THE EXPERIENCES OF VICTIMISED WOMEN OF GROUP INTERVENTIONS IN A PSYCHIATRIC CLINIC IN GAUTENG PROVINCE

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This research is for women who have been victimised and are speaking from the soul.

"The more that women understand what is important to them and let their voices of their souls guide them, the greater chance they have for growth and development."

(Virginia O’Brien, 1998: 72)
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I

SUMMARY

Violence stalks the streets of our erstwhile civilised cities and towns, and has also involved too many homes, transforming them from places of protection into pits of powerlessness and victimization. No immunization to this epidemic is afforded by culture, social class, economic states, education or ever religious affiliation. It is time to lift the shroud of silence and to shine the spotlight of truth on this social dilemma (Couden, 1999: 5).

This research begins with the journey of awareness, which is intended to lead to healing, mental health and wholeness for the victimised women. It is intended to give victimised women a voice, since they are the experts of their own lives. Through sharing of their experiences, it is hoped that such awareness will positively impact our families, communities, churches and the wider society.

The objectives of this research are to:

- Explore and describe the experiences of victimised women of group interventions in a psychiatric clinic.
- Formulate guidelines for the promotion of mental health of victimised women of group interventions.

A qualitative (Creswell, 1994: 102), explorative and descriptive (Mouton, 1996:102-103), and contextual (Mouton, 1996: 133) research design was followed. Data was collected through phenomenological interviews (Pilot & Hungler, 1989:328) with victimised women who met the sampling criteria. Consent was obtained from the psychiatric clinic, the participants, and the psychiatrists in charge of the participants. Data was analysed using the Tesch’s (in Creswell, 1994: 155) descriptive method. An independent coder analysed the data together with the researcher and a consensus discussions were held.
A literature control was conducted in order to recontextualize the data and to compare and differentiate similarities with other studies done on victimised women of group interventions. However, during the literature control it seemed that little has been done on victimised women and group interventions.

In phase one of the research, the researcher made conclusions that the group interventions had an effect on victimised women. Group interventions enabled these women to understand that they can do something about being victimised. The main themes that came out were ventilating of emotions, support for each other in the group interventions, a sense of being empowered and a sense of forgiveness towards their perpetrators.

In phase two guidelines were described for the advanced psychiatric nurse-specialist to facilitate and promote the mental health of victimised women. An empowerment programme based on the suggestions given by Goodman and Fallon (113) described on the survey list by Dickoff et al (1968: 423).

Conclusions, limitations and recommendations for the nursing practice, nursing education and research in nursing have been made.
TABLE OF CONTENTS

SUMMARY

CHAPTER 1: BACKGROUND AND RATIONALE

1.1 Introduction

1.2 Background and rationale

1.3 Problem Statement

1.4 Objectives

1.5 Paradigmatic Perspective

1.5.1 Nursing Model

1.5.2 Meta-theoretical assumptions

1.5.3 Theoretical assumptions

1.5.3.1 Theoretical definitions

1.5.3.2 Definitions of concepts

1.5.3.3 Central theoretical assumptions

1.5.4 Methodological assumptions

1.6 Research design and method
1.6.1 Research design 19

1.6.2 Research method 19

1.6.2.1 Phase 1: The exploration and description of the experiences of victimised women experiences of group interventions 19

1.6.2.2 Phase 2: The formulation and description of guidelines of the advanced psychiatric nurse-specialist to facilitate and promote mental health of victimised women. 21

1.7 Measures of trustworthiness 21

1.8 Ethical aspects of the research 22

1.9 Conclusions, limitations and recommendations 23

1.10 Division of chapters 23

1.11 Summary 23
CHAPTER 2: RESEARCH DESIGN AND METHOD

2.1 Introduction 24

2.2 Objectives of the study 24

2.3 Research method and design 24

2.3.1 Research design 24

2.3.1.1 Qualitative 25
2.3.1.2 Explorative 25
2.3.1.3 Descriptive 25
2.3.1.4 Contextual 26

2.3.2 Research method 26

2.3.2.1 Phase 1: The experiences of victimised women of group interventions 26
  a) Population and sampling 27
  b) Sampling criteria 27
  c) Data collection 27
    i) Phenomenological interviews 28
    ii) Pilot study 29
    iii) Field notes 30
    iv) Role of the researcher 31
  d) Data analysis 31
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3.2.2</td>
<td>Phase 2: The formulation and description for the advanced psychiatric nurse-specialist</td>
<td>33</td>
</tr>
<tr>
<td>2.4</td>
<td>Measures of trustworthiness</td>
<td>34</td>
</tr>
<tr>
<td>2.4.1</td>
<td>Credibility</td>
<td>34</td>
</tr>
<tr>
<td>2.4.2</td>
<td>Transferability</td>
<td>34</td>
</tr>
<tr>
<td>2.4.3</td>
<td>Dependability</td>
<td>34</td>
</tr>
<tr>
<td>2.4.4</td>
<td>Confirmability</td>
<td>34</td>
</tr>
<tr>
<td>2.5</td>
<td>Ethical Aspects</td>
<td>37</td>
</tr>
<tr>
<td>2.6</td>
<td>Recommendations, limitations and guidelines</td>
<td>39</td>
</tr>
<tr>
<td>2.7</td>
<td>Summary</td>
<td>39</td>
</tr>
</tbody>
</table>
CHAPTER 3: RESULTS AND DESCRIPTION OF
RESULTS AND LITERATURE CONTROL

3.1 Introduction 40

3.2 Operationalisation of the research
and description of the sampling criteria 41

3.3 Description of the results and literature control 44

3.3.1 The experiences of victimised women of group interventions
as a way of ventilating their emotions. 45

3.3.1.1 Victimised women experience the group interventions
as a way of re-telling their unheard stories. 45

3.3.1.2 Victimised women experience the group interventions
as emotional. 46

3.3.1.3 Victimised women recognize different emotions, positive
and negative emotions in regards to their relationships
and group interventions. 48
3.3.2 Group interventions are seen as by victimised women as supportive environment.

3.3.2.1 Victimised women experienced support within themselves in the group interventions.

3.3.3 Victimised women experience a sense of being empowered in the group interventions.

3.3.3.1 Group interventions are experienced by victimised women as a learning process.

3.3.3.2 Victimised women experience positiveness in the group interventions.

3.3.4 Victimised women experience a "feeling of forgiveness" towards their perpetrators.

3.3.4.1 Victimised women felt a sense of forgiveness towards perpetrators.

3.4 Conclusion
CHAPTER 4: GUIDELINES, LIMITATIONS AND RECOMMENDATIONS

4.1 Introduction

4.2 Description of guidelines for the advanced psychiatric nurse-specialist

4.2.1 The role of the advanced psychiatric nurse specialist in the empowerment programme for victimised women.

4.2.2 Victimised women and the empowerment programme.

4.2.3 The context where the empowerment programme for victimised women will be implemented.

4.2.4 The procedure related to empowerment programme for victimised women.

4.2.4.1 The relationship phase.

4.2.4.2 The working phase.

4.2.4.3 The termination phase.

4.3 Limitations and practical problems.

4.4 Recommendations.
LIST OF ANNEXURES

ANNEXURE A: Research Ethics Committee

ANNEXURE B: Consent form for the psychiatric clinic

ANNEXURE C: Consent form of the participants for the research study

ANNEXURE D: Consent form for the psychiatrists to give permission for patients to participate in the research.

ANNEXURE E: Example of a verbatim transcription of one of the interviews

ANNEXURE F: Field notes

ANNEXURE G: Protocol to the independent coder

LIST OF TABLES

Table 2.1 Strategies of trustworthiness

Table 3.1 Summary of the main categories and subcategories identified in the data in regards to experience of victimised women of group interventions.
CHAPTER 1

BACKGROUND AND RATIONALE

A JOURNEY OF A THOUSAND MILES BEGINS WITH A SINGLE STEP
(OLD CHINESE PROVERB)

1.1 INTRODUCTION

Attitudes are continuing to change through the efforts of men and women who realize that abuse whether be it physical or emotional, not only harms the partner but also the family and ultimately our society as whole (Evans, 1992: 12).

Research indicates that group work with women who were victimised is powerful component of these women treatment plan and healing process. There is very little research done on the how and do's of conducting group interventions with the theoretical and philosophical basis of the format.

The stories of victimised women need to be understood, to assist them to go through a journey of self-awareness and recovery path. Chew (2000: 1) clarifies the responsibility of facilitators of group interventions to honour and respect victimised women. She states that "the experiences of victimised women must be respectfully heard.

Through the researcher's experience in a psychiatric clinic where victimised women are admitted, the researcher saw a need to give victimised women a voice, to express their feelings and needs about the group interventions in a psychiatric clinic.
1.2 BACKGROUND AND RATIONALE

South Africans live in a particularly violent and abusive society, so that in some ways, everyone experiences some form of violence. McKendrick and Hoffman in Mashishi (1998: 1) demonstrate this clearly when they argue as follows:

"By being a part of society,
the lives of all are touched and
tarnished by violence; perpetrating it,
legally or illegally; being a victim of it,
directly or indirectly; and
being a witness to it, first hand or
via the media".

Why women are the primary and consistent targets of victimisation between adults, can among others, be explained in terms of the patriarchal structuring of gender relationships in a number of societies. The subordinate status of women in these societies is encoded in a variety of linguistic, legal, institutional and economic practices. Women in these societies experience inequality in relation to men, which is supported by a complex ideological framework in which ideas of masculinity and femininity are constructed. Within this ideological framework, men are seen as enlightened, strong minded, decisive and independent. Women by contrast are considered inferior, weak and passive. These traditional stereotypes of femininity based on hierarchy of power vested in males may legitimise women abuse and stage for violence in relationships. It is their capacity as women within the patriarchal system which make some women the obvious targets of domestic abuse (McKendrick & Hoffman in Mashishi, 1998: 2).
Throughout her life a woman's social status is perceived to be derived from her relative position to a man: as daughter, housewife, wife and mother of 'his' children. The rituals of courtship and intrigues of romance organise the everyday lives of most women. The anticipation of marriage structures their future: to marry, to marry well and stay married. Both women and men enter marriage with different socially created expectations and obligations. Men are expected to be the heads of the household and to be providers and protectors. One of the promises of marriage made to women is a relationship of safety and trust. In a battering relationship that trust is violated since the supposed protector becomes the perpetrator of terror (Maconachie, Angless & van Zyl, 1993:2).

Violence against women has attracted wide attention in our society. Individuals in the legal sector, feminists, moral advocates, theorists, therapists, health workers and politicians each have particular understandings about the causes of this phenomenon and how best to intervene. These understandings and related interventions, alone or in combination, are used to help women in clinics or institutions and women’s shelters (Walker, 1990: 43; Stulberg, 1989: 67; Carmen, 1982: 42). However, many of these interventions are designed to treat symptoms of a particular individual while ignoring the experiential worlds of victimised women in group intervention. Individual treatments are frequently employed while working with battered women. Flemming (1980: 45) argued that facilitators of therapeutic groups needed to support and encourage these women to explore their experiences and to help them identify and understand the concomitant emotions. The group interventions should offer victimised women a place where they can do at their own paces those things which they cannot do elsewhere, especially in those areas which have been most strongly forbidden to them in the outside world (Collier, 1982:266).

The experience of victimization takes away the woman's sense of having the power to protect her. According to Walker (1994:311), the facilitators of therapeutic groups have to emphasise on assisting the women to understand that they have control over much of their lives even if they could not prevent the abuse. In addition, they need to re-empower victimised women by
identifying their strengths. The women need to understand the dynamics of abuse, so as to be able to break the cycle of abuse. Walker (1990:55) has described a cycle of abuse with three components, a tension-building phase, followed by a brief phase in which the abuse erupts and finally the post-abuse phase or the honeymoon phase. During the third phase, there is relief from tension, and the perpetrator is often attentive, loving and quite remorseful. During the honeymoon phase, the perpetrator's affectionate behaviour and promises to be "good" and validating the victim's belief that he can and will change and consequently, this phase serves as a powerful reinforcement for the victim to remain in the relationship (Carmen, 1982:51).

Every woman needs her own sense of psychological and emotional power to develop and live her life as fully as possible. Collier (1982:261) argues that therapists need to assist victimised women to uncover power within themselves by experiencing control over their emotional lives and the power of making choices. In addition, the therapist assists women validate their feelings, ideas and dreams especially those who have been suppressed.

The therapeutic group provides the ideal setting for exploring the research. According to Flemming (1980: 46) the group therapy process enables victimised women to validate each other's strengths, develop mutual support systems, breakdown their isolation and to help each other perceive a variety of possibilities for growth. Such therapy assists these women to overcome the effects of the abuse and to make sense of themselves and the experience in a way that frees them to live a satisfying life (Durant & White, 1992:73; Walker, 1990:151). Hence it becomes important to find ways of motivating battered women to attempt new behaviour so that they can experience success. Each new success helps to return some individual power to them. Thus self-esteem rises as these women take control of their lives (Walker in Whalen, 1996:125).

The aim of the group interventions should be to empower women to make changes so that things will be better for them. Their stories need to be heard. They need to see, feel and hear the differences between the autonomy and dependence and to do something difficult completely independently. In
addition, they need to express feelings in confrontation instead of avoiding them with silence, kindness, tactfulness or sympathy. They need to trust others' ability to survive and to trust themselves. Furthermore, they need to experience taking a risk, however small, to be forceful instead of compliant and to be direct and confrontative in pursuit of what they want or believe in. Lastly, they need to nurture themselves in the ways they have given care and attention to others (Collier, 1982: 265).

