Total
		Sexual assault by someone you know	Sexual assault by a stranger	
SOCIAL_REACTIONS	Never	0	3	3
	Rarely	44	27	71
	Sometimes	18	15	33
	Frequently	4	2	6
	All the time	1	1	2
Total		67	48	115

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	5.007 ^a	4	.287
Likelihood Ratio	6.068	4	.194
Linear-by-Linear Association	.075	1	.784
N of Valid Cases	115		

a. expected count is .83.

The p-value for the Pearson's chi square statistic (5.007) is greater than the significance level of 0.05 therefore the null hypothesis is not rejected concluding that there is no statistically significant association between the level of Social Reactions and whether the victim knew the perpetrator or not.

H_0 : the mean level of social reactions is the same across all the levels of education

H_1 : at least one of the means of social reactions is different

ANOVA

SOCIAL_REACTIONS

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1.719	4	.430	.841	.502
Within Groups	56.246	110	.511		
Total	57.965	114			

The p-value of 0.502 is greater than the significance level of 0.05. Therefore, the null hypothesis that there is no statistically significant difference in the mean level of Social Reactions across all the levels of education, is not rejected. This suggests that no particular education level can be regarded as having a significant contribution to the change in the level of Social Reactions. All education levels contribute equally to the level of Social Reactions.

H_0 : the mean level of social reactions is the same across all relationship status

H_1 : at least one of the means of social reactions is different

ANOVA

SOCIAL_REACTIONS

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.569	4	.142	.273	.895
Within Groups	57.396	110	.522		
Total	57.965	114			

The p-value of 0.895 is greater than the significance level of 0.05. Therefore, the null hypothesis that there is no statistically significant difference in the mean level of Social Reactions across all relationship statuses, is not rejected. This suggests that no particular relationship status can be regarded as having a significant contribution to the change in the level of Social Reaction. All relationship statuses contribute equally to the level of Social Reaction.

H_0 : there is no association between the Social Reactions levels and the victim's community standing

H_1 : there is an association between these two variables

ANOVA

SOCIAL_REACTIONS

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1.065	6	.177	.337	.916
Within Groups	56.901	108	.527		
Total	57.965	114			

The p-value of 0.916 is greater than the significance level of 0.05. Therefore, the null hypothesis that there is no statistically significant difference in the mean level of Social Reactions across all levels of community standing, is not rejected. This suggests that no particular level of community standing can be regarded as having a significant contribution to the change in the level of Social Reaction. All levels of community standing contribute equally to the level of Social Reaction.

H_0 : there is no correlation between the Social undermining and the victim's community standing

H_1 : there is an association between these two variables

Correlations

	Please tell me where you think you stand at this time in your life, relative to other people in your community.	SOCIAL_UNDEMINING
Please tell me where you think you stand at this time in your life, relative to other people in your community.	Pearson Correlation Sig. (2-tailed) N	1 .376 .422 115
SOCIAL_UNDERMINING	Pearson Correlation Sig. (2-tailed) N	.076 .422 115

The p-value of 0.422 is greater than the significance level of 0.05. Therefore, the null hypothesis is not rejected with a conclusion that there is no statistically significant correlation between the two variables. If there is any variation in the Social Undermining, it does not necessarily mean that it resulted from the variation in the level of community standing.

H_0 : there is no association between the Social undermining and whether the victim knew the perpetrator or not.

H_1 : there is association between the two variables

SOCIAL_UNDERMINING * Most Bothersome Traumatic event

Cross tabulation

Count

		Most bothersome traumatic event		Total
		Sexual assault by someone you know	Sexual assault by a stranger	
SOCIAL_UNDERMINING	NOT AT ALL	48	37	85
	MODERATE	17	10	27
	QUITE A LOT	2	1	3
Total		67	48	115

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.445 ^a	2	.801
Likelihood Ratio	.449	2	.799
Linear-by-Linear Association	.434	1	.510
N of Valid Cases	115		

a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is 1.25.

The p-value for the Pearson's chi square statistic (0.445) is greater than the significance level of 0.05 therefore the null hypothesis is not rejected concluding that there is no statistically significant association between the level of Social Undermining and whether the victim knew the perpetrator or not.

H_0 : the mean level of social undermining is the same across all relationship status

H_1 : at least one of the means of social undermining is different

ANOVA

SOCIAL UNDERMINING

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.501	4	.125	.474	.754
Within Groups	29.030	110	.264		
Total	29.530	114			

The p-value of 0.754 is greater than the significance level of 0.05 therefore the null hypothesis that there is no statistically significant difference in the mean level of Social Undermining across all levels of community standing is not rejected. This suggests that no particular level of relationship status can be regarded as having a significant contribution to the change in the level of Social Undermining. All levels of relationship status contribute equally to the level of Social Undermining.

H_0 : the mean level of social undermining is the same across all the levels of education

H_1 : at least one of the means of social undermining is different

ANOVA

SOCIAL_UNDERMINING

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.653	4	.163	.622	.648
Within Groups	28.877	110	.263		
Total	29.530	114			

The p-value of 0.648 is greater than the significance level of 0.05. Therefore the null hypothesis that there is no statistically significant difference in the mean level of Social Undermining across all levels of education, is not rejected. This suggests that no particular level of education can be regarded as having a significant contribution to the change in the level of Social Undermining. All levels of education contribute equally to the level of Social Undermining.

4.7.3 Correlations of PTSD and Social Support

In this section, the relationship between the two variables of interest, PTSD and Social Support, is evaluated. PTSD is correlated to social support, social reactions and social undermining.

H_0 : there is no correlation between the level of PTSD and Social Support Level

H_1 : there is association between the two variables

Correlations

		PTSD_LEVEL	SOCIAL_SUPPORT
PTSD_LEVEL	Pearson Correlation	1	-.142
	Sig. (2-tailed)		.130
	N	115	115
SOCIAL_SUPPORT	Pearson Correlation	-.142	1
	Sig. (2-tailed)	.130	
	N	115	115

The p-value of 0.13 is more than the significance level of 0.05. Therefore the null hypothesis is not rejected leading to the conclusion that there is no statistically significant correlation between the two variables. If there is any variation in PTSD levels it does not necessarily mean that it resulted from the variation in the level of social support.

H_0 : the mean level of PTSD is the same across all the level of Social reactions

H_1 : at least one of the means PTSD is different

ANOVA

PTSD_LEVEL

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	1.550	4	.387	.335	.854
Within Groups	127.372	110	1.158		
Total	128.922	114			

The p-value of 0.854 is greater than the significance level of 0.05. Therefore, the null hypothesis that there is no statistically significant difference in the mean level of PTSD across all social reaction levels, is not rejected. This suggests that no particular level of social

reactions can be regarded as a having a significant contribution to the change in the level of PTSD. All social reaction levels contribute equally to the level of PTSD.