For the purpose of this research, group interventions and group therapy will be used interchangeably to indicate the interpersonal interaction between group members. Group interventions will be defined as structured or semi-structured process of therapeutic interventions in which the behaviour and emotional responses of the individual members of a group towards one another and towards the group facilitator are used to improve the mental health of the group members (Hastings-Vertino & Wooldridge 1996: 138).

The aim of group therapy is the development of a healthy group, which will of itself, be the vehicle of therapeutic change (Brammer et al, 1989:231). Yalom (1995:6-9) identified eleven essential and interdependent therapeutic factors that assist group members to experience change in different ways. These are instillation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group, and development of socializing techniques, imitative behaviour, interpersonal learning, group cohesiveness, catharsis and existential factors.

The instillation and maintenance of hope is crucial in all group interventions, not only is hope required to keep the patient in therapy so that other therapeutic factors may take effect, but faith in a treatment mode can itself be therapeutically effective (Yalom, 1995: 6).

Universality refers to the awareness of the group member that he or she is not alone in having problems, that others share similar problems, complaints or difficulties (Kaplan & Sadock, 1994:841). After hearing other members disclose concerns similar to their own, group members report feeling more in
touch with the world and describe the process as a "welcome to the human race" experience (Yalom, 1995:8).

With imparting information, the group members acquire knowledge about new growth areas, such as social skills, behaviour and the process of their illness or life situation. They receive advice, obtain guidance and attempt to influence or be influenced by other group members and the facilitator (Kaplan & Sadock, 1994: 841).

The intrinsic act of giving and thus of receiving through giving, putting another person's need before one's own and learning, is the value in giving to others. Group members are enormously helpful to one another in the therapeutic process. They offer support, reassurance, suggestions and insight and share similar problems with another (Yalom, 1995:17).

Furthermore, the group re-creates the family of origin for some members who can work through original conflicts psychologically through group interaction. The corrective recapitulative possibilities gives the members of the group a chance to relive familial conflicts in the safe atmosphere of the group by exploring new possibilities and challenging existing relationships and behaviour (Yalom, 1995:19-20). In addition, there should be a development of socializing techniques. This is developed through social learning. Socializing techniques is the process of obtaining basic social skills through interaction with others and is a therapeutic factor in all therapy groups (Yalom, 1995: 20).

Imitative behaviour implies that the group members model themselves consciously on aspects of the other group members as well as of the therapists and this modelling of new behaviour can launch an adaptive spiral. Imitative behaviour is more relevant in the early stages of a group as group members look for senior members to identify with. It is also known as spectator therapy as one group member learns from another (Yalom, 1995: 20-21).
Interpersonal learning is a broad and complex therapeutic factor that facilitates therapeutic change. According to Yalom (1995:42-44) interpersonal learning as a therapeutic factor becomes evident if we consider the following: the group provides the setting for group members to learn through feedback of others and self-observation about significant aspects of their interpersonal behaviour, by accepting personal responsibility for the shaping of their own interpersonal world they have the power to change it. Transference and insight play a vital role in the therapeutic process and can be linked to interpersonal learning. Transference is a form of interpersonal perceptual distortion in the relationship with the therapist. This implies projection of feelings, thoughts and wishes onto the therapist who represents an object from the patient's past. Insight is the conscious awareness and understanding of one's own psychodynamics and symptoms of maladaptive behaviour. It occurs when one discovers something important about one's behaviour, motivational system or one's unconscious (Yalom, 1995: 44-45).

Hostility and anxiety become more overt in the stage of group cohesion. Feelings and expressed concerns are dealt with more directly by the group. As similarities are identified and discussed, thoughts and feelings are revealed and conflicts and frustrations handled, group cohesiveness develops. As group cohesiveness increases there is a proportionate increase in the productivity of the group. The result of increased group cohesiveness and productivity is a change in the communication pattern. No longer do individual group members speak directly to individuals; they now address themselves to the entire group. This inter-group communication pattern enhances the opportunity for emotional and social re-education. The group is able to focus its attention on fulfilling the identified therapeutic goals (Perko & Kreigh, 1988:305).

Research has shown that catharsis on its own may not be effective in the group interventions. It is part of the process and must be complemented by other factors. Effective catharsis is linked to the interpersonal process of expressing emotions in a social context. Supportive group members strengthen the value of catharsis and often catharsis is more helpful late
rather than early in the course of the group. Catharsis may also enhance the development of cohesiveness in the group (Yalom, 1995: 22-23).

It is of utmost importance that members learn that there is a limit to the guidance they can get from others, because of a basic isolation in existence. According to Yalom (1995: 23-24) group members weighed the following existentially oriented items heavily, realization that “I must face my life alone no matter how close I get to other people,” learning that, “I must take the ultimate responsibility for my life no matter how much support I get from others.”

It is the facilitator’s role to develop strategies and skills to facilitate the emergence of the therapeutic factors and to support the creation of change in the group. The facilitator is responsible to create and set the machinery of therapy in motion and to keep it operating with maximum effectiveness. The role of the therapist can be identified as creating and maintaining the group, culture building and activating and illuminating of the here-and-now (Yalom, 1995: 112).

The facilitator must create favourable conditions for the change process to take place and that implies careful planning, decision-making and stage setting. In the planning stage the context and ability of the facilitator should be assessed. The physical setting must quiet, free from distractions, private, available for every session and big enough to easily accommodate members with comfortable, informal, identical seating arranged in a circle (Yalom, 1995:267). For the group sessions that are going to be held with victimised women, the formal structure will be a closed a group. Members will be contracted to stay together for the entire life of the group. This will provide an intense, shared, complete experience of beginning, working together and ending, high level of trust- needed for interpersonal change. The size of the group will be between seven and ten members. The group will be done in three sessions to be meaningful to use the process effectively and to assist member’s work through their issues. The group sessions will lasts for one-hour fifteen minutes.
Culture building refers to the facilitator's task of shaping the group into a therapeutic social system based upon an unwritten code of behavioural rules or norms. The researcher will create a group culture conducive to effective group interactions and supportive of the therapeutic factors. The researcher will encourage the learning opportunities that the group interventions creates by shaping the norms namely: free interaction with members with different experience and coping styles; disclosure and feedback; the development of trust through sharing and closeness; being accepted and supported by peers and taking the risk of being different (Yalom 1995: 112).

The researcher will activate and illuminate the aspect of the here-and-now. This is done to activate effective change. Experiencing the here-and-now is vital for behavioural and characterological change, because this focus facilitates the development of each member's social microcosm. The researcher during the group interventions will use the aspect of the here-and-now principle. This facilitates feedback, catharsis, meaningful self disclosure and the process of obtaining socializing techniques (Brammer et.al 1989: 239 & Yalom 1995: 129-130). The researcher's goal is to guide the members of the group to a point where they accept, one or all, of the following premises relative to making personal changes like: making a decision to change: "Only I can change the world I have created for myself," believing that they are able to change: "There is no danger in change," making a commitment to change even though it may be a fearful process: "I can change; I am potent" (Yalom: 1995: 167-168).

All types of group therapy or intervention, regardless of the theoretical framework, have an orientation phase, a working phase and a termination phase. This will help the researcher to predict the members' behaviour and to plan interventions accordingly.

1.3 PROBLEM STATEMENT

It is important to realize from the outset that, in general, people's behaviours are an attempt to cope with difficulty and sometimes just to survive. For the victimised women it requires great energy to take on the task of moving on
with their lives and learning about therapy or visiting a lawyer or a magistrate court for a court interdict. They need self-support in order to make healthy changes in their lives.

The problem statement for this research can be put through the use of a following narrative:

Joelina is a thirty-six-year-old woman, whose abusive husband left her. She got involved with a recent boyfriend who also abused her physically and emotionally. Currently, Joelina is admitted in a psychiatric institution for depression. She describes her life script as follows:
"After my husband left, I had no support. I had nothing. I had nothing. I had no one to turn to. I mean for the first two months I was probably, I couldn't even take care of my own children. I was just crying, a basket case basically. I mean, I was as low as a person could possibly get. Um, I mean without killing myself. And I realized that wasn't the solution because what he wanted was the children and a new woman in his life and she would replace me and I wasn't going to give him that. With my recent boyfriend I had to live because similar abusive acts were happening in this relationship as were in my marriage. I started blaming myself for all this happenings. I began to feel down and out, until a friend advised me to see a professional, that's how I landed in this psychiatric clinic."

Based on this story and other related stories that will be heard during the individual in-depth interviews the following questions can be asked:

1. What are the experiences of victimised women of group interventions in a psychiatric clinic?
2. What guidelines can be described by the psychiatric-nurse-specialist for the facilitation and promotion of mental health for victimised women of group interventions?
1.4 OBJECTIVES OF THE STUDY

The research aims to:

1. explore and describe the experiences of victimised women of group interventions in a psychiatric clinic.
2. formulate guidelines for the facilitation and promotion of mental health for victimised women of group interventions.

1.5 PARADIGMATIC PERSPECTIVE

The paradigmatic perspective of the Department of Nursing Science (Rand Afrikaans University; Department of Nursing Science, 2000:2) will be accepted by the researcher and will be used in this research. The meta-theoretical component is illustrated by means of strategic work ethics as constituted in the mission and vision statements of the Department of Nursing and the assumptions according to the Theory for Health Promotion in Nursing. The theoretical component is configured through research and theory from the Theory for Health promotion in Nursing. The methodological component is described by means of the research model.

The above-mentioned paradigmatic perspective will be discussed with reference to the model of research in nursing, the meta-theoretical, theoretical and methodological assumptions.

1.5.1 Nursing Model

The Theory for Health Promotion in Nursing (THPN) is accepted by the researcher as the nursing model as it is used by the Rand Afrikaans University. The purpose of the theory is aimed at the promotion of health of the individual, family, group, and community. The four central concepts of the Theory for health promotion in nursing refers to the person, nursing,
environment and health (Rand Afrikaans University; Department of Nursing, 2000:4).

1.5.2 Meta-theoretical assumptions
The meta-theoretical component of this research will be illustrated by means of strategic work ethics as follows:
Within the framework of the Constitution of South Africa and the mission statement of the Rand Afrikaans University, a Christian approach and strive towards excellence is described and endorsed. The following ethics are explained as aimed at:
- Unconditional acceptance of people and respect for human rights.
- Sensitivity toward cultures through empathy and caring.
- Realising and facilitating virtues such as honesty, commitment, trustworthiness, acceptance of responsibility and accountability, courage and perseverance.
- Promoting co-operation and empowerment by being consumer friendly and helpful through availability and accessibility (Rand Afrikaans University; Department of Nursing, 2000:2).

In this research, the researcher will view victimized women in group interventions in a psychiatric clinic as holistic and interaction with their environment. This environment implies an internal and external environment. Victimised women’s environment consists of physical, mental, social and spiritual dimensions (Rand Afrikaans University; Department of Nursing, 2000:5).

Victimised women’s relative mental health status is reflected through the challenges that they are faced with in abusive relationship. Victimised women’s internal environment will be described within the following dimensions, body which in this research it will refer to their physical status during the abusive relationship. Physically, during the abusive relationship, victimised women experience different psychological or physical symptoms. This most entails depressive episodes clustered around marital problems. Victimised woman can complain of feeling tired most of their time and stressed out. Also, there can be a change in eating, sleeping pattern. There
can also be physical conditions such as headaches, chest pains, back pains, allergic reactions, hyperventilation.

Psychologically, victimised women are faced with emotional and motivational barriers. They are expected to provide the emotional cohesion in relationships. Furthermore, victimised women are held responsible that their relationships should be a success. They are made to feel that it is more important to meet the needs of their partners than their own needs. Victimised women may believe that their role in the relationship is to refine the man, to somehow chisel away his rough edges by long-suffering and gentleness. Thus they neglect their own feelings or personal development (Couden, 1999: 30).

The third dimension of the internal environment is the spiritual dimension and it includes victimised women's relationship to God and it also involves their conscience, namely the spirit aspect for them to distinguish between right and wrong (Rand Afrikaans University; Department of Nursing, 2000: 6). Victimised women lose their sense of self-worth. They often see themselves as deserving the abuse. Maybe, they look upon in the Scripture by referring to Ephesians 5: 22-24 as a reason of staying in the abusive relationship. The text says: "Wives, submit to your husbands..." However, some may look upon the Scripture for support for their situation.

The external, physical dimension of victimised can includes situations whereby how the community looks upon them. We live in a society that legitimises and permits wife battering and society in turn, suffers the consequences (Carmen, 1982: 47). In their own communities, women are commonly blamed for being battered and many consequently uphold the privacy of the relationship by remaining silent. Thus voicing 'marital' problems therefore may reflect negatively on women in the community. Denial is operative in homes in which abuse occurs, thus victimised women often feel trapped and afraid to leave the abusive relationship (Maconachie, Angless & Van Zyl; 1993: 2).
Socially, women are trapped by cultural norms that dictate that men are responsible for the economic support of families, while women must bear the full responsibility for child rearing (Carmen, 1982: 49). The expectations of change in the family has been traditionally the responsibility of the women. Women have been counselled to go home and be more loving and submissive (Couden, 1999: 60). This practice makes sense when examined within its historical context.

The spiritual dimension of victimised women includes values and religious aspects in the external environment (Rand Afrikaans University, Department of Nursing, 2000:7). The religious welfare system in South Africa also view women battering as an individual problem within a particular relationship (Maconachie, Angless & Van Zyl, 1993:3). Victimised women, whether they stay in an abusive relationship or leave, they need to have a support system. In particular, the church as a support system is of utmost importance for victimised in abusive relationship, as many victims turn to the church when in crisis. A final word about the spiritual dimension. Paul says that the human body, at least for Christians, is the temple of God (1 Corinthians 6:19,20). We cannot honour our bodies and minds by allowing others to abuse us. We are of great value to God, “having been brought with a price.” When our bodies and minds are under strain of living in an abusive atmosphere, we cannot fulfil God’s plans for us to live a content, productive life. It is appropriate, then, to take every precaution necessary to protect victimised women in our care so that peace, honour and love may prevail (Couden, 1999: 71).

The different patterns of interaction between the two environments necessitates the advanced psychiatric nurse-specialist to facilitate the promotion of mental health for victimised women of group interventions in a psychiatric clinic. As well as the identification and bridging of obstacles in the promotion of mental health (Rand Afrikaans University, Department of Nursing, 2000:7).
1.5.3 Theoretical assumptions

The theoretical assumptions of this research will be described according to the Theory of Health Promotion in Nursing (Rand Afrikaans University, Department of Nursing, 2000: 1-16).

1.5.3.1 Theoretical definitions

Victimised women embody dimensions of body, mind and spirit. They function in an integrated part, interactive manner with the environment (Rand Afrikaans University, Department of Nursing, 2000:4).

Psychiatric Nursing is an interactive process whereby the advanced psychiatric nurse-specialist as a sensitive therapeutic professional facilitates the promotion of health through the mobilisation of resources (Rand Afrikaans University, Department of Nursing, 2000:4).

Environmental includes an internal and external environment. The internal environment consists of dimensions of body, mind and spirit. The external environment consists of physical, social and spiritual dimensions (Rand Afrikaans University, 2000:4).

Health is a dynamic interactive process in the victimised women's environment. These interactions in victimised women's environment reflect the relative health status of victimised women. This interaction contributes or interferes with the promotion of health (Rand Afrikaans University, Department of Nursing, 2000:4). In this research, it will be focused on the mental health, whereby health and mental health will be used as synonyms.

1.5.3.2 Definitions of concepts

The main concepts found in this research are defined as follows:

(i) VICTIMISED WOMEN: Victimised women will be defined as those women, who are in or have been in an abusive relationship. In this
research, the term victimised women and battered women will be used interchangeably to indicate both the physical and emotional aspects of the abuse.

(ii) ABUSE: Abuse will refer to any repeated acts of physical or psychological force, or repeated threats thereof, used against a woman by her partner. Abuse among other things can mean, blaming, threatening, intimidation, manipulation, emotional blackmail, enforced isolation, keeping without money, locked in, deprived of food or using children to enforce compliance. It can also include negative criticism, calling names and belittling comments (Finucane, 1999:13).

(iii) FACILITATION: Facilitation refers to a dynamic, interactive process for the promotion of health through the creation of a positive environment, mobilisation of resources as well as the identification and bridging of obstacles in the promotion of health (Rand Afrikaans University, Department of Nursing, 2000:7).

(iv) PROMOTION OF MENTAL HEALTH: It refers to psychiatric-mental health activities that contribute to a greater degree of the person's wholeness. These activities include individual psychotherapy, group psychotherapy, mental health education and support group work sessions (Poggenpoel, 1995:93).

(v) ADVANCED PSYCHIATRIC-NURSE SPECIALIST: An advanced psychiatric nurse-specialist is someone with a clinical Masters degree or an advanced diploma in Psychiatric Nursing with additional clinical experience under supervision of a psychiatric nurse-specialist and/or other field specialist in a related discipline. She or he has an in-depth knowledge and competency or expertise in advanced psychiatric nursing (Greeff & Poggenpoel, 1991:24).
(vi) GROUP INTERVENTIONS: It refers to a structured or semi-structured process of therapeutic intervention in which the behaviour and emotional responses of the individual members of a group towards the group facilitator are used to improve the mental health of the group members (Hastings-Vertino & Wooldridge, 1996: 138).

1.5.3.3 Central theoretical assumptions

The central theoretical assumptions of this study is:

Understanding the experiences of victimised women of group interventions in a psychiatric clinic, through exploring and describing of this experience. Thus it can provide a basis for the formulation of guidelines for the advanced psychiatric-nurse-specialist to facilitate the promotion of mental health of victimised women for group interventions.

1.5.4 Methodological assumptions

Botes (1998: 9-15) model for research in nursing will be used in this research as a point of departure. The model represents the activities of nursing on three levels or orders. The first order is nursing practice. Nursing practice is the research domain for nursing. The practice situation is thus the primary source of research themes. This practice has certain characteristics which make demands of how research should be done. The second order represents the theory of nursing and research methodology. The activities in question here are research and theory development. The third order represents the paradigmatic perspective of nursing (Rand Afrikaans University; Department of Nursing, 2000:9).

The assumptions of the model for research in nursing (Rand Afrikaans University; Department of Nursing; 2000:10) as well as their relevance in this research will be described as follows:
• **The purpose of nursing is functional by nature.** It implicates that nursing science entails mainly applied research, which addresses current health problems experienced by the South African community and provides solutions. According to Couden (1999:45) women need to learn how to state assertively their rights, needs or feelings in the face of verbal, emotional or physical abuse.

• **The research problem and objectives direct the research design and methods.** This research has a purpose to explore and describe the experiences of victimised women of group interventions in a psychiatric clinic, and on these grounds be able to assist the advanced psychiatric nurse-specialist to formulate and set up guidelines in order to facilitate and promote the mental health of victimised women of group interventions. Since the purpose of the research is to explore and describe the experiences of victimised women of group interventions in a psychiatric clinic, this research will be conducted in a qualitative, exploratory, descriptive and contextual by nature. This research will be operationalised by means of individual in-depth phenomenological interviews to find out from the victimised women by asking the research question "**How was it for you to be in the group interventions?**"

• **Because of the functional nature, nursing research is using usefulness as criteria for validity.** In this research, the utility will be given within the experiences of victimised women in group interventions in a psychiatric clinic.

Furthermore, using the usefulness as criteria for validity will be lined within the field of psychiatric nursing, whereby the advanced psychiatric nurse-specialist as an interactive process facilitating the promotion of mental health of victimised women of group interventions.
In this research, all measures for trustworthiness will be applied as suggested by Lincoln and Guba (1985:289-329). The measures of trustworthiness will be implemented to support the usefulness of research findings.

1.6 RESEARCH DESIGN AND METHOD

1.6.1 Research design

As the aim of this research is to explore and describe the experiences of victimised women, a qualitative, explorative, descriptive and contextual research design will be used. Within a holistic framework, qualitative research seek to explore the depth, richness and complexity inherent in the phenomenon (Burns & Grove, 1987:75). Qualitative research aims at understanding and interpreting the meanings and intentions that underlie everyday human action (Mouton in de Vos, 1998: 240). The research design will be fully discussed in chapter two.

1.6.2 THE RESEARCH METHOD

The research method will be executed in two phases.

1.6.2.1 Phase 1: The exploration and description of victimised women experiences of group interventions in a psychiatric clinic.

Qualitative data will be generated through use of phenomenological interviews (Burns & Grove, 1987:82). The sample will consist of victimised women during group interventions in a psychiatric clinic. A purposive, non-selective sampling method will be used to select victimised women who are knowledgeable about the issues under the study. The participants will be purposefully selected according to the following criteria:

- admission in psychiatric clinic.
• have been or are in a victimised relationship.
• willingness to participate in research.

The sampling criteria will be done as shown above, in order to allow the researcher to meet women who will provide rich, deep and concrete material of experience.

A phenomenological method of interviewing will be used (Burns & Grove, 1987:82). A central question will be asked during a semi-structured, in-depth interview of approximately forty-five to sixty minutes to determine the experiences of victimised women of group intervention in a psychiatric clinic.

The central question that will be asked is: “How was it for you to be in the group interventions?” each interview will be audio-taped. Bracketing (Burns & Grove, 1987:80) will be done to achieve an open context about the phenomenon understudy. Known information will be “bracketed”. Intuiting (Burns & Grove, 1987: 80) will then take place to focus on the experiences of victimised women in group interventions in a psychiatric clinic.

Field notes will be compiled after each interview to describe the underlying themes and dynamics during sessions (Wilson, 1989:454). There will be four types of field notes which can be used, namely observation notes, theoretical notes, methodological notes (Schatzman & Strauss in Wilson, 1989; 434-436) and personal notes (Wilson, 1989: 435) Field notes will be discussed in depth in chapter two.

A pilot study will be conducted in a form of the first focus group to refine the methodology of the research (Burns & Grove, 1987: 57).

In this research, data will be analysed through use of an open coding system according to Tech’s descriptive method (in Creswell, 1994 :155). An independent coder will need to promote the trustworthiness of the study (Poggenpoel,1998: 155).

Final themes identified in this research will be re-contextualised within the Theory for Health and Promotion in Nursing (Rand Afrikaans University, 2000: 1-16). Data analysis will be discusses further in chapter two.
Literature review will be conducted to gain in-depth knowledge necessary to execute the study.

1.6.2.2 Phase 2: The formulation and description for the advanced psychiatric nurse-specialist to facilitate and promote mental health for victimised women of group interventions.

The data which will come out of phase one will serve as a purpose for deriving and describing the guidelines for the advanced psychiatric nurse specialist to facilitate and promote the mental health for victimised women in group interventions in a psychiatric clinic. Literature control will be contingent when this phase is been carried out, to give light about similar, different and unique contributions in this research.

To follow is the brief discussion to ensure measures of trustworthiness.

1.7 MEASURES OF TRUSTWORTHINESS

Strategies in this research will be ensured by applying the Guba's model of trustworthiness (Lincoln & Guba, 1985: 289-329). These strategies are as follows:

- Credibility: Truth value is operationalised through credibility in qualitative research (Lincoln & Guba, 1985: 296). In this research credibility will be ensured through prolonged engagement, extensive field examination, peer examination (Lincoln & Guba, 1985: 301) and establishing authority of the researcher and reflexivity.

- Transferability: In qualitative research, applicability is operationalised through transferability (Lincoln & Guba, 1985: 296). Transferability will be ensured by a complete thick description of demographics and results in phase 1 and phase 2, purposeful sampling, the context and participants (Lincoln and Guba, 1985: 310) and literature control.
- Dependability: In qualitative research, consistency is operationalised through dependability. In this research dependability will be ensured through the dependability audit, thick description of research methods, triangulation, peer group examination, stepwise replication and code-recode procedure (Lincoln & Guba, 1985:305).

- Confirmability: Neutrality is evaluated against the criteria of confirmability. In this research confirmability will be ensured through the confirmability audit, triangulation and reflexivity journal (Lincoln & Guba, 1985: 305).

The above measures of trustworthiness will be discussed in-depth in chapter two.

1.8 ETHICAL ASPECTS OF THE RESEARCH

The research will comply within the ethical guidelines set by Democratic Nursing Organisation of South Africa (1998: 2.3.2-2.3.4). The following standards will be considered:

- The researcher will plan and execute the research in a way which will foster justice, beneficence and exclude harm or exploitation of victimised women.
- The researcher will ensure the right to self-determination of victimised women.
- Confidentiality and anonymity will be ensured.
- The researcher will ensure that the quality of research demonstrates integrity and trustworthiness.

The abovementioned ethical aspects will be discussed in-depth in chapter two.
1.9 CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

The necessary conclusions and recommendations will be made at the end of the study with specific reference to what this research has contributed. Shortcomings will be addressed and also measures of how to overcome these shortcomings.

1.10 DIVISION OF CHAPTERS

Chapter 1: Background and rationale.

Chapter 2: Research design and method.

Chapter 3: Phase 1: The exploration and description of the experiences victimised women of group interventions in a psychiatric clinic, data analysis and literature study.

Chapter 4: Phase 2: Description of guidelines for the advanced psychiatric-nurse specialist to facilitate and promote mental health for victimised women, a literature control, conclusions, limitations and recommendations.

1.11 SUMMARY

This research hopes to assist victimised women to move from a transition of being a victim to a survivor through a process of many realisations about themselves in relation to men, the batterers, their children, other women, social institutions and the rest of the society.

The background and rationale of the planned research is described in this chapter. An in depth description of the research design and method will be discussed in chapter two.
CHAPTER TWO
RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

>All dances make a statement and begin with a question, what do I want to say in this dance? (Janesick in Denzin & Lincoln, 1994: 210).

In chapter one, an overview of the research study was discussed. In this chapter a description of the research design and method of the research will be discussed.

2.2 OBJECTIVES OF THE STUDY

The objectives of this research is two fold:

1. To explore and describe the experiences of victimised women of group interventions in a psychiatric clinic.
2. To describe guidelines for the advanced psychiatric nurse-specialist to facilitate and promote mental health for victimised women of group interventions.

2.3 RESEARCH DESIGN AND METHOD

Below, the research design and method will be described.

2.3.1 Research design

A research design is a set of guidelines and instructions to be followed in addressing the research problems (Mouton, 1996: 107). In this research a
qualitative (Creswell, 1998: 15), explorative (Mouton, 1996: 103), descriptive (Mouton, 1996: 102) and contextual (Mouton, 1996: 133) will be followed to describe the experiences of victimised women of group interventions.

The following section describes the research design according to qualitative, explorative, descriptive and contextual nature thereof.

2.3.1.1 Qualitative

Qualitative research is conducted to generate knowledge concerned with meaning and discovery (Burns & Grove, 1987: 85). The aim of qualitative research is to understand and interpret the meanings and intentions that underlie everyday human action (Mouton in de Vos, 1996: 240). Since the objective of this research is to describe and explore the experiences of victimised women of group interventions, qualitative research seems to be an effective method to gain more insight in the perceptions, experiences and making of sense of the phenomena of victimised women of group interventions.