H_0 : the mean level of PTSD is the same across all the level of Social undermining

H_1 : at least one of the means PTSD is different

ANOVA

PTSD_LEVEL

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	5.292	2	2.646	2.397	.096
Within Groups	123.630	112	1.104		
Total	128.922	114			

The p-value of 0.584 is greater than the significance level of 0.05. Therefore, the null hypothesis that there is no statistically significant difference in the mean level of PTSD across all social undermining levels, is not rejected. This suggests that no particular level of social undermining can be regarded as a having a significant contribution to the change in the level of PTSD. All social undermining levels contribute equally to the level of PTSD.

4.8 Summary

This chapter presented the results of the data analysed as they are. The reasons to why or how such results sufficed were not explored in this chapter but will be discussed in Chapter 5.

In brief, the results of the study indicate that the ages of participants ranged from 18 years to 55 and the majority were in the age group of 18 to 25 years. The majority had low levels of education, low monthly income and unemployed.



Most of the participants were sexually assaulted by someone they knew. No-one was injured during the assault, and the assault occurred in the past one to three months after data collection.

An important point to note is that although the majority of participants felt helpless and terrified, only a fraction more than half of them thought that their lives were in danger. The majority also did not think someone else's life was in any danger.

The majority of the participants did not hold or support the rape myths. Nevertheless, it is important to note that few rape myths seemed to get a substantial support and in particular Question 13. This myth scored the least for strongly agree and the third highest for strongly agree, and the highest for agree and neutral.

Almost all the participants reported receiving adequate social support with only six participants being unsatisfied with social support they received. Correspondingly, most of the participants reported no social undermining and no negative social reactions. Only 7% of the participants indicated that their social network reacted negatively to them after disclosure. No relationship was found between any type of social support and any demographic characteristic and trauma, except between positive social support and community standing where the correlation was found to be low and positive.

The incident of PTSD appeared to be high among the participants with 71.3% of them meeting its DSM-IV Diagnostic Criteria. Despite this slight difference, no correlation was found between PTSD and all the demographic characteristics. Furthermore, there was no significance statistical association between PTSD and social support, social reactions, and social undermining.

CHAPTER FIVE

DISCUSSION, CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter discusses the results that were given in the previous chapter. The conclusions drawn are based on these results. Lastly, the limitations of the study and recommendations will be made.

The study described the relationship between social support and PTSD among sexual assault survivors. The cross-sectional ex post facto study was conducted at a local TCC in Ngaka Modiri Molema district of NWP in the RSA. Structured interviews were used as a data collection instrument in the sample of 115 women who have been sexually assaulted. The interview guide comprised of demographics, social support grid, PTSD Checklist-Specific Version, and the rape myth scale. The discussion, conclusions and recommendations in this chapter will be guided by the three objectives of the study which were:

Objective 1: To determine the incidence of PTSD among sexually assaulted women;

Objective 2: To determine whether social support reduces or increases the risk of developing PTSD among sexually assaulted women; and

Objective 3: To determine whether sexually assaulted women who receive social support develop PTSD or not.

This will ultimately address the investigation and description of the impact of social support on PTSD among sexual assault survivors.

5.2 Discussion of findings of the study

This section will discuss the findings and will compare them to previous studies. This section will also determine possibilities that could have led to discovery of such results.

5.2.1 The Incidence of Sexual Assault: Objective 1

The majority of participants met the DSM-IV-TR Diagnostic Criteria for PTSD. More than a half, 71.3%, of participants were found to have PTSD. This could be expected to a certain degree because sexual assault has been found to be the number one traumatic event that can lead to PTSD development (Breslau, 2009: 202; Masho & Ahmed, 2007: 266; Ullman *et al*, 2007:827b). Similarly, in a study conducted by Littleton and Henderson (2009: 158) in three universities in the USA found that 76% of 346 participants met the diagnostic criteria of PTSD.

In contrary, Gill (2007: 83) reports that out of a sample of 250 women who were primarily African Americans from primary health clinic in an urban setting only 14.8% were diagnosed PTSD which is arguably a low prevalence. The difference in the results could be due to the fact that Gill (2007: 83) included women who reported all kinds of trauma and the context was an urban setting while the context of this study was primarily rural and all the participants were from rural areas in the NWP of the RSA. The high prevalence of PTSD is often the case in studies that used samples composed of only sexually assaulted women as Elklit and Christiansen (2010: 1480) argued after discovering that 45% of their participants met the full PTSD criteria.

On the other hand, Schumm et al (2006: 829) found 22% of women who have been sexually assaulted as adults or abused as children to have a diagnosis of probable PTSD, a prevalence they argued to be more than what was found in epidemiological studies. It is important to note the heterogeneous nature of their participants as well as their finding that sexual assault alone made a woman six times more vulnerable to developing PTSD. Their sample was comprised of women who experienced various traumatic events but discovered that sexual assault was the leading predictor to PTSD.

According to the National Women Survey (Zinzouw, Resnick, McCauley, Amsradter, Ruggiero & Kilpatrick, 2012: 897), 34% of sexual assault survivors on whom force or threat of force was used, 30% of those on whom drugs were used to intoxicate and incapacitate prior the assault, and 52% of all sexual assault survivors met the DSM-IV criteria for PTSD in the USA. The sample of this was comprised of all women who were sexually assaulted

irrespective of how the assault took place, which corresponds to the 52% prevalence that was discovered by Zinzouw *et al* (2012: 897).

It can be concluded that such high number of participants did suffer from PTSD as sexual assault has been found to elicit such high prevalence of this disorder in other studies. The incidence of PTSD elicited by this study, and in response to the first objective, is therefore that 71.3 % which indicate a high prevalence of PTSD among sexual assault survivors in Ngaka Modiri Molema district of the NWP of RSA.

5.2.2 The Relationship between PTSD and Social Support: Objectives 2 and 3

It is important to note that the majority of participants reported quite a lot social support in this study. This is supported by the fact that social reactions and social undermining were far less than common towards the participants. Furthermore rape myths were uncommon among the participants of the study. These results all concur that social support reported by these women was high.

The correlational analysis, as seen in the previous chapter, carried out showed that there is no correlation between social support and PTSD despite the fact that both are found to be high among the participants. This contradicts the majority of studies carried before which were in a different context and found affirmative results to the existence of such association. One of such studies is one carried by Ullman *et al* (2007: 828b) in the metropolitan area of Chicago in the USA. In this study it was found that social support was related to more severe PTSD which the researchers argued that it may appear that social support leads to PTSD but it could be because women with more PTSD symptoms were looking for help more than others. Another study still elicited positive association between positive social support and an increase in PTSD (Ullman *et al*, 2007: 31a). In this study Ullman *et al* found that the high degree of global support led to the same outcomes as high frequency of negative social reactions which is more PTSD symptoms.