2.3.1.2 Explorative

According to Mouton (1996:103) the aim of the explorative studies is to establish the facts, to gather new data and to determine whether there are interesting patterns in the data. In this research, the researcher will explore the field to learn what is there, what meanings are attached to the discoveries and how the meanings can be organized.

2.3.1.3 Descriptive

The data generated in qualitative studies is descriptive in nature and is depicted in words and pictures (Creswell, 1994: 162). Descriptive knowledge includes data, facts, empirical generalisations, narratives, stories and provides truthful descriptions of phenomena in the world (Mouton, 1996: 102). The purpose is to provide a picture of situations as they naturally happen (Burns &
In this research the aim is to describe the experiences of victimised women of group interventions. Guidelines for the advanced psychiatric nurse-specialist to facilitate and promote mental health of victimised women of group interventions will be described.

2.3.1.4 Contextual

A contextual study by nature is described in Mouton (1996:133) as a strategy aiming at investigating a single case or limited number of cases in an in-depth manner in a specific context. This research is contextual in nature as it focuses on victimised women in a psychiatric clinic and guidelines for the advanced psychiatric nurse-specialist will be described in this specific context.

It is not the aim of this research to generalise the findings, however to explore and describe within the specific context.

2.3.2 Research method

The research will carry out into two phases. In the first phase, the experiences of victimised women of group interventions will be explored and described. In the second phase guidelines for the advanced psychiatric-nurse specialist will be described based on the results of phase one to facilitate and promote mental health for victimised women of group interventions.

2.3.2.1 Phase 1: The experiences of victimised women of group interventions in a psychiatric clinic.

The aim of this phase is to describe the experiences of victimised women of group interventions in a psychiatric clinic. This phase will include data obtained through individual in-depth phenomenological interviews and field notes. Phase one will be described under the following headings: a) population and sampling, b) sampling criteria, c) data collection, and d) data analysis.
a) Population and sampling

Population will be individuals who have common characteristics that the researcher will be interested in studying (Roscoe in Mouton, 1996: 134). In this research the population will consists of victimised women who are in or are leaving or are out of an abusive relationship.

The sampling frame refers to the set of all cases from which the sample will actually be selected (Mouton, 1996: 135). In this research, the sampling frame of women who have been or are victimised in their relationships will be selected. A purposeful, non-selective sample (Burns & Grove, 1987: 218) will be done with the target group of victimised women. This will allow the researcher to meet people that will provide rich, deep and concrete material. The number of women selected will depend on the saturation of collected data that will be determined by repetitive themes across participants (Steyn & Poggenpoel, 1999: 46; Valle & Halling, 1989: 47).

b) Sampling criteria

The criteria will be women who:

- have given consent to participate in the research.
- are admitted in a psychiatric clinic.
- have been in or are leaving the abusive relationship.
- can express themselves in English or Afrikaans and
- are at least between the ages of 28 and 50

c) Data collection

The data collection method in this research will be described under the following headings: i) phenomenological interview, ii) pilot study, iii) field notes and iv) role of the researcher.
i) Phenomenological interview

A phenomenological inquiry is descriptive and qualitative in nature. The goal of a phenomenological inquiry is to describe what people experience in regard to some phenomenon and how they interpret those experiences (Pilot & Hungler, 1989: 328). A phenomenological interview will be held with the victimised women. A central question will be asked during the semi-structured, in-depth interview of forty-five to sixty minutes to determine the experiences of victimised women of group interventions in a psychiatric clinic. The central question will be: How was it for you to be in the group interventions? Each interview will be audio-taped and transcribed verbatim. Field notes will be compiled after each interview to describe underlying themes and dynamics during the session.

The basic steps involved in a phenomenological interview namely, bracketing and intuiting will be considered. Bracketing refers to the process of identifying and holding in abeyance any preconceived beliefs and opinions one might have about the phenomenon under investigation. The researcher will bracket out the world and any presuppositions in an effort to confront the data in pure form. Intuiting occurs when the researcher remains open to the meanings attributed to the phenomenon by those who have experienced it (Pilot & Hungler, 1989: 328).

The following non-directive communication techniques will be used in this research:

- Reflecting: Reflecting is conveying to the sender his expressed thoughts and related feelings. Reflecting is used as non-directive communication technique in this research, to acknowledge to the participants that the message they are conveying has been received and that the researcher and the facilitator is searching for understanding of the message (Perko & Kreigh, 1988: 251).
• **Paraphrasing:** That is being communicated is assimilated and repeated by the researcher or the facilitator to clarify that the message is being understood (Wilson & Kneisl, 1992: 150).

• **Clarifying:** Clarifying is an attempt to find meaning of the communicated message. This communication technique is used to promote and encourage for the communication between the participants, to facilitate the recognition of individual difference, to decrease distortions in perception and to decrease the level of verbal distortions (Perko & Kreigh, 1998: 251).

• **Summarizing:** Summarizing develops a concise resumé of the communicated message. The purpose of this non-directive communication technique is to facilitate recall of important points; to promote clarification and achieve new understandings; to provide a basis for developing a plan of actions and to bring a discussion of a particular subject to a conclusion (Perko & Kreigh, 1998: 254).

• **Silence:** Silence is communicating without verbalization. Silence is used to convey the receiver’s interest, acceptance and understanding.

ii) **Pilot study**

*Every dance is to some greater or lesser extent a kind of fever chart, a graph of the heart (Martha Graham).*

The pilot study can be viewed as a “dress rehearsal” of the main investigation, it is similar to the researcher’s planned investigation but on a small scale (Strydom, 1998: 179). The purpose of the pilot study as an investigation is to view if the planned project is feasible and to bring possible deficiencies in the methodology procedure to the fore (Strydom, 1998: 180).

In this research the purpose of the study will be to:

- determine whether the proposed study is feasible.
- identify problems with the design.
- determine whether the sample is representative of the population.
- give the researcher experience with the participants, methodology and research instruments.
The first individual in-depth phenomenological interview will be held as a pilot study with one participant. The goal will be to outline the researcher’s contribution to the research, to establish the nature of questions to be asked and to prevent misunderstandings on behalf of the participants (Woods & Catanzaro, 1988: 500).

iii) Field notes
During the interviews field notes will be taken. Field notes are being used as a method to preserve data for analysis. According to Wilson (1989: 435) there are four ways in which the researcher can be able to gather data during interviews. These ways are namely observational notes, theoretical notes, methodological notes and personal notes.

- **Observational notes**: This notes gives an account of what happened. With this notes the researcher tries not to make any interpretations. The researcher and assistant moderator will during the group interventions take notes and capture important aspects of the discussion. The notes will include observations such as silent agreement, obvious body language, indications of group mood, irony or contradictory statements when the meaning is opposite of what is said. This information can provide insight into the nature of the discussion and is not necessary to capture on the recording (Krueger, 1994: 147).

- **Theoretical notes**: The researcher is able to make systematic self-conscious observations to derive meaning from some or all observational notes.

- **Methodological notes**: These notes serves as reminders, instructions and critical comments for the researcher.

- **Personal notes**: This notes is about the researcher’s reactions, reflections and experiences.

The abovementioned field notes will be made during or immediately after the interview (Schurink in De Vos, 1998: 286). See application in annexure F.
iv) Role of the researcher

In qualitative research, the researcher self is the research instrument (Schurink, 1998: 258) and the researcher needs to do self-examination as well as the mastery of interpersonal skills and data analysis techniques.

In order to be effective in conducting qualitative research, the researcher must have ascended to an open context and be willing to continue to let go of sedimented views (Burns & Grove, 1987: 80). Thus, in order to accomplish this, the researcher must develop specific strategies such as bracketing and intuiting, to facilitate openness during data collection and analysis. Bracketing refers to the process of identifying and holding in abeyance any preconceived beliefs and opinions the researcher might have about the phenomenon under investigation (Polit & Hungler, 1989: 328).

Intuiting is the process of actually “looking at” the phenomenon. During intuiting, the researcher focuses all awareness and energy on the participants of interest (Burns & Grove, 1987: 80). The researcher will go with an ‘open mind’ context in the field by putting aside her own perception and what she knows about the subject.

d) Data analysis

In qualitative research, the researcher usually works with a wealth of rich descriptive data. Analysis means reconstructing the inherent significance structures and the self-understanding of individuals by staying close to the subject. The overall coherence and meaning of the data is more important than the specific meaning of its parts. This leads to the use of methods of data analysis that are more holistic, synthetic and interpretative (Mouton, 1996: 169).

In this research, the phenomenological interviews that will be recorded, will be transcribed verbatim and the data will analysed according to Tesch’s data analysis method (in Creswell, 1994: 155).
A method of open coding will be used. Coding is the process whereby data is broken down, conceptualised and put back together in new ways. Open coding is the part of analysis that pertains specifically to the naming and categorising of phenomena through close observation of data (de Vos & van Zyl, 1998: 271). Open coding will be carried out by the researcher and also done by an independent coder.

The independent coder will be an advanced psychiatrist nurse-specialist who has experience in qualitative research. A protocol with guidelines will be given to the fellow coder. When the open coding is done, the researcher and the independent coder will meet to have consensus discussions about themes and categories which have been independently identified.

Tesch (in Creswell, 1994:155) provided eight steps to be considered when coding. These are:

1. Getting the sense of the whole. This means that reading through the transcriptions carefully.
2. One phenomenological interview is chosen and read through. The underlying meaning is sought and the coder has to write his or her thoughts on the margin.
3. A list of all topics is made. Similar topics are clustered together.
4. The list is taken and the original data is looked at. The topics are abbreviated as codes and write the codes next to the appropriate segments of the text.
5. The most descriptive wording for the topics has to be found, and then turned into categories.
6. A final decision has to be made on the abbreviation for each category and indicate in the alphabet form.
7. The data material belonging to each category is assembled in one place and a preliminary analysis is performed.
8. If necessary, the researcher can recode the existing data.

Data will be analysed in the language in which the phenomenological interview was conducted (Poggenpoel, 1998: 345).

Literature control will be conducted to get a comprehensive picture of the topic under investigation. Literature review will function as a mechanism of
comparing the findings from the study with the information as a mechanism of comparing the findings from the study with the information in the literature (Burns & Grove, 1987: 129).

When the data has been collected and analysed, the experiences of victimised women of group interventions has been described, phase two will be conducted.

2.3.2.2 Phase 2: The formulation and description of guidelines for the advanced psychiatric nurse-specialist to promote mental health of victimised women of group interventions.

In phase two the guidelines will be formulated up the psychiatric nurse-specialist, to promote the mental health of victimised women of group interventions in a psychiatric clinic.

These guidelines will be drawn in accordance with the themes identified in phase one of the research. Guidelines drawn will be discussed with the advanced practitioner in psychiatry, also with victimised women will be asked to comment and evaluate these guidelines.

In this research methods of trustworthiness will be discussed to evaluate the quality and findings of data.

2.4 MEASURES OF TRUSTWORTHINESS

In qualitative research, the validity and reliability are described through strategies of trustworthiness. In this research Guba's model of trustworthiness will be used. This will be done through operationalising the criteria set by Lincoln & Guba (1985: 289-329), credibility, dependability, transferability and confirmability.

2.4.1 Credibility

Credibility focuses on the truth of the data and conclusions of the study. Lincoln and Guba (1985:289) point out that the credibility of an inquiry involves two aspects and these are:

- Carrying out the investigation in such a way that the believability of the findings is enhanced.
- Taking steps to demonstrate credibility.

The credibility of this research will be maintained through prolonged engagement, triangulation, member-checking and peer examination. See application in table 2.1; pp. 36-38.

2.4.2 Transferability
In Lincoln and Guba’s framework, transferability refers to the generalizability of the data, that is, the extent to which the findings from the data can be transferred to other settings or groups. The responsibility of the researcher is to provide sufficient descriptive data in the research report that the community of science can evaluate the applicability of the data to other contexts (Polit & Hungler, 1993: 255). Strategies used to address transferability is the sample selection and the type of sample is referred to as nominated sample. Another strategy is dense description (Krefting, 1991:220). See application in table 2.1; pp. 36-38.

2.4.3 Dependability
The dependability of qualitative data refers to the stability of data over time and over conditions. The researcher will deal with data sources separately and conduct, essentially, independent inquiries through which data can be compared (Pilot & Hungler, 1993: 255). In this research, dependability will be confirmed through dense description, triangulation and code-recode procedure. See application in table 2.1; pp 36-38.

2.4.4 Confirmability
Confirmability refers to the objectivity or neutrality of the data such that there would be agreement between two or more independent people about the data’s relevance or meaning (Pilot & Hungler, 1993: 255). Inquiry audits will be used to establish the confirmability of the data. In this research the confirmability audit, triangulation and reflexive analysis will be developed to enable the researcher to come to conclusions about the data. See application in table 2.1; pp 36-38.

In summary, the strategies described above are used to establish the truth-value, consistency, neutrality and applicability of the research and are critical
to the accurate representation of subjective human experience (Krefting, 1991:220). A comprehensive summary of the strategies of trustworthiness will be discussed in a table form below.

Table 2.1 is a summary of the strategies that are to be implemented in this research to ensure trustworthiness.

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>CRITERIA</th>
<th>APPLICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credibility</td>
<td>Prolonged engagement</td>
<td>Potential participants for interviews will be met in the group interventions. Group interventions will be conducted over a period of three days. Field notes will be taken.</td>
</tr>
<tr>
<td>Triangulation</td>
<td>Individual in-depth phenomenological interviews will be held with participants until data is saturated. Observation, theoretical, methodological and personal notes will be made during the interviews. Literature control will be done after phase 1 and phase 2.</td>
<td></td>
</tr>
<tr>
<td>Reflexivity</td>
<td>A field note journal will be kept.</td>
<td>The researcher will continuously reflect on her own values, perceptions, feelings and how these will influence data collection and data analysis.</td>
</tr>
<tr>
<td>Member checking</td>
<td>Discussions with study leaders will be held on research methods and the research process.</td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Structural coherence</td>
<td>Focus will be based on the experiences of victimised women and guidelines thereof to facilitate and promote their mental health.</td>
<td></td>
</tr>
<tr>
<td>Authority of the researcher</td>
<td>The researcher has experience in psychiatric nursing.</td>
<td></td>
</tr>
<tr>
<td>Authority of the researcher</td>
<td>The researcher's study leaders have doctoral degrees in psychiatric nursing and the other study leader in education.</td>
<td></td>
</tr>
<tr>
<td>Authority of the researcher</td>
<td>A pilot study will be conducted.</td>
<td></td>
</tr>
<tr>
<td>Transferability</td>
<td>Nominated sample</td>
<td>Purposive sampling will done regarding the victimised women.</td>
</tr>
<tr>
<td>Transferability</td>
<td>Nominated sample</td>
<td>The psychiatrist, professional nurses will be used as the referral system to assist in the selection of victimised women.</td>
</tr>
<tr>
<td>Dense description</td>
<td>Complete description of demographics and research results will be done.</td>
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<tr>
<td>Dense description</td>
<td>Guidelines in phase 2 will be fully discussed.</td>
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<tr>
<td>Dense description</td>
<td>Literature control will be done after the execution of phase 1 and phase 2.</td>
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<tr>
<td>Dependability</td>
<td>Dense description of research methodology</td>
<td>Research methodology will be fully described.</td>
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<tr>
<td>Dependability</td>
<td>Dependability audit</td>
<td>Field notes, audiotapes and transcriptions will be saved.</td>
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<tr>
<td>Dependability</td>
<td>Triangulation</td>
<td>Different sources of data, different gathering methods will be used.</td>
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<tr>
<td>Dependability</td>
<td>Code-recode</td>
<td>Consensus discussion between the researcher</td>
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</table>
and the independent coder will be held.

<table>
<thead>
<tr>
<th>Confirmability</th>
<th>Confirmability audit</th>
<th>A clear description of the methodology will be provided.</th>
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<tbody>
<tr>
<td>Triangulation</td>
<td></td>
<td>The following material will be saved: audio-tapes, field notes, data reduction and analysis, reconstruction and synthesis products.</td>
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<td>Reflexivity</td>
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The ethical aspects which will be taken into consideration for the purpose of this research will be discussed below.

2.5 ETHICAL ASPECTS

To ensure the rights and responsibility of all the role players in this research, the researcher will during planning, implementation, evaluation and during conducting interviews with participants adhere to ethical standards as prescribed by Democratic Nursing Organisation of South Africa (1998: 2.3.2-2.3.3). These ethical standards are discussed below:

2.5.1 The research is planned and executed in a way which will foster justice, beneficence and exclude harm or exploitation of participants in accordance with the following criteria:

Assessment of possible discomfort will be conducted by the researcher prior to the commencement of the research project and any possible discomfort of the participants will be explained during the process of obtaining informed consent. The participants will not be victimised if they refuse to participate in the research or withdraw from the research. A contact person will be made available to participants for questions regarding the research project.
2.5.2 The right to self-determination by the participants in the research project will be ensured by the researcher in accordance with the following criteria:
Voluntary participation with ability to withdraw at any time without penalty. Informed consent will be obtained from the relevant participants and authority. The victimised women will be asked for consent beforehand of the interviews and from their own psychiatrist, for the permission to conduct research with their clients. Transparency will be upheld in terms of the objectives of the research, type of data to be collected, method of data collection and possible benefits to the participants.

2.5.3 Confidentiality and anonymity will be ensured in accordance with following criteria:
The researcher will ensure that no linking between the individual identity of participants or organisation to the data can be made. The researcher will ensure the privacy, worth and dignity of the participants.

2.5.4 Quality research will be ensured in accordance with the following criteria:
The researcher will demonstrate integrity that is honesty, to act in good faith, adherence to pre-determined agreements throughout the research process. The researcher will execute her studies under the guidance of mentors and adhere the rules and regulations set up of the institution where she studies. The researcher will adhere to the standards of planning, implementation, evaluation and reporting of the research results. Feedback of results will be made available to the participants and the clinic where the research was conducted.
2.6 RECOMMENDATIONS, GUIDELINES AND LIMITATIONS
Guidelines will be compiled in accordance with the nursing practice in psychiatry to promote and facilitate the mental well being of victimised women.

2.7 SUMMARY
A qualitative, exploratory, descriptive and contextual design is selected to discuss the research question. The next chapter, chapter 3 will fully discuss the results of the phenomenological interviews as well as the literature control.
CHAPTER 3

RESULTS AND DESCRIPTION OF RESULTS AND LITERATURE CONTROL

3.1 INTRODUCTION

In chapter two, the research design and method was discussed. In chapter three, the results of the phenomenological interviews will be described and the results will be verified by means of literature control. The results will be described by identifying the data namely by themes. The themes will be reflected within the theory of health promotion in nursing.

Below is a poem taken from Margie Thomas (1996:2) in a journal of working on issues of violence and abuse.

SILENT NO MORE

generations bring down generations
filled with broken dreams
so-called happy families
that are not what they seem

we’ve been silent too long

breaking cycles upon cycles
that have gone on too long
showing the ugly side
that was hidden and wrong

facing all the fears
learning a new way
because it can’t stay like this
it cannot stay like this

we’ve been silent too long

and now that we’ve found each other
there is one thing for sure
we won’t be silent no more
This poem is an excellent example of a group of victimised women who came together and addressed the issue of violence, abuse and violation of their rights by perpetrators. For them, enough was enough, they were not going to be silent anymore. The group interventions addressing victimisation was a way for them to voice out their frustration of their lives and being victimised.

3.2 OPERATIONALISATION OF THE RESEARCH AND THE DESCRIPTION OF THE SAMPLING CRITERIA

The sample which was selected consisted of seven participants who met the sampling criteria which was fully discussed in chapter two. The sample was chosen out three group interventions addressing victimisation with the assistance of a gate-keeper, psychiatric nurses and psychiatrist.

At the end of each group interventions, it was explained to the women about the research, research purpose and the research method. The willing participants made appointments, to participate in the interviews.

Written consent was obtained from the psychiatric clinic, psychiatrist and the participant victimised woman self. See annexure B, C, D.

Seven, semi-structured, in-depth phenomenological interviews were held with victimised women who met the sampling criteria. These in-depth phenomenological interviews were conducted at the clinic in a quiet office, to get the finer nuances of the experiences of victimised women of group interventions. Each interview was conducted between fifteen to thirty minutes and one of the interviews lasted for about sixty minutes.

The following explanation reflects the distinguishing features of the participants who participated in the interviews:

- The composition according to race group was as follows. Six of the participants were white and one black.
- The composition according to home language was follows.
(3) Three of the participants’ home language was Afrikaans.
(3) Three of the participants’ home language was English.
(1) One of the participants’ home language was Tswana, however the participant was willing to speak in English during the interview.

- **Age of the participants:**
  One participant was 32 years old.
  Five of them were in their 40's.
  One of them was 52 years old.

- **Socio-economic status:**
  One of the participant was a teacher.
  Three of the participants were housewives.
  One of the participant was administrative clerk working for a nursing organisation.
  Two of them were policewomen working in different departments.

It seems that lifelong victimisation was the pattern for many of these women, who gave their remarkable lives stories of victimisation.

Most of the women in the group interventions described incidents in their relationships of physical or verbal abuse. Some of them had left their marriages for brief periods and others were intending to leave their relationships. A contact person as referral for further individual or family therapy or as a support system was indicated to the participants who were uncomfortable about the process of the group interventions.

The above description of the composition of participants gives an indication of diversity of the sampling size and the potential to generate a rich description of the experience of victimised women of group interventions.

The group interventions were closed series of three sessions. The women were referred by their psychiatrists and professional nurses to the group interventions. After the second session, no new member was accepted because the group members have already established a rapport with each other. A new member who has not been part of the group in the first session would have greater difficulty building relationships and understanding the process in the group. Safety issues also make it important not to include new
members after the initial group-building session. It also unfair to a group to have to hold back and repeat old discussions for a new member when the original group have a limited sessions. The group interventions were conducted by a male counsellor facilitator, the researcher acted as a co-facilitator. The first session discussed the rules of the group. This included confidentiality and respect for unique differences of each individual. At the beginning of the group information was given to the women about the topic of victimisation. This information included, the definition of victimization and its effects on the victim and other related members of the family. The women were given an opportunity to relate to the topic and to discuss what influence does victimisation have on the here and now of their relationships. The second session focused on the dynamics of victimisation and transactional analysis model of Eric Berne, to indicate the relationship between self-esteem and assertiveness. Walker's (1990:8) three model of interactions that form a “cycle of violence” was emphasized in an effort to inform the group members of the dynamics of abuse and to assist them recognize warning signs and other stages in predictable patterns of abuse and how they get reinforced in their particular situations. The three stages are tension-building, acute battering incident and kindness and contrite loving behaviour (honeymoon phase). An exercise homework was given to victimised women to write a letter to the perpetrator. Instructions were given on how to post the letter and it was indicated to them to bring feedback in the following session. The third session concentrated on communication styles and how to respond and deal with victimisation. Feedback about the letters written to the perpetrator was discussed at the beginning of the session, the feedback from the group members differed individually, for others it brought out positive feelings and others negative. Some of the members of the group did not do their homework. Exploration into this behaviour was given little attention due to time constraints. Summary of the three sessions was done. At the end of each session, victimised women were also given a chance to share their experiences of the three days period.
3.3 DESCRIPTION OF THE RESULTS AND LITERATURE CONTROL.

Table 3.1 Summary of the main categories and subcategories identified in the data in regards to experience of victimised women of group interventions in a psychiatric clinic.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Subcategories</th>
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<tbody>
<tr>
<td>3.3.1 Ventilating of emotions regarding the theme of victimisation.</td>
<td>3.3.1.1 Victimised women experience the group interventions as a way of re-telling their unheard stories.</td>
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<td>3.3.1.2 Victimised women experience the group interventions as being emotional.</td>
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<td>3.3.1.3 Victimised women recognize different emotions, positive and negative emotions in regards to their relationships and group interventions. These are:</td>
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<tr>
<td></td>
<td>a) determination and frustration</td>
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<td>b) affection and rejection</td>
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<td>c) hope and determination</td>
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<td></td>
<td>d) happiness and sadness</td>
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<tr>
<td>3.3.2 Group interventions are seen by victimised women as a supportive environment.</td>
<td>3.3.2.1 Victimised women experienced support within themselves in the group interventions.</td>
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<tr>
<td>3.3.3 Victimised women experience a sense of being empowered in the group interventions.</td>
<td>3.3.3.1 Group interventions are experienced by victimised women as a learning process.</td>
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<tr>
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<td>3.3.3.2 Victimised women experience positiveness in the group interventions.</td>
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<td>3.3.4 Victimised women experience a feeling of forgiveness towards their</td>
<td>3.3.4.1 Victimised women felt a sense of forgiveness towards their</td>
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3.3.1 THE EXPERIENCES OF VICTIMISED WOMEN OF GROUP INTERVENTIONS AS A WAY OF VENTILATING THEIR EMOTIONS.

Victims of abuse are often extremely reluctant to disclose that they have been victimised for many different reasons the fact their trust in other people has been damaged by their abuse experience. Most abuse victims are better at hiding their experiences regarding the abuse than facilitators are in recognizing them. Others have experienced so many insidious forms of abuse that they do not recognize certain acts as abusive. Turner & Shapiro in Rubin (2000: 11) postulated that victimised women are engaged in denial and avoid acknowledging the painful impact on their already troubled lives of recent or anticipated loss of an idealized relationship, marital role and emotionally and other forms of security.

To follow is the main categories that indicated and brought about an environment of expanded choices in behaviour and attitude of victimised women of group interventions.

3.3.1.1 Victimised women experience the group interventions as a way of re-telling their unheard stories

Everyone creates, tells, listens to, changes, and re-tells stories. As stories are told, people name and shape the meaning of daily events of their lives and communicate that meaning to others. Voice is given to their unique experience; then, through familial and community stories, voices are shared and joined. Stories allow for both continuity and change (Roberts, 1994: 1). Women in abusive relationship encounter risk of being ridiculed, assaulted and being injured by the perpetrators for showing what they are feeling. They wear masks on daily basis, because they feel embarrassed or afraid to share what they are feeling (Ogawa, 1996: 14).

The dominant experience is that victimised women knew that they were in abusive relationship; but did not know how to ask for help. One of the women
said: “I thought my husband was kind to me, until he called me “utterly worthless” and “boring” and ignored me for few days. I began to feel very small and unimportant.”

Turner (2002: 3) contends that a group is effective in assisting victimized persons to promote healing in that the participants are allowed and encouraged to talk to each other about what they have not been allowed to articulate, namely what happened to them. In addition, she further suggests that each time victimised women speak to each other about their experiences, they put more distance between themselves and the pain, and the more they continue to talk, the less victimised they feel.

Victimised women had a need to express their feelings because they felt that there were no other group interventions gives them an opportunity them to express their feelings. As one woman relates: “My greatest fear in coming to this group was, no one will listen nor believe my story. I am happy to have participated in this group because I could take out what was paining me and ask questions.”