Nonetheless, other studies did find a negative correlation between social support and PTSD. In an experimental single-case, multiple-baseline across-subjects design involving three participants carried out by Billette *et al* in 2008, more social support was associated with less

PTSD. An increase in the satisfaction with received social support enhanced the efficacy of Cognitive-Behaviour Therapy (CBT) in treating PTSD (Billette *et al*, 2008: 891). It was found that positive social support (positive reactions) substantially reduced the possibilities of negative trauma outcomes such as PTSD while negative social support (negative reactions) were associated with PTSD symptomatology among 115 university women who have been sexually assaulted (Borja *et al*, 2006: 911). A negative association was noticed again by Schuum *et al* (2006: 830) a study of a sample consisting of 777 women who either have been abused as children or sexually assaulted as adults. Women reporting high social support scored lower for PTSD whereas those with low social support had high PTSD scores.

On the other hand, there are studies that did not find any relationship between the two variables. In a sample of 86 university women (51 of which experienced natural disasters and 35 sexual assault) social support was found not to have any impact on PTSD and Depression in both sub-samples (Borja *et al*, 2009: 123). The absence of such relationship could be influenced by the fact that many factors that are said to be beyond the characteristics of the sexual assault and the survivor (Campbell, Dworkin & Cabral, 2009: 238).

5.2.3 Application of the conceptual framework to the findings of the study: the Stress-Buffering model

The adapted model of the study was the Stress-Buffering model that argued that social support will moderate the development of PTSD among sexually assaulted women.

The study focused on women who have experienced sexual assault of whom majority were 18 and 25 years of age, had low levels of education and low socio-economic status. The majority also reported high level of social support and low negative social reactions as well as low social undermining. Despite that, the majority of the participants were found to be having PTSD. This application of the stress-buffering model as adapted for the study is summarised in Figure 5.1.

The results of this study seem to contradict this as no correlation was found between social support and PTSD. Despite that, it could not be concluded from this study that social support has no effect on PTSD based on the number of reasons.

Firstly, the majority of participants reported high incidence of both PTSD and social support. Lack of any association between the two could be due to the fact that all the participants were from the same background which was primarily rural. Arguably, these similar backgrounds may have led to participants receiving the same type of or ineffective social support. And the fact that the support system of the participants had low financial income could impact negatively on effectiveness of the social support they could render to the participants as indicated by Lincoln *et al* (2005: 762). Furthermore, the education level of the participants was low and this might as well have an impact on the social support one receives.

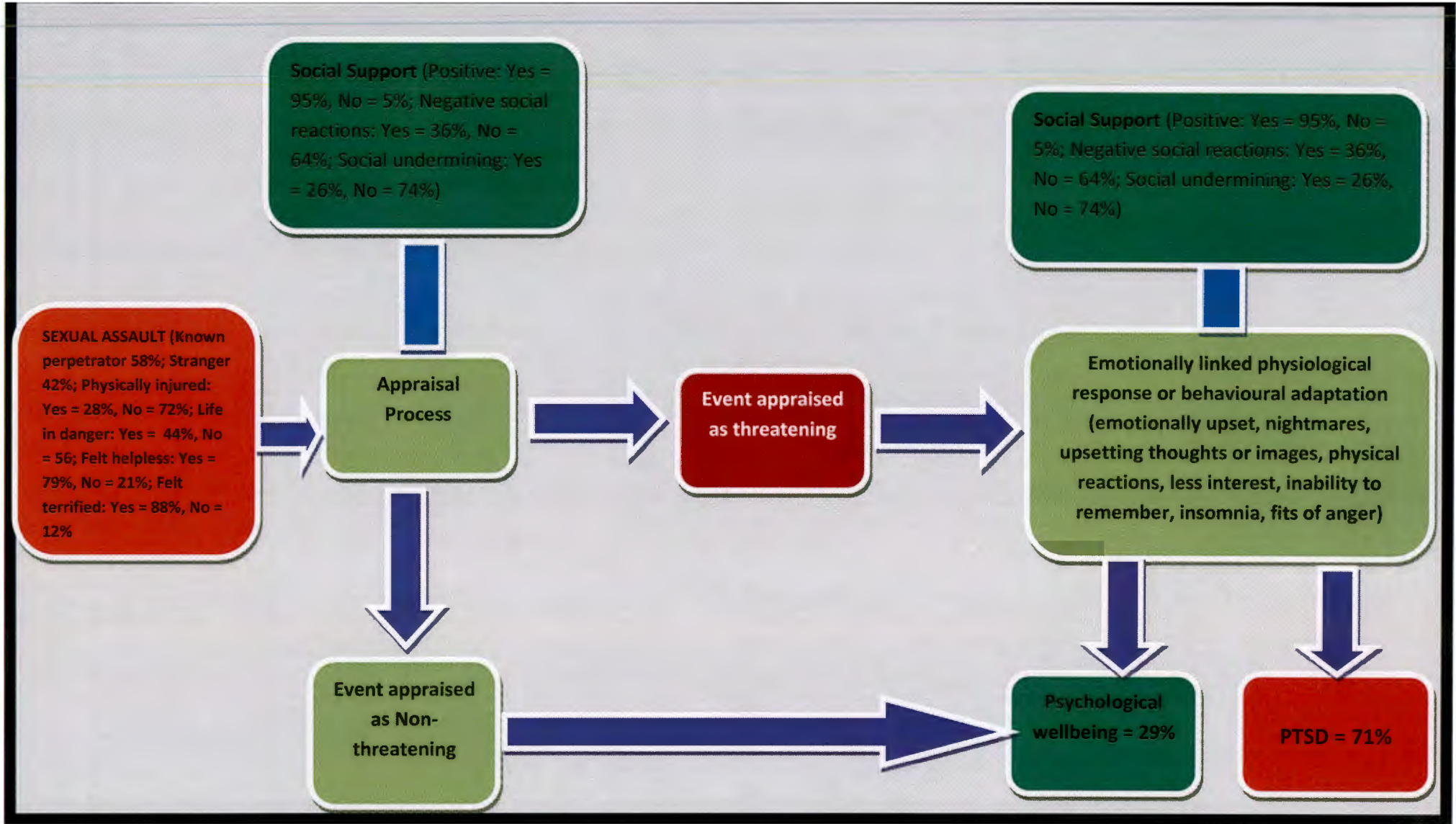


Figure 2.2. The representation of results in relation to the adapted Stress Buffering model

The other factor might be the time or point at which data was collected. At the time of data collection, the participants were still provided with the health care services at TCC, and this could have an impact on their perceived and received social support. Perhaps the results on social support could have been different if the data was collected when the participants were no longer receiving health care services from TCC. Conversely, the prevalence of PTSD might also be different if data was collected at a later state.

The other reason that could have led to these results where sexual assault and social support are both high among the participants may be the fact that majority of the participants reported being assaulted by someone they knew. It could be that these participants were receiving social support but may have perceived that support in a negative manner due to sexual assault by someone known to them. Hence, the conclusion that the results of this study oppose the argument of the model could not be founded.

5.3 Conclusions of the study

In conclusion there is no significance statistical relationship between social support and PTSD among sexually assaulted women found in this study. On the other hand, concluding this in just once-off results cannot be founded. Many studies that found that association were major surveys with high numbers of participants and either longitudinal studies or intensive literature reviews, while this study used only 115 participants. The minimum number of participants in majority of such studies was at least 2, 000 participants (Lincoln *et al*, 2005: 758; King *et al*, 2006: 2983; Lincoln, 2000: 246).

The participants in the majority of such studies were not in the process of therapy and the participants in the study were still attending post-trauma treatment at TCC. It also important to note that the results of this study also showed high incidence of PTSD as well as high reported social support, and this can indicate some form of relationship. This may be due to the fact that these participants experienced the assault not long ago and were consequently experiencing support from their social network/support system and PTSD was beginning to develop at the time of data collection. Therefore, there are possibilities that a follow-up on them would elicit the very different results and explanation to the present ones. Other therapies were also found to increase the symptoms of PTSD temporarily. This may also be

the case as the participants in the study were undergoing therapy. On the other hand, low socio-economic status, which characterised the participants of this study, was also found to render social support ineffective due to a significant limitation on the range and availability of supportive resources in the support system (Lincoln *et al*, 2005: 762).

It is therefore argued here, that the results of this study may indicate some sort of association of social support and PTSD although the analysis found no significant association between the two variables. The conclusion of that there is no correlation between these constructs is regarded as premature at this stage. This is because the results bring about the suspicion of the existence of association rather than the confirmation of no association.

5.4 Limitations of the study

The study was carried out successfully but it was not without some shortcomings. As indicated above, the study was cross-sectional ex post facto and utilised data collected at six months after the assault with only 115 participants. As indicated, this makes the findings of the study inconclusive. Consequently, it could not be concluded that social support and PTSD are not associated in the context of sexual assault as the results of the study suggest. This necessitates undertaking a longitudinal study or a same type of study, cross-sectional with high number of participants.

This also would indicate the limited time that the researcher had to undertake longitudinal or high-participants studies as the study was carried out as an academic requirement that had a stipulated time-frame. The researcher was not be able to undertake more sophisticated research designs such as longitudinal studies and high-participants studies, such as surveys, as it would not be feasible to complete in the predetermined period of the education qualification.

The homogeneity of the participants was another hurdle of the study. Almost all of the participants were of the same race, had low income, low educational status, were from one district, out of four, and in one province, out of nine out of nine provinces in the country. This markedly reduced the generalizability of the results, if not making it impossible, because it could not be argued that other people in the province, let alone the country, and across

various races, marital, educational and socio-economic statuses would manifest in the same manner after the ordeal of sexual assault.

5.5 Recommendations of the study

Despite the limitations discussed early in this chapter, numerous recommendations could be drawn from the conclusions and results of the study. These recommendations will be made based on the service provision, education as well as future research.

5.5.1 Recommendations for health care provision

Recommendations for the provision of health care by health professionals are:

- Social support should be integrated into the provision of health services for sexual assault survivors;
- social support must be utilised in conjunction with other mental health care treatments to augment them;
- thorough assessment of the individual sexual assault survivor's social support must be carried prior this integration;
- professional support should also be provided to survivors of sexual assault especially in the first six months after the assault; and
- support groups for the survivors of sexual assault must be formulated in communities and health providers must provide health education and carry out campaigns on sexual assault and its negative effects on an individual and the community.

5.5.2 Recommendations for nursing education

Recommendations for the developers of nursing education curriculum include:

- Sexual assault and its aftermath should be included in the training of nurses at the basic level, i.e. basic nursing degree or basic nursing diploma;
- nurses should be trained in collecting forensic evidence and conducting assessment in sexual assault victims; and
- in-service training for nurses and all health care professionals on providing professional support to sexual assault survivors should be carried out.

This is due to the fact that results indicated that a nurse is likely to encounter a sexual assault victim in health services given the prevalence of sexual assault.

5.5.3 Recommendations for further research

The recommended areas for future research are as follows:

- Longitudinal design to determine the association of social support and PTSD among sexual assault survivors;
- Large-scale surveys to provide for the current prevalence of sexual assault and PTSD in RSA;
- Determine the most-reported type of social support reported by the survivors of sexual assault;
- Identification of determinants of types of social support after an individual has experienced sexual assault;
- Determining the manner in which the health care professionals may integrate social support in the care of sexual assault survivors; and
- Identification of factors that affect the manner in which social support and PTSD are related among sexual assault.

All these are seemingly the best options to enable the victims of sexual assault to transform with ease into survivors of sexual assault which seems to be a pandemic in the country.

5.6 Summary

This chapter concluded the study report in the following manner. The results of the study did not indicate a statistically significant correlation between social support and PTSD among sexually assaulted women, but also led to the reasonable suspicion of the existence of such association and the possible reasons of such outcomes were discussed. These discussions were based on the three objectives of the study as well as the stress-buffering model which guided the study. The implications of the results on the health care practice and nursing education were also indicated. Finally, the research the limitations of the research study and ways with which future researchers may avoid these hurdles were also explained. It is hoped

that these recommendations will furthermore elicit the relationship of social support and PTSD among sexual assault survivors and improve the quality of care rendered to survivors of this ordeal.