Gazda in Turner (2002: 4) argues that an encounter in which two or more people experience and understand each other, is the core of the group process. It is not just the meeting and the sharing of experiencing or the comprehending of the other that allows change or healing to take place. It is this kind of supportive encounter that the victims of abuse have an opportunity to experience in the small group work. It is necessary that women should be willing to explore themselves in the group interventions and to be adventurous to regain themselves again.

3.3.1.2 Victimised women experienced the group interventions as emotional.

Victimised women experience the group interventions as being emotional. Emotions that regularly persist alert us to compare what we are experiencing to the purpose we have identified for our lives (Ogawa, 1996: 13). There was a sense in the group interventions that victimised women needed to express their feelings in confrontation instead of avoiding them with silence, kindness, tactfulness or sympathy. Two of the women relate to this: “Maar die eerste
The first session was emotional; because I have... there is mistakes and things which I discovered in myself and also about the abuser and realised on what I should look at. The second session was more emotional, but there I also learnt something.

Another illustration of the emotional component is related like this: “I could not hide my feelings, I was very emotional, I just on the pills, and the pain came out... like pouring out. And ‘uhm’ about it I cried too much. ‘Uhm’, I could feel that other people...uhm’ and I got older, so yes, I did not expect this of me...being able to open up, because I have never opened up.”

It seems that the group interventions offered victimised women a place where they can do at their own paces those things that which they cannot do elsewhere, especially those areas which have been most strongly forbidden to them in the outside world, like ventilating their emotions.

According to Yalom (1995:26) emotional experience provide the group members with a sense of liberation from inner restraints as well as an enhanced ability to explore more deeply their interpersonal relationship. Open expression of affect is without question vital to the group therapeutic process. The intensity of emotional expression is highly relative and must be appreciated from each member’s experiential world.

Yalom (1995:89) further argues that strong expression of emotions enhances development of cohesiveness, members who express strong feelings toward another and work honestly with these feelings will develop close mutual bonds.
3.3.1.3 Victimised women recognize different emotions, positive and negative emotions in regards to their relationships and group interventions.

From the data, the theme of positive and negative emotions about their relationship and the group intervention comes out many times. Recognizing and honouring their emotions, seems as the way of recognizing and honouring themselves and the spirit of life within them.

- **determination and frustration as related to their relationships.**
  Victimised women expressed the need to understand and express themselves more adequately in order to achieve more understanding in their relationships. The feeling of determination calls forth the awareness of an intention to reach the desirable state. As one woman relates her story in the group: "It took courage to speak about the unspeakable. I thought I'd never speak about it. But as the sessions went on I felt determined to speak about this, the hurt, pain that I covered for so long."
  Some of the women felt frustrated in the group interventions, because it did not come up with the solutions that they needed. Negative emotions were experienced of anger and resentment towards the facilitators and the perpetrators. One of the women said: "In my first session, it was still very confusing for me. I realised that there is no hope for my situation. I expected that the group leaders to help me with my situation."

- **affection and rejection as related to their relationship.**
  Wilson and Kneisl (1992; 810) describes the need for affection as the need to establish and maintain a satisfactory relation between the self and other people with regard to love and affection. Victimised women's perception of affection was through sharing their stories together; their joy and sorrows.
Evans (1992:64) argues that in an abusive relationship, victimised women are often left with a feeling of having said something that is unacceptable or not worthwhile. Thus they experience a feeling of rejection. The response was some of the victimised women experienced a feeling the perpetrators' indifference, criticism, disregard and so forth as a kind of rejection that they were not aware of and could not acknowledge it as victimization. This brought about confusion and uncertainty. In the group interventions they felt heard and understood. As seen in the following illustration: “Walking into this group I knew that whoever was here would believe me. Sometimes, because there is so much pretence, disbelief and silence. I can doubt my own reality. But sitting and listening to other women’s stories, it is different. I can honestly say: ‘I do understand you and I believe you’. What you are saying is the truth. It changes it for me too. I am believed.”

- Hope and disappointment as related to the group interventions.
  At the end of the third session of the victimisation group, the theme of hope came out many times. Victimised women who wanted to stay in their relationships, hoped that in time their relationships will improve. Others hoped that ‘their hurt’ may heal in time. For one woman what she has learned in the group interventions would be a process to keep up to. This is how she relates it “It is a continual healing journey. I have made mistakes and maybe I will learn from them. That’s one of the ways to learn.” Some of the victimised women were disappointed that because the sessions were only three. They were disappointed that, maybe the sessions should be continued on out-patient basis, because they have not really reached that a point of making decisions about their relationships.

- Happiness and sadness as related to the group interventions.
  It takes courage for the victimised women to speak about their experiences because of the stigma that accompanies the labels of ‘abuse victim’ or ‘abuse survivor’. For the victimised women, it was important to speak, to express their voices, knowledge’s and to share experiences together in the group interventions. About the happiness and sadness, this is illustrated by what one of the women in the group interventions said: “I was very happy to see
that it was such a large group. And also very sad to see that there is so many people that are being victimized and thirdly I’m grateful there is a group such as this to help people to get through it.”

3.3.2 Group interventions are experienced by victimised women as providing a supportive environment.

Most women achieved a new awareness mainly by seeing themselves in the mirror held up to them by support and encouragement of other members. They all rushed to empathize, support and rescue each other. One of the women describes the support she experienced in the group like this: “Daar was samewerking, daar was geen agteraf gepratery nie, daar was ondersteuning. Dit was wonderlik gewees.” (“There was cooperation amongst each others back, there was no talking behind each other, there was support. It was wonderful.”) According to Gottlieb (1983: 69) the group offers unique supportive provisions because of its compositions and processes. The very fact that people make contact with peers who are experiencing similar environment events is reassuring. Through the group process, victimised women compared notes about the strategies of coping that have used previously in their experiences of victimisation. The group experience provides a “psychological sense of community” that cannot be obtained from traditional intervention (Gottlieb, 1983:70). Group interventions are conducive to the creation of supportive social networks, their offer victimised women a broader range of “reparative relationships” (Stalker, 2002: 2).

3.3.2.1 Victimised women experienced support within themselves in the group interventions.

Victimised women experienced a “feeling of belonging” regarding to the support and assistance that they give each other. Victimised women described each other in the group interventions as contributing to the supportive environment that they were experiencing. One of the woman’s positive experience is described by the following remark: “Die groep help
Turner (2000:5) maintains that a group intervention bonds people who have been isolated for months or even years, unable to talk about what have happened to them. It brings about a sense of relief to a group of women who have been isolated for so long in that they are able to talk about their feelings in connection with victimisation. She says: "group members feel very close to each other after having shared such vulnerable feelings. Furthermore, she argues that it is important for the facilitators of the group to be emotionally available during the group interventions.

According to Gottlieb (1983:22) being in a supportive environment leads the participants to believe that she is cared for and loved, that she is esteemed and valued and that she belongs to a network of communication and mutual obligation. The group experience counteracts feelings of loneliness and uniqueness that compound the stress of life events by offering the company of peers who "feel with" one another (Gottlieb, 1983:25).

3.3.3 Victimised women experience a sense of being empowered in the group interventions.

The experience of victimisation takes away the women’s sense of having the power to protect herself. Empowerment encourages the women to participate in making decisions about her own life. Empowering women means ensuring their full participation in every aspect of development (Wolfensohn, 2000:1). The group interventions serve as a sounding board which assists to expand the women’s own range of choices. Walker in Whalen (1996: 65) advocates that it is important to allow women in the group interventions to regain power so that they may re-experience power in other relationship in their lives.
Below are several aspects that victimised women of group interventions experienced related to the sense of being empowered.

* **personal strength**

At the end of each series of group interventions, victimised women shifted their perceptions of themselves from being a victim to a survivor. As one of the women relates: “I am so tired of being a victim. I just wanted now to speak about how I survived what I went through in my life. I want to move on. The sense of wanting to survive and wanting to move on is stronger in the end.”

Walker in Whalen (1996: 65) suggests that it is necessary for the facilitators to use several techniques in group interventions to promote the building of self-esteem of victimised women by supporting her existing strengths and helping her re-evaluate her self-worth and competence.

* **self-determination**

Victimised women had a need to understand and express themselves more adequately in order to achieve more understanding in their relationship. One of the woman describes: “Die groep het my geheel binnekant. Ek kan nou verstaan wat het aangegaan in my verhouding met my man. Ek kan nou my eie besluite neem. As ek more hies uitstap, het ek ‘n positiewe kyk op die lewe.” (“The group healed me inside. Now I can understand what happened in my relationship with my husband. I can now make my own decisions. When I go out tomorrow I will have a positive outlook on life.”) Victimised women need to feel understood, validated and affirmed about their experiences. It is then that the can contemplate change at the level of belief in change. Validation means listening carefully to their experiences (Durrant &White, 1992: 135).

* **Decision-making ability**

In two of the series of group intervention, victimised women came to an agreement that it is not easy to make decisions immediately related to their relationships, but however could take responsibility of their own lives when they are discharged form the clinic. As one of the women describes her
situation: "Ek is in 'n situasie waar ek is vasgevang in die situasie. Ek kan nie regtig uitkom uit die situasie nie. En my situasie is as ek terugkom by die huis, gaan presies dieselfde situasie wees, as waarin ek nou is, maar ek kan hier leer om myself sterker te maak en om die situasie beter te hanteer." ("I am in a situation where I am tied up in the situation. I cannot really come out of the situation. In my situation when I go back home, it is going to be exactly the same situation as I am in now, but here I can learn to be strong for myself, to handle the situation better").

Literature indicates that decision-making can strike a note of fear in victimised women. Thus it is easier for victimised women make the decisions to stay for the time being in their relationships. They may feel guilty because they feel they are compromising their feelings and new understandings for material considerations and they worry about what others will think (Goodman & Fallon, 1995:174-175). Empowerment encourages the women to participate in decisions about their own lives. The facilitators in the group interventions should serve as sounding board to help these women to expand their own range of choices (Walker, 1994:114).

- Expanding alternatives

The victimised women explored options about their relationships. Some of the women limited their options by saying they still need to weigh their options in their relationships. Some of them worked on a potential short and long term consequences of their actions so that they can be prepared for their reactions they experience. One of the woman relates: "I really see life at another angle. There are options in life, let me say that... there are options if this doesn't work, then I have to look at other options. That's what I have learnt."

Literature demonstrate that empowering victimised women enables them to determine what is best for their lives if they are offered support advocacy, resources and information (Whalen, 1996: 51). New information brings about change. This entails people thinking about their problem in a different way.
3.3.3.1 Victimised women viewed the group interventions as a learning process.

Victimised women experience the group interventions as being educative. One of the women remarks: "Ek voel die derde les wat ons gehad het, was vir my absoluut ook 'n oog-oop-maker sodat ek het my lewe kan aangaan", ("I feel that the third session we had was for me an eye-opener in order that I can go on with my life.")

According to Collier (1982:265) women come to group interventions seeking expansion of themselves. Women need opportunities to experience with a new range of behaviours, not just that they may judge the validity of behaviours, but so that they may have time to identify and overcome their habitual feminine responses. Expansion, in other words, is internal development as well as external achievement.

Walker in Whalen (1986:65) suggests that women can learn new cognitions from others in the group and women can benefit from the group norms that support positive behavioural change.

Victimised women of group interventions experienced that in the group interventions they learnt new communication styles, to talk about victimisation, how to respond to the perpetrator. One of the women describes this experience as follows: "You can love yourself, and you can interact with people ‘uhm’ and you can face the perpetrator, not on the parent adult level, but on the adult-adult level. And you can talk to that person without degrading the other person as well."

Collier (1982: 271) argues that victimised women have to learn new techniques to express new attitudes. She suggests that the following areas in which women need to improve their communication styles are direct statements of wants and needs, negotiation, conflict resolution, confrontation and communication of one's own experience.

3.3.3.2 Experience of positiveness in the group interventions.

There was a “feeling of positiveness” in the group interventions. This feeling seemed to take out the group effect that it had on victimised women.
One of the women described the effect like this: “As ek more hier uit stap, het ek ‘n positiewe kyk op die lewe, (“When I walk out of here tomorrow, I have a positive outlook on life.”) Another victimised woman remarks: “I feel that I have learnt a lot by just attending and being present ‘uhm’ to able to help myself, through the difficulties that I still have in my life. And that is the first in my life that I’m really a person.”

Right up against this theme of positiveness, was the need for victimised women to have more sessions on this group intervention of victimisation. This is indicated by one of the women as saying: “I’d like to say if this group can be repeated, I would go all over again.”

Another unique theme was prominent was to conduct an individual session about victimisation. One of the woman points it out like this: “Ek dink net elke persoon moet individueel ook n kans gegee word, nadat ons in die groep was, miskien as sy nog bietjie skaam is of bietjie rou is in die begin, nog met die beraders kan praat, (“I think each person should give be given individual attention, after the group, maybe she feels shy or it is still raw in the beginning to can still talk to the counsellors.”)

Group interventions uncovers what was there in the first place, it increases love, courage, positivity, creativity and curiosity and reduces fear and hostility. It is possible that group members can discover positive areas of themselves, the ability to care for another, to relate closely to others and to experience compassion (Tudor, 1999: 114).

3.3.4 Victimised women experience a “feeling of forgiveness” towards their perpetrators.

Victimised women acknowledge that there was so much to be rid of. They felt that there is a need to do one comprehensive past history deleting, that is, to forgive, to clear out a lifetime of negative feelings and then to do daily forgiving to keep them on track. They also related the forgiveness to God. As one woman relates: “I pray to God to please help me to forgive the perpetrator in my life.” Another woman remarks like this: “Ek vergewe jou, ek spreek jou vry. Ek sal dit kan doen. Ek kan werk aan my verhouding
met God. Dis wonderlik.” (“I forgive you, I set you free. I can do that. I can work on my relationship with God. It is wonderful.”)