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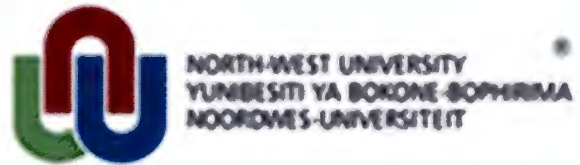
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APPENDIX 1: The letter of Ethical Approval from the NWU Ethics Committee



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ETHICS APPROVAL OF PROJECT

Ethics Committee
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2010-11-19

This is to certify that the next project was approved by the NWU Ethics Committee:

<p>Project ID# : The Aftermath of Rape on Mental Health of Survivors in North West and Limpopo Provinces</p> <p>Project leader: Prof M Maselesole</p> <p>Ethics number: NWU-00110-10-A2</p> <p><small>2010, 11-19-17</small></p> <p>Expiry date: 2015/11/17</p>
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The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

The formal Ethics approval certificate will be sent to you as soon as possible

Yours sincerely

Ms. Manelise Huisman
NWU Ethics Secretariat

APPENDIX 2: Permission letter submitted to Thuthuzela Care Centre

North-West University (Mafikeng Campus)

P/Bag X 2046

Mmabatho

2735

30/August/2010

Thuthuzela Care Centre

Mafikeng Provincial Hospital

Lichtenburg Road

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2475

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am currently conducting a research project in collaboration with University of California in Los Angeles. We are currently investigating on the aftermath of trauma as a result of Sexual Assault among women within the age range of 18- 55 years. This study will be conducted at the Thuthuzela centre in Mafikeng.

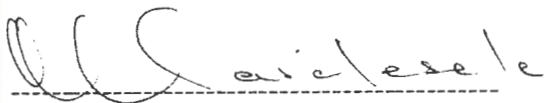
We will be collecting data from rape survivors: Firstly, interviews will be conducted during their second visit to the hospital, then after 6months and the last interviews will be conducted after 12 months.

This study is conducted under the supervision of Professor M, Davhana- Maselesele in collaboration with University of California (Los Angeles) USA. We will prefer to collect data starting around November/December 2010 then will continue in 2011 and 2012.

Participants will be informed that all information disclosed by them to the interviewers will be kept confidential, and receive informed consent prior to the interview. In an effort to address safety, all participants will be informed of their right to withdraw from the study at any time or refuse to answer any question without any negative consequences. Participants will also be asked what they understand about each paragraph read to them during the consent process to ensure their informed consent.

We will conduct interviews with participants and where need arise we will be able to refer them to a social worker/psychologist at the hospital. The information gathered will assist in curriculum development to ensure that training of health professionals is on an informed basis.

Thanking you in advance.



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APPENDIX 3: Informed consent form

INFORMED CONSENT

THE FULUFHELO (HOPE) PROJECT: SOUTH AFRICA

You are asked to participate in a research study conducted by Prof. Mashudu Maselesele of the North-West University at Mafikeng, South Africa. You were selected as a possible participant in this study because you are a female over the age of 18 who is able to communicate in English, Tshivenda, Xitsonga or Setswana. Your participation in this research study is voluntary.

Why is this study being done?

Many women in our community have had sexual experiences against their will, which may afterwards affect their emotional health. The aim of this study is to obtain a greater understanding of the short and long-term effects of sexual assault and treatment services.

What will happen if I take part in this research study?

If you volunteer to participate in this study, the researcher will interview you using a survey that contains the following sets of questions:

- **Demographic information:** These will include questions about your age and marital status, where you live, your level of education, what work you do, your level of income, use of drugs or alcohol, your religion and any experience you may have going to a doctor as well as a traditional healer.
- **Questions about traumatic incidents:** This section will include questions on the sexual assault that brought you to the clinic, as well as questions about whether you have had

any traumatic experiences in the past. We will also ask you questions about how you feel about these traumatic incidents and how they have affected your daily life.

- Questions about your cultural beliefs: These questions will be asked in order for you to describe cultural beliefs about your role as a woman, sexual practices, and experiences that happened sexually against your will.
- Questions about support: These questions will ask about any support you have received from friend, family and your community and the different ways that you have been dealing with the sexual assault incident.
- Questions about the services provided at the clinic.

How long will I be in the research study?

Your participation in the study will take a total of about 90 minutes. We will also interview you again in 6 months and then again after one year.

Are there any potential risks or discomforts that I can expect from this study?

- You may experience possible discomfort or tiredness from 90 minutes in the interview.
- You may also experience possible distress coming from the discussion of any traumatizing or life threatening events you may have experienced.
- During the interview, you may disclose sensitive personal information such as personal or family problems that you may have or have had in the past. The research team has taken several steps to ensure that this information is kept strictly confidential, but if it were to be exposed to others, your reputation could potentially be harmed.

Are there any potential benefits if I participate?

You could be having symptoms of trauma for which you may benefit from treatment. If this is discovered during this study, you will be referred to suitable health practitioners at the hospital or elsewhere.

The results of the research may also help health professionals find better ways to examine and assist people from this community who have experienced trauma.

Will I receive any payment if I participate in this study?

You will not receive any payment for participating in this study. At the end of the study interview, you will receive a food voucher. We will also give you a bus voucher for return visits and light meals will be offered during return visits if necessary.

Will information about me and my participation be kept confidential?

Any information that is obtained in connection with this study and that can identify you will remain confidential. It will be disclosed only with your permission or as required by law.

We will keep your participation private by following these steps: The screening form and consent form will be the only documents containing your name. In addition, the screening form will be the only document containing your date of birth. Please remove the names on the demographic document. These two documents will therefore be kept in a locked office of the Principal Investigator, in a filing cabinet separate from the study survey.

The study survey will not have any information that can identify you as a person. It will be labelled with a code that the research team can link to your screening - and consent form. The survey will be kept in a locked cupboard in the locked office of the Principal Investigator. The list of all participants and their code numbers will be kept in a locked cabinet in a different room. These steps are designed to ensure that if an unauthorized person tried to obtain any of these documents, it would still be very difficult for them to know which participant the information belongs to.

Withdrawal of participation by the investigator

The investigator may withdraw you from participating in this research if circumstances arise which make it necessary. If it becomes extremely hard for you to understand or answer the study questions, you may have to drop out, even if you would like to continue. The investigator will make the decision and let you know if it is not possible for you to continue.

What are my rights if I take part in this study?

You may change your mind about participating at any time and stop participating without penalty or loss of benefits to which you were otherwise entitled.

You can choose whether or not you want to be in this study. If you volunteer to be in this study, you may leave the study at any time without consequences of any kind. You are not giving up any of your legal rights if you choose to be in this research study. You may also refuse to answer any questions that you do not want to answer and still remain in the study.

Who can answer questions I might have about this study?

If you have any questions, comments or concerns about the research, you can also talk to the principal investigator Prof. Mashudu Maselesele, North-West University (Mafikeng Campus), P/Bag X2046, Mmabatho, 2735, email: mashudu.maselesele@nwu.ac.za.

SIGNATURE OF STUDY PARTICIPANT

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

Name of Participant

Signature of Participant

Date

FUTURE USE OF DATA

Please check the appropriate box below and initial:

I agree to have my data stored for future use by the Principal Investigator and/or research team. Initial _____

I do not want my data stored for future use by the Principal Investigator and/or research team. Initial _____

SIGNATURE OF PERSON OBTAINING CONSENT

In my judgment, the participant is voluntarily and knowingly giving informed consent and possesses the legal capacity to give informed consent to participate in this research study.

Name of Person Obtaining Consent

Contact Number

Signature of Person Obtaining Consent

Date

CITI Collaborative Institutional Training Initiative

Human Research Curriculum Completion Report

Printed on 5/3/2013

Learner: Isaac Ontchebile Mokgaola (username: IsaacMokgaola)

Institution: University of California, Los Angeles

Contact Mahikeng, South Africa

Information Department: ACADEMIC ADVANCEMENT PROGRAM

Phone: 073 444 0288

Email: 13160966@nwu.ac.za

Human Research - Social & Behavioral Researchers & Staff:

Stage 1. Basic Course Passed on 07/12/12 (Ref # 7683916)

Required Modules	Date Completed	
History and Ethical Principles - SBR	04/02/12	4/4 (100%)
Defining Research with Human Subjects - SBR	04/02/12	5/5 (100%)
The Regulations and The Social and Behavioral Sciences - SBR	07/09/12	4/5 (80%)
Assessing Risk in Social and Behavioral Sciences - SBR	07/09/12	3/5 (60%)
Informed Consent - SBR	07/11/12	4/5 (80%)
Privacy and Confidentiality - SBR	07/11/12	3/5 (60%)
Research With Protected Populations - Vulnerable Subjects: An Overview	07/12/12	4/4 (100%)
University of California, Los Angeles (UCLA)	07/12/12	4/4 (100%)

For this Completion Report to be valid, the learner listed above must be affiliated with a CITI participating institution. Falsified information and unauthorized use of the CITI course site is unethical, and may be considered scientific misconduct by your institution.

Paul Braunschweiger Ph.D.

Professor, University of Miami

Director Office of Research Education

CITI Course Coordinator

APPENDIX 5: Report of Responsible Conduct of Research

CITI Collaborative Institutional Training Initiative (CITI)

Responsible Conduct of Research Curriculum Completion Report Printed on 5/3/2013

Learner: Isaac Ontchebile Mokgaola (username: IsaacMokgaola)

Institution: University of California, Los Angeles

Contact Information Mahikeng, South Africa

Department: ACADEMIC ADVANCEMENT PROGRAM

Phone: 073 444 0288

Email: 13160966@nwu.ac.za

Social and Behavioral Responsible Conduct of Research OPTIONAL: This course is for investigators, staff and students with an interest or focus in Social and Behavioral research. This course contains text, embedded case studies AND quizzes.

Stage 1. Basic Course Passed on 07/23/12 (Ref # 7683915)

Required Modules	Date Completed	
The CITI Course in the Responsible Conduct of Research	07/12/12	no quiz
Introduction to the Responsible Conduct of Research	07/12/12	no quiz
Introduction to Research Misconduct	07/12/12	no quiz
Research Misconduct 2-1495	07/13/12	4/5 (80%)
Case Study - Truth or Consequences 2-1217	07/13/12	3/3 (100%)
Case Study - In the Field, No One Will Know 2-1218	07/13/12	3/3 (100%)
Case Study Plagiarism 2-1472	07/13/12	2/2 (100%)
Case Study No News Is Not Good News 2-1494	07/13/12	3/3 (100%)
Data Acquisition, Management, Sharing and Ownership 2-1523	07/13/12	3/5 (60%)
Case Study - Data Management - Share and Share Alike 2-1440	07/13/12	2/3 (67%)

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Case Study - Data Management Who Owns Research Data? 2-1200	07/14/12	3/3 (100%)
Case Study - Data Management The New Clinical Data Manager BioMed	07/14/12	no quiz
Publication Practices and Responsible Authorship 2-1518	07/14/12	4/5 (80%)
Responsible Authorship - The Chair as an Author 2-1378	07/14/12	2/2 (100%)
Authorship and Publications - The Grateful Author 2-1379	07/17/12	5/5 (100%)
Peer Review 2-1521	07/17/12	4/5 (80%)
What is Responsible Peer Review 2-1374	07/17/12	4/4 (100%)
Peer Review and Controversial Research 2-1370	07/17/12	2/3 (67%)
Responsible Mentoring 2-1625	07/17/12	6/6 (100%)
Mentoring Case Study: O, What a Tangled Web We Weave	07/17/12	4/4 (100%)
Mentoring Case Study: The Graduate Student Laborer	07/17/12	3/3 (100%)
Mentoring Case Study: Sherry's Secret	07/19/12	3/4 (75%)
Mentoring Case Study: Lisa Bach's Case	07/18/12	3/3 (100%)
Mentoring Case Study: The Business of Mentoring	07/18/12	4/4 (100%)
Mentoring Case Study: Too Much Help is Just Too Much!	07/18/12	3/3 (100%)
Conflicts of Interest and Commitment 2-1462	07/19/12	5/6 (83%)
Col Case Study - The Case of the Promising New Technology 2-1484	07/20/12	4/4 (100%)
Col Case Study -The Case of the Entrepreneurial Psychologist 2-1457	07/20/12	3/3 (100%)
Col Case Study - Janet's Suspicions 2-1459	07/20/12	4/4 (100%)
Collaborative Research 2-1434	07/20/12	5/5 (100%)
When Collaborators Disagree 2-1314	07/20/12	2/3 (67%)

Why Can't We All Just Get Along 2-1180	07/23/12	3/3 (100%)
Collaborations Between Academics 2-1393	07/23/12	4/4 (100%)
When Collaborators Become Competitors 2-1401	07/23/12	2/3 (67%)
Marriage Has Its Advantages 2-1405	07/23/12	2/2 (100%)
The CITI RCR Course Completion Page	07/23/12	no quiz

For this Completion Report to be valid, the learner listed above must be affiliated with a CITI participating institution. Falsified information and unauthorized use of the CITI course site is unethical, and may be considered scientific misconduct by your institution.

Paul Braunschweiger Ph.D.
Professor, University of Miami
Director Office of Research Education
CITI Course Coordinator

CITI Collaborative Institutional Training Initiative

UCLA HIPAA Curriculum Completion Report Printed on 5/3/2013

Learner: Isaac Ontchebile Mokgaola (username: IsaacMokgaola)

Institution: University of California, Los Angeles

Contact Information Mahikeng, South Africa

Department: ACADEMIC ADVANCEMENT PROGRAM

Phone: 073 444 0288

Email: 13160966@nwu.ac.za

UCLA HIPAA:

Stage 1. Stage 1 Passed on 07/23/12 (Ref # 8331788)

	Date	
Required Modules	Completed	
UCLA HIPAA	07/23/12	7/7 (100%)

For this Completion Report to be valid, the learner listed above must be affiliated with a CITI participating institution. Falsified information and unauthorized use of the CITI course site is unethical, and may be considered scientific misconduct by your institution.