True forgiveness is defined as conscious choice in which individuals give up their legitimate claim for retaliation following and interpersonal offence and substitute conciliatory responses. Forgiveness represents a motivational shift from relationship-destructive tendencies to relationship-constructive tendencies. It enhances the victims’ position of moral superiority (Zechmeister & Romero, 2002: 675-676).

Literature indicates that it is important to learn the true value of forgiveness the forgetting of the anger, fear and pain associated with the past and the freedom of living a life from within. The value of forgiveness is not in its power to grant freedom to the perpetrator but in its power to give wholeness to the victim of abuse. Forgiveness is required for physical and mental health, that we love and forgive ourselves and others (Sullivan, 1995: 3).

According to Augsburger (2000:1-3) there are five steps to interpersonal forgiveness and restored relationships. These are restoring the attitude of love, releasing the painful past, reconstructing the relationship, reopening the future, and reaffirming the relationship. All of these stages focuses on forgiveness that is mutual recognition, that repentance is genuine and that right relationships have either been restored or are now achieved. Augsburger (2000:2) argues that not every forgiveness leads to a continuing relationship between the victim and the perpetrator, nor not every healed injury will result in the resumption of the previous relationship. There is time to say “Goodbye and a time to say “hello” and a time to say “May the Lord watch between us as we part from each other in mutual respect and friendly parting.” Sullivan (1995:3) states that the victims of abuse do not deserve to be victims but the damage cannot be repaired by the offender, nor can it be repaired by punishment of the offender. The victim is healed, made free by her willing removal of the feelings associated with the victimization. This change of feeling may be helped by the action of others but the work of change must be done by the victim of abuse. A quote of forgiveness taken from Sullivan’s
article on the secret of forgiveness: "Forgiveness, healing, happens inside yourself. It is from God, for you, because you ask, because you desire it with all your heart. It cannot happen if you insist on keeping the hatred, sorrow, pain, anger, resentment, jealousy, envy, lust, deceit-any of the negative feelings or actions. Keeping these feelings or actions means you are not yet ready to be forgiven or healed."

3.4 Conclusion

A comprehensive amount of data was generated by asking victimised women this question, "How was it for you to be in the group interventions?" After the data has been open coded and categories identified, the experiences of victimised women were explored and described.

It is clear in the data generated that the group interventions had an effect on victimised women. Also that, the group intervention can be extended to more sessions instead of three sessions. This limitation will be discussed in chapter four.

During the series of the group interventions, the researcher had an open mind regarding the victimisation that victimised women experienced. The researcher’s personal experience of victimisation made it difficult for the researcher to be open minded. It was necessary for the researcher to conduct an inventory of the researcher’s own personal attitudes and beliefs regarding victimisation.

In the light of the above-mentioned, the guidelines for the advanced psychiatric-nurse specialist will be described to facilitate the mental health of victimised women.

"BY THE CROWD THEY HAVE BEEN BROKEN, BY THE CROWD THEY SHALL BE HEALED" (GAZDA, 1982:9)
CHAPTER 4

GUIDELINES, LITERATURE CONTROL, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

In chapter three is the experiences of victimised women of group interventions explored and described by using main categories. The main categories that mainly came out were ventilating of emotions, a sense of being empowered, support for each other in the group interventions and a sense of forgiveness towards their perpetrators. Based on these themes, guidelines for the advanced psychiatric nurse-specialist to facilitate and promote mental health of victimised women of group interventions will be described.

The researcher agrees with Parrish (1990: 76) when she recommends the following goals for group interventions. These are:

- The group must provide a safe, supportive environment in which members can share experiences and feelings of the past and present.

- The group must provide the encouragement that will enable its members to explore and express long-suppressed emotions in an appropriate manner.

- The group must create a consistently predictable environment that allows members to learn trust.

- The group must enable members to practice decision making and problem solving, which will allow them to gain control of their lives.
• The group must provide a setting in which members can practice and experiment with new behaviours and interpersonal communication skills, enabling them to close personal relationships.

These goals are interdependent and do not occur separately.

4.2 DESCRIPTION OF GUIDELINES FOR THE ADVANCED PSYCHIATRIC NURSE- SPECIALIST

The advanced psychiatric nurse-specialist as an integral part of the health delivery system must take stock of the influence of violence on people as whole persons and must base her interaction with individuals, families and communities on their identified mental health needs and problems (Poggenpoel, 1995: 91).

The guidelines for the empowerment programme for victimised women which will be consequently introduced will be based on the main categories which were described in chapter three. These guidelines will be specific, suitable and practicable within this specific context.

Furthermore, the guidelines of an empowerment programme for victimised women will be described by utilising Dickoff et al (1968: 420) model, with reference to the agent, recipient, procedure, context and terminus. Within the context of this research the above concepts can be described as follows:

Agent: advanced psychiatric nurse-specialist

Context: is the psychiatric clinic

Procedure: use of group interventions to develop new skills such as assertiveness skills, communication skills, conflict management.
Terminus: is the facilitation and promotion of mental health.

4.2.1 The role of the advanced psychiatric nurse-specialist in the empowerment programme for victimised women.

The agent: is the person who implements the activity (Dickoff et al, 1968: 423). In this programme of empowerment for victimised women, the advanced psychiatric nurse-specialist is the agent who is responsible for the planning, implementation and evaluation of empowerment programme in the psychiatric clinic.

When the advanced psychiatric nurse-specialist participates in this programme, it will be necessary for her to conduct an inventory of her own personal attitudes and beliefs regarding victimisation. Positive, ideal attributes for the advanced psychiatric nurse-specialist includes creativity, personal insight, integrity, sense of ethical values. The desired qualities have a great deal to do with the advanced psychiatric nurse-specialist’s own personal value system, which reaffirms the importance of the advanced psychiatric nurse-specialist to undertake a soul-searching of attitudes and prejudices and how these are communicated to victimised women (Beck et al, 1988: 125).

4.2.2 Victimised women and the empowerment programme

The recipient: is the victimised women in the psychiatric clinic. The victimised women are in such a position that they are dependent on their interaction with the advanced psychiatric nurse-specialist in order to mobilise resources that will promote their mental health, which is the integral part of wholeness.

During the process of the group interventions, both the advanced psychiatric nurse-specialist and victimised women gain personal growth. They both benefit in that they look up alternatives of recovery in the lives of the victimised women.
The empowerment programme should be aimed at assisting victimised women to develop more positive attitudes and better interpersonal skills, transfer behaviour and skills developed in the group to situations outside of the group (Zimpfer, 1981: 11).

**4.2.3 The context where the empowerment programme for victimised women will be implemented.**

The context should be comprehensive and formed through assessing the clinical situation and formulation of goals.

The advanced psychiatric nurse-specialist assesses the clinical situation by looking for factors, which will affect the group interventions in a clinical set up. This includes referrals by other members of the multidisciplinary team to reduce group turn over and instability. In addition, the advanced psychiatric nurse-specialist and victimised women formulate goals and expectations to be achieved in the group interventions (Yalom, 1985: 458).

**4.2.4 The procedure related to the empowerment programme for victimised women.**

The procedure is described in hand with the Dickoff et al.'s (1968: 423) model with integration of the group process.

The procedure and content of the empowerment programme will be described by utilising the phases of the group process. These are, the relationship phase, working phase and termination phase. During these three phases certain strategies and attitudes are employed, which together can lead to the attainment of goals in group interventions; namely the facilitation and promotion of mental health.
Below, the relationship, working and termination phases of the group process will be discussed within the context of this study:

### 4.2.4.1 The relationship phase

In the relationship phase, the advanced psychiatric nurse-specialist creates an atmosphere of warmth and acceptance by introducing non-threatening aspects during introductions (Moloto, 1993: 95). The advanced psychiatric nurse specialist should create a context within which aspects related to types of abuse that could have been experienced by victimised women. She must also be open minded regarding these types of abuse, must also be aware of the subtle indications of abuse and must ask appropriate questions (Walker, 1994: 205).

During this phase, the advanced psychiatric nurse-specialist assists victimised women to identify the norms of the group, to formulate goals. These goals can include personal and general goals. The aim is to achieve a sense of identification or belonging to the group (Beck et al, 1998: 532).

The advanced psychiatric nurse specialist assists to shape the norms by being the technical expert and a model-setting participant. She wishes to encourage the learning opportunities that the group intervention creates by shaping norms namely: (a) free interaction with members with different experience and coping styles; (b) disclosure and feedback; (c) the development of trust through sharing and closeness; (d) being accepted and supported by peers and (e) taking the risk of being different (Aveline & Dryden, 1998: 9; Yalom, 1995:112).

### Guidelines that the advanced psychiatric nurse-specialist can use during the relationship phase:

- Create and promote an environment of warmth and acceptance in which therapeutic factors such as acceptance for each other and universality can flourish. Create the opportunity for victimised women to introduce
themselves; work to sustain a therapeutic rather than a social role; include all
group members and encourage sharing.

- Allow victimised women to tell their stories related to the theme of
  victimisation. Listen actively using minimal verbal responses and
  validating their experiences by exploring and reflecting about their
  stories.

- Encourage the group process by addressing issues presented in the
  group interventions promptly, calmly and fearlessly even if they are not
  entirely of positive nature.

- Promote member-to-member interaction by encouraging members to
  talk with each other. Ensure that all the group members of the group
  intervention participate. Reflect and clarify on members who are quite in
  the group interventions. For example an advanced psychiatric nurse-
  specialist can say: "Well participant 1 and participant 2, you two have
  had a good chance to get into some more important issues. I guess we
  need to hear about some of the matters that others have on their minds.
  We'll get back to your concerns later. Participant 3, you looked like you
  were going to say something a few minutes ago."

- Demonstrate understanding of the group member's feelings,
  keeping your voice tone consistent with group member's
  positive and negative emotions in group interventions. Ensure focusing
  by dealing promptly with defacilitatory tendencies amongst the group
  members by giving information, questioning, clarifying and ensuring that
  each member contributes and is relevant to the phase and stage in the
  process (Moloto, 1993:97).

- Before the group ends, elicit comments from all the members of the
  group concerning their individual experiences of the first session and
  then summarize the process and the relevance of the sessions to each
4.2.4.2 The working phase

The first step to take in the working phase will be to give information about the theme of victimisation. This will include, definition of victimization, cycle of violence, dynamics of abuse, transactional analysis indicating the relationship between self-image and assertiveness.

The group interventions are done over three sessions depending on the stay of the victimised women in the psychiatric clinic. The length of the sessions can last anywhere from one to two hours with the average length being one and half hours. However the limit set should be constant (Kaplan & Sadock, 1998: 478).

In the working phase, the advanced psychiatric nurse-specialist can use different strategies to develop new skills, to express new attitudes. The areas in which women especially need to improve their communication styles are direct statement of wants and needs, negotiation, conflict resolution, confrontation and communication of one's own experience (Collier, 1982: 271).

The relationship life skill, assertiveness can be utilised as part of the empowerment programme as suggested by Goodman & Fallon (1995:113).

♦ Assertiveness

Assertiveness is the expressing of own needs, wants or feelings without violating the rights of others. When one is assertive, it means that she is honest, direct and sincere and treat other persons as equal and valuable.

The use of assertiveness behaviour helps reverse the cycle of abuse, frustration and low self esteem that occurs when one cannot claim rights or set boundaries. Assertiveness as a life skill in the empowerment programme will assists women to negotiate, resolve their conflicts and to regain their self-confidence and be able to deal with power games in their abusive relationships.
Women and assertiveness

In our culture, women are often treated as "second class citizen". According to Goodman and Fallon (1995:116) it is important and helpful to look at how culture socializes women because it explains a lot about their own behaviour. It is no small wonder that women find it difficult to learn to be assertive because of the way they have been socialized to be quiet good, to "keep the peace" and "not to rock the boat" or say anything if we feel transgressed. She further discusses that as women, it is well aware that culture does not initially respond positively to assertive women. A woman with clear boundaries maybe seen as a threat to the balance of power in the family or work environment. This can be negotiated and common ground can be found.

Another important issue for women to consider is the fact that they place tremendous value on friendship, commitment, sensitivity and loyalty. This is a gift for women. However as victimised women, it can be that it is extraordinarily done and sometimes inappropriately so.

The advanced psychiatric nurse-specialist will have to inform victimised women that learning to be assertive consists of risks also. This include losing some friendships that they have valued highly. Also they may have to end some loyalties that they can discover to be destructive to them. Being assertive will assists women in defining which friendships they should be valuing and which commitments they should honour.

In addition Goodman and Fallon (1995:121) summarizes stumbling blocks to assertiveness, these are cultural attitudes towards women; fear of retaliation and conflict; lack of knowledge of assertiveness as a skill; fear of being labelled; fear of losing friendships or other relationships; fear of stirring up anger within oneself; belief that we do not really deserve to be assertive and lack of readiness to assume responsibilities that may result from being assertive. All of these stumbling blocks have their valid concerns, however both the advanced psychiatric nurse-specialist and victimised women can
examine, analyse and discuss them and can identify how to conquer these pitfalls.

According to Goodman and Fallon (1995:113) it is necessary that women review their rights in relationship. Evans (1996:122) suggests the following as basic rights in the relationship:

- The right of goodwill from the other.
- The right to emotional support.
- The right to be heard by the other and to be responded to with courtesy.
- The right to have your own view, even if your partner has a different view.
- The right to have your feelings and experience acknowledged as real.
- The right to receive a sincere apology for any jokes you find offensive.
- The right to live free from accusations and blame.
- The right to live free from criticism and judgment.
- The right to have live free from emotional and physical threat.
- The right to be called no name that devalues you.
- The right to be respectfully asked rather than ordered.