Paul Braunschweiger Ph.D.
Professor, University of Miami
Director Office of Research Education
CITI Course Coordinator

APPENDIX 7: Data collection instrument of the study

SURVEY FORM 1 (BASELINE)

Welcome, thank you for participating in the Fulufhelo Project. Fulufhelo stands for "hope" and we would like to ask you questions about your experiences and how they are affecting you. If you have any questions or need to stop, please let me know.

SECTION A: DEMOGRAPHICS

We'd like to get some information about you. I am going to read you some questions and please answer to the best of your ability.

A1. How old are you? _____

A2. Which province do you current live in?

1. North-West Province
2. KwaZulu-Natal
3. Western Cape
4. Limpopo (Venda)
5. Other: _____

A3. Have you always lived in this province?

0. No
1. Yes

A3a. If no, where else have you lived before? (specify): _____

A4. How do you describe your ethnicity?

1. Zulu

2. Venda
3. Tsonga
4. Tswana
5. Other (specify): _____

A5. What is your current marital status?

0. Never married
1. Married, living with husband
2. Married, but not living with husband
3. Separated
4. Divorced
5. Widowed

A6. What is your relationship status?

0. You have not had a relationship in the past 3 months
1. You live with one partner
2. You see/date one person regularly
3. You see, date more than one person regularly
4. You date occasionally

A7. What is your highest level of education?

0. None
1. Less than matric
2. Matric
3. University degree
4. Diploma
5. Other (specify): _____

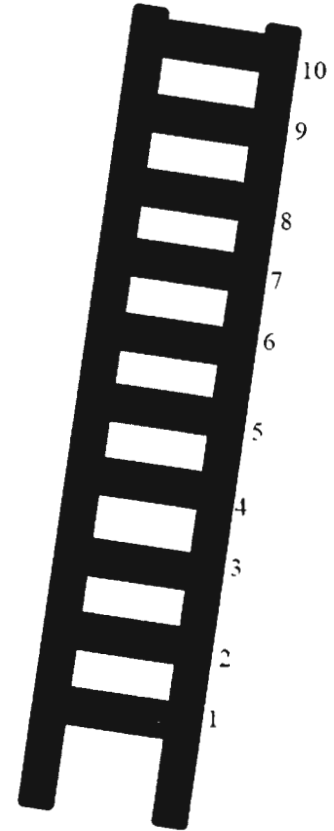
A8. What is your working status?

- 0. Unemployed
- 1. Unable to work
- 2. Retired
- 3. Homemaker
- 4. In school
- 5. Working part time
- 6. Working full time
- 7. Other (specify): _____

A9. How many children do you have? _____

A10. Which of the following best describes your total monthly personal income?

- 0. R0 - R500
- 1. R500 - R900
- 2. R1000 - R2999
- 3. R3000 - R5999
- 4. R6000 - R8999
- 5. R9000+



A11. This ladder represents where people stand in their communities.

People define community in different ways: please define it in whatever way is most meaningful for you. At the top of the ladder the people who have the highest standing in their community. At the bottom of the ladder are the people who have the lowest standing in the community.

Please tell me where you think you stand at this time in your life, relative to other people in your community.

Rung number: _____

A12. How many people in your household, including yourself, depend on your grant or income?

A13. What is the main language spoken in your home? _____

A14. What is your religion?

0. No religion (*SKIP TO B1a*)
1. Christian (e.g. Protestant, Baptist, Methodist, etc.)
2. Eastern (e.g. Muslim)
3. Catholic
4. Judaism
5. Other (specify): _____

A15. How important is your religion in your life?

1. Not at all
2. Somewhat
3. Very

SECTION B: SOCIAL SUPPORT GRID

These questions are about your current social life. We are interested in the most important person who provides you with personal support such as talking over a problem or giving you concrete help. Also include someone who is important to you but who are not helpful.

B1. What is their relationship to you?

1. Partner, significant other, or husband
2. Family member or relative
3. Friend
4. Work or school associates
5. Neighbors or community member
6. Doctors
7. Traditional healer
8. Religious leader
9. Other: _____

B 2. What is their gender?

1. Male
2. Female

B 3. Did you tell them about the rape?

0. No (SKIP TO F7)
1. Yes

B 4. Since they found out, has your relationship with them got:

1. Less close
2. Stayed the same
3. Closer

B 5. Since they found out, has your relationship with them got:

1. Worse
2. Stayed the same
3. Better

B 6. Are you comfortable talking with them about the incident?

0. No
1. Yes

SOCIAL SUPPORT	Not at all or a little (1)	Moderate (2)	Quite a lot (3)
B7. How much do they give you useful information or advice?			
B8. Listen to you when you need to talk?			
F9. Show that they care about you?			
FB0. Help you with specific problems or give you things you need?			
B11. How satisfied are you with the support you have received from this person?			

SOCIAL UNDERMINING			
B12. Acted in an unpleasant or angry manner toward you?			
B13. Criticized you?			
B14. Make your life difficult?			

Considering all the people you have told about the incident, to what extent have they...

SOCIAL REACTIONS	Never (1)	Rarely (2)	Sometimes (3)	Frequently (4)	All the time (5)
B15. Acted as if you were damaged or somehow different now					
B16. Avoided talking to you or spending time with you					
B17. Told you to stop thinking and/or talking about it					
B18. Tried to take control of what you did or the decisions you made					
B19. Told others about your experience without your permission					
B20. Told you that you could have done more to prevent this experience from occurring					
B21. Expressed so much anger at the person who assaulted you that you had to calm them down					

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B22. Made rude, insensitive or inappropriate remarks about your experience					
--	--	--	--	--	--

SECTION D: PTSD SYMPTOMS

This section deals with experiences that have bothered or upset you in your lifetime.

D1. Please tell me which of the traumatic events you have experienced or witnessed has bothered you the most?

- 1. Accident
- 2. Disaster
- 3. Non-sexual assault by someone you know
- 4. Non-sexual assault by a stranger
- 5. Sexual assault by someone you know
- 6. Sexual assault by a stranger
- 7. Combat (war)
- 8. Sexual contact under 18 with someone 5 or more years older
- 9. Imprisonment
- 10. Torture
- 11. Life-threatening illness
- 12. Other: _____

D2. How long ago did this traumatic event happen?

- 1. Less than 1 month

2. 1 to 3 months

3. 3 to 6 months

4. 6 months to 3 years

5. 3 to 5 years

6. More than 5 years ago

<i>During this traumatic event...</i>	No (0)	Yes (1)
D3. Were you physically injured?		
D4. Was someone else physically injured?		
D5. Did you think your life was in danger?		
D6. Did you think that someone else's life was in danger?		
D7. Did you feel helpless?		
D8. Did you feel terrified?		

<i>In the past month...</i>	Not at all or only one time (1)	Once a week or less / once in a while (2)	2 to 4 times a week / half the week (3)	5 or more time a week / almost always (4)	N/A
D9. Did you have upsetting thoughts or images of the traumatic event that came into your mind when you didn't want them to?					
D10. Did you have bad dreams or nightmares about the traumatic event?					
D11. Did you relive the traumatic event, acting or feeling as if it was happening again?					
D12. Did you feel emotionally upset when you were reminded of the traumatic event (for example, feeling scared, angry, sad, guilty, etc.)?					
D13. Did you experience physical reactions when you were reminded of the traumatic event (for example, breaking out into a sweat, heart beating fast)?					
D14. Did you try not to think about, talk about, or have feelings about the traumatic event?					
D15. Did you try to avoid activities, people or places that remind you of the traumatic event?					
D16. Were you not able to remember an important					

part of the traumatic event?					
D17. How often have you had much less interest or participated much less often in important activities?					
D18. How often have you felt distant or cut off from people around you?					
D19. How often have you felt emotionally numb, for example, being unable to cry or unable to have loving feelings?					

	Not at all or only one time (1)	Once a week or less / once in a while (2)	2 to 4 times a week / half the week (3)	5 or more time a week / almost always (4)	N/A
D20. How often have you felt as if your future plans or hopes will not come true, for example, you will not have a career, marriage, children or long life?					
D21. How often have you had trouble falling or staying asleep?					
D22. How often have you felt irritable or had fits of anger?					
N23. How often have you had trouble concentrating, for example, drifting in and out of conversations, lose track of a story on the television, forgetting what you read?					
D24. How often have you felt overly alert, for example, checking to see who is around you, being uncomfortable with your back to a door, etc.?					
D25. How often have you been jumpy or easily startled, for example, when someone walks up behind you?					

D26. Since the traumatic event, did you start or increase your use of alcohol, drugs or tobacco?

- 0. No (SKIP to N30)
- 1. Yes

	No (0)	Yes (1)	N/A
D27a. Alcohol (start)			
D27b. Alcohol (increase)			
D27c. Tobacco (start)			
D27d. Tobacco (increase)			
D27e. Marijuana (start)			
D27f. Marijuana (increase)			
D27g. Other drugs (start)			
D27h. Other drugs (increase)			

D28. How long have you experienced these problems?

- 1. Less than 1 month
- 2. 1 to 3 months
- 3. More than 3 months
- 4. N/A

D29. How long after the traumatic event did these problems begin?

- 1. Less than 6 months
- 2. 6 or more months
- 3. N/A

In the past month, have the problems interfered with...

	No (0)	Yes (1)	N/A
D30. Work			
D31. Household chores and duties			
D32. Relationships with friends			
D33. Fun and leisure activities			
D34. Schoolwork			
D35. Relationships with your family			
D36. Your sex life			
D37. General life satisfaction			
D38. Overall level of functioning in all areas of your life			

Disassociation:

Please choose the response that best describes your experiences and reactions during the rape incident and immediately afterwards. If this does not apply to your experience, choose "not at all true".

	Not at all true (1)	Slightly true (2)	Somewhat true (3)	Very true (4)	Extremely true (5)
1. I felt confused; that is, there were moments when I had difficulty making sense of what was happening.					

SECTION E: RAPE MYTH SCALE

The next section is on attitudes or beliefs that some people have about sex and rape which you may or may not agree with. On a scale of 1-5, please indicate the extent to which you agree or disagree with the following statements.

	Strongly disagree (1)	Disagree (2)	Neither agree nor disagree (3)	Agree (4)	Strongly agree (5)
E1. When a woman talks and acts sexy, she is inviting rape					
E2. When a woman is raped, she usually did something careless to put herself in that situation					
E3. Any woman who teases a man sexually and doesn't finish what she started realistically deserves anything she gets					
E4. Many rapes happen because women lead men on					
E5. Men don't usually intend to force sex on a woman, but sometimes they get too sexually carried away					
E6. In some rape cases, the woman actually wanted it to happen					
E7. Even though the woman may call it rape, she probably enjoyed it					

S8. If a woman doesn't fight back, you can't really say that it was a rape					
E9. A rape probably didn't happen if the woman has no bruises or marks					
E10. When a woman allows petting to get to a certain point, she is implicitly agreeing to have sex					
E11. If a woman is raped, often it's because she didn't say "no" clearly enough.					
E12. Women tend to exaggerate how much rape affects them					
E13. When men rape, it's because of their strong desire for sex					
E14. It is just part of human nature for men to take sex from women who let their guard down					

	Strongly disagree (1)	Disagree (2)	Neither agree nor disagree (3)	Agree (4)	Strongly agree (5)
E15. A rapist is more likely to be Black or Colored than White					
E16. In any rape case, one would have to question whether the victim is promiscuous or has a bad reputation					
E17. Rape mainly occurs on the "bad" side of town					
E18. Many so-called rape victims are actually women who had sex and "changed their minds" afterwards					
E19. If a man pays all the bills, he has the right to have sex with his partner whenever he wants					

Thank you for your time and participation, we will be contacting you again when the time nears for us to interview you again in about 6 months.

APPENDIX 8: Certificate for language editing

CERTIFICATE OF LANGUAGE EDITING

The dissertation titled:

**SOCIAL SUPPORT AS A MODERATOR OF POST TRAUMATIC STRESS
DISORDER AMONG SEXUAL ASSAULT SURVIVORS IN NGAKA MODIRI
MOLEMA DISTRICT, NORTH-WEST PROVINCE**

by

ISAAC O. MOKGAOLA

for the degree

MASTERS IN NURSING SCIENCES

in the

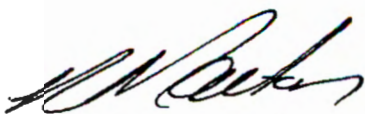
FAST

NORTH-WEST UNIVERSITY

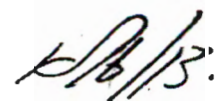
MAFIKENG CAMPUS

has been edited for language by

DR. NELDA MOUTON, MA, PhD (English), {NWU, Potch Campus}



DR NELDA MOUTON



DATE