These rights should belong to anyone, assertiveness does not violate, but rather helps in respecting the rights of others (Goodman & Fallon, 1995:113). The advanced psychiatric nurse-specialist can divide the group members into pairs, with each partner taking turn to read these rights to each other. After reading through the rights the members of the group can then spend time
sharing any difficulties they may have with them. The exercise can be completed by each person selecting a right and owning that particular right. It is important that the advanced psychiatric nurse-specialist stresses positives of assertiveness in the group interventions.

**Guidelines that the advanced psychiatric-nurse specialist can use during the working phase:**

- Encourage victimised women to express their feelings through telling of their stories. Show understanding and caring by reflecting their feelings about their stories. Listen actively by making use of minimal verbal responses as victimised women express their experiences. Show empathy and understanding towards victimised women to facilitate open and trusting exchanges.

- Foster member-to-member interaction by enhancing the opportunity of members to assist each other and to have practice in applying new psychological learning in a real situation (MacKenzie, 1990: 105).

- Focus the process of the group issues on the here-and-now principle. Keep eye contact with group members and use effective body language (Moloto, 1993: 97).

- Assist victimised women to develop new behaviours. Brainstorm together about ways of dealing with victimisation. Role play and model some of the techniques of assertiveness to increase their self-esteem.

- Allow the group members to summarize by allowing the to re-iterate events in the relationship phase to link with the introduction of learning new behaviours (Moloto, 1993: 98).

- Explore emotional reactions of the participants. An example of a question which can be asked in the group interventions can be as follows, "What was it like to speak of these matters that you have always
kept secret?" "The experience of telling other members of the group about your story sounds like you took a risk in the group to share; how was it for you?"

- Keep focusing on the here-and-now. Bring the victimised women back to statements made in the group interventions. Probe if necessary for further reactions about the theme of victimisation. Compare and contrast between some of the responses in order to reveal important differences in how members react to the same events in victimisation.

- Reflect victimised women's feelings and give warmth, provide them with feedback by specifically describing behaviours, like "you feel worthless because of the degrading remarks you have heard most part of your life: catharsis."

- Encourage victimised women to brainstorm and prioritise ideas on how to deal with victimisation according to their practicality, applicability and reality for themselves.

- Assist victimised women to evaluate their decisions and progress reward achievement by using encouraging statements.

- Encourage the learning and assimilation of newly learnt behaviours by encouraging victimised women to practice in the group interventions. Give victimised women homework and ensure enough opportunity for the group members to give feedback on the homework- appraise positive results (Moloto, 1993: 99).

- Serve as a resource person guiding group members by calling attention to certain events or processes in the group interventions and facilitate unique outcomes such as problem solving, communication, self-empowerment and personal growth. Refer victimised women to psycho-educational groups such as self image, forgiveness,
regaining hope and other related to groups to the theme of victimisation.

- Explore support systems available to individual members. Encourage support for each other in the group interventions by implementing therapeutic factors such as universality, cohesion and altruism in order to enhance their self-esteem through assisting each other in the group interventions.

- Allow the group members to evaluate the entire process by giving each member a chance to evaluate any of the previous sessions and let them express their individual experiences of that particular session (Moloto, 1993: 99).

- Move into the next session of termination when the victimised women come to a consensus that they are ready for closure.

4.2.4.3 Termination

According to Moloto (1993:100) hope should be instilled by re-emphasizing positive of the group member's progress- focus on observed unity, sharing, trusting and allowing themselves to be trusted.

The advanced psychiatric nurse-specialist can ask the women to share positive characteristics with each other. According to Evans (1996:153) this assists women in thinking of themselves in stronger and more positive ways. She includes a list of affirmations which these women can use to support themselves. These are:

- I can trust my own feelings and perceptions.
- I deserve freedom from mental anguish.
- I am not the cause of another's irritation, anger or rage.
- I can say no to what I do not like or want.
- I am an important human being.
- I can decide for myself what is best for me.
- I am not alone, I can ask others to help me.
The above list can be practised by victimised women in the group interventions with the assistance of the advanced psychiatric nurse-specialist.

**Guidelines that can be followed by the advanced psychiatric nurse-specialist can use during the termination phase:**

- Summarize the group process of what has been happening in the previous phases, relationship and working phase. Encourage victimised women to review the process of the group to assist them to internalise the group experience.

- Reflect feelings and assist group members to achieve unattained aspects of progress. Allow them the opportunity to discuss their feelings about ending the group interventions. Explore separation anxiety and deal with silence by involving the inactive members. Listen actively to verbal and non-verbal messages and reflect these to victimised women to ensure effective dealing with separation anxiety (Moloto, 1993: 101).

- Ensure group consensus of what the group interventions yielded for all the members and ensure that their expectations have been achieved by individual members and by the group itself.

- Serve as a resource person, announce your availability to victimised women. Refer to other multi-disciplinary team if it is necessary for any members of the group. Arrange for follow-up sessions if it is the need for all members (Okun, 1987: 76-77).

### 4.2 LIMITATIONS AND PRACTICAL PROBLEMS

- It is possible that three group interventions held with victimised women not a true reflection of experiences and results of other women in the psychiatric clinic who did not attend the group interventions. The real effectiveness of the group interventions needs to be done on a longer
period, on an out patient basis as a support group to see any beneficial results.

- The researcher held one focus group after three sessions of the group interventions were conducted. The focus groups did not succeed since some of the participants did not want to stay another hour long after the group interventions were conducted. Thus phenomenological interviews as a method for collecting data was utilised.

- Not all the victimised women could tell their stories in the group interventions due to the time constraints.

4.2 RECOMMENDATIONS

The recommendations for this study will be made with specific reference to the psychiatric nursing practice, psychiatric nursing education and psychiatric nursing research.

4.4.1 For Psychiatric Nursing Practice

The advanced psychiatric nurse-specialist can implement mental health nursing activities directed toward continuing and preserving the mental health status of victimised women. These activities include short-term individual psychotherapy, mental health education.

In addition, the advanced psychiatric nurse-specialist can also implement activities such as long-term supportive therapy and support group work session. She can initiate self-help groups, whereby victimised women can share their similar experiences and support each other (Poggenpoel, 1995: 97).
4.4.2 For Psychiatric Education

The Theory of Health Promotion in Nursing should be used as a basis when examining the curriculum regarding education for facilitating mental health of victimised women, to assists the student psychiatric nurse to facilitate and promote mental health for victimised women.

Psychiatric nurse educators can teach the psychiatric nursing student on the basis of domestic violence, its effects on the children, the victim and perpetrator. It can be a learning experience for students to integrate their group process with the theme of victimization.

4.4.3 For Psychiatric Nursing Research

Research can be done on the implementation of evaluation of the guidelines. The focus can be placed on the individual’s personal growth by re-assessing the assertiveness skill. Follow up groups can be done with victimised women who have gone through the assertiveness skill training and their experiences can be documented to make recommendations for facilitating the mental health of victimised women of group interventions.

4.3 CONCLUSION

An unintended but welcome outcome of the research process was its impact on the women participants. Throughout the process of conducting the group interventions the women, at first, found it very painful to recount their experiences associated with victimization. At the end of these series of group intervention, several times the women stated that they have found it valuable to participate in the group interventions despite the emotional strain and time commitment it demanded.

Even though the research process was separate from therapeutic interventions, the very fact that the women received sustained attention and interest from the researcher resulted in secondary therapeutic effects. Hoff (1990: 169) describes this kind of relationship and positive side effects as
"going native" this means that the researcher becomes totally absorbed into the culture being researched.

From the research study it seems that more sessions of this nature and follow up sessions should be conducted.
BIBLIOGRAPHY


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ANNEXURE A

CONSENT FROM THE RESEARCH COMMITTEE
TO WHOM IT MAY CONCERN

TITLE OF RESEARCH PROJECT: "The Experiences of Victimised Women of Group Interventions in a Psychiatric Clinic in Gauteng Province."

RESEARCHER: Annie Temane

SUPERVISORS: Prof. M. Poggenpoel and Prof. C. Myburgh

The Research Ethics Committee of the Faculty of Education and Nursing of the Rand Afrikaans University evaluated the research proposal and consent letters of the above research project and confirms that it complies with the approved Research Ethical Standards of the Rand Afrikaans University.

The study supervisor and researcher demonstrated their intent to comply with the approved Ethical Research Standards during conduct of the research project.

Yours sincerely

ANNATJIE BOTES (PROF)
CHAIRPERSON: FACULTY RESEARCH ETHICS COMMITTEE
ANNEXURE B

CONSENT FORM: FOR THE PSYCHIATRIC CLINIC
REQUEST FOR CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

Annie Ternane, an M. Cur. (Psychiatric Nursing Science) student at the Rand Afrikaans University, is presently engaged in a research project entitled: "The experiences of victimised men in group intervention in a psychiatric institution." The research project is done under the supervision of Professor M Poggenpoel and Professor CPH Myburgh.

The main objective of this study is firstly to explore and describe the experiences of victimised men in group interventions in a psychiatric institution.

Secondly, to formulate guidelines for the advanced psychiatric nurse-specialist to facilitate and promote mental health for victimised women in group interventions.

A semi-structured, in-depth interview will be conducted with victimised women of forty-five to sixty minutes to determine the experiences of victimised women in group intervention. The interviews will be audio-taped with written consent of the participating women. I will ensure the confidentiality of the institution and the participating women by omitting names. Confidentiality will be ensured by erasing the audio-tapes, when the necessary information is obtained.

This research, the benefit of victimised women will be, their moment at that time to voice out experiences in group intervention. Long-term benefit will be the guidelines formulated to facilitate and promote mental health for the victimised women in group intervention. Feedback will be given to the institution, participants and the guidelines which have been formulated.
By completion of the abovementioned, if you agree, give informed consent in order that the research can be executed in your institution.

Thank you for your kind co-operation.

Signed ........................................................................................................on ........................................................................................................

Day of ........................................................................................................2002.

SIGNATURE: INSTITUTION

[Signature]

A THEMANE (Ms)
CUR (Psychiatric Nursing Science) student
RESEARCHER

[Signature]

MARIE POGGENPOEL
STUDYLEADER

[Signature]

MARIE POGGENPOEL
STUDYLEADER
ANNEXURE C

CONSENT FORM OF THE PARTICIPANTS FOR THE RESEARCH STUDY
Dear Participant

PARTICIPATION IN A RESEARCH PROJECT

I hereby invite you to participate in a research project aimed at providing information of sharing, healing and hope.

I, Annie Temane, an M. Cur. (Psychiatric Nursing Science) student at the Rand Afrikaans University, is engaged in a research project entitled "The experiences of victimised women in group intervention in a psychiatric institution." The research project is done under the supervision of Professor M Poggenpoel and Professor CPH Myburgh.

This is your opportunity to voice your experience with regards to group interventions. This research will be used to describe guidelines to facilitate and promote mental health for victimised women.

Your contribution is of extreme importance in this research as you are the expert of your life. A semi-structured interview will be conducted with you approximately for forty-five to sixty minutes.

The interview will be audio-taped with your permission. After completion of data analysis, all these audio-tapes will be erased. At all times anonymity and confidentiality will be ensured by omitting names and the name of the institution.

Although you consent to participation, you have the right to withdraw at any stage of the research. You are also assured that at no stage of the research, you will be forced to participate in this research.

Thank you for allowing me into your world.
Signed ...........................................................................................................................................
on ...........................................................................................................................................
day of .......................................................................................................................................... 2002.

SIGNATURE: PARTICIPANT

M A THEMANE (Ms)
M. CUR (Psychiatric Nursing Science) student
RESEARCHER

PROF M POGGENPOEL
STUDYLEADER

PROF CPH MYBURG
CO-STUDYLEADER
ANNEXURE D

CONSENT FORM FOR PSYCHIATRISTS TO GIVE PERMISSION FOR PATIENTS TO PARTICIPATE IN THE RESEARCH

UNIVERSITY OF JOHANNESBURG
Dear Psychiatrist

REQUESTING CONSENT FOR RESEARCH

I, Annie Temane, an M. Cur. (Psychiatric Nursing Science) student at the Rand Afrikaans University, is presently busy with the research project entitled: "The experiences of victimised women in group intervention in a psychiatric institution" under the guidance and supervision of Professor M Poggenpoel and Professor CPH Myburgh.

The goal of the research is to explore and describe the experiences of victimised women in group intervention. From this guidelines will be described for the advanced psychiatric nurse to facilitate and promote mental health of victimised women.

With your permission, I would like that your patients, who have been or are in victimised relationships, should be referred to the researcher for the purpose of executing this research. The research will be conducted in the form of a semi-structured in-depth interview of approximately forty-five to sixty minutes. The interviews will be audio-taped with the consent of the participants, your consent for women participants to take part in the research, for verification by an independent expert.

I undertake to ensure anonymity of your patients in this research by excluding their names. Confidentiality will be ensured by erasing the audio-tapes after use.

Sir/madam, by completion of the above-mentioned, you give informed consent for patient/patients to participate in this research project.

Thank you for your kind co-operation.

Signed ........................................ on .........................................................

day of ......................................................... 2002.

SIGNATURE OF PSYCHIATRIST
ANNEXURE E

EXAMPLE OF A VERBATIM TRANSCRIPTION OF ONE OF THE INTERVIEWS
ANNEXURE E

Verbatim transcription of one of the phenomenological interviews.

Key: A: Annie
     R: Respondent

A: Good day, L and how are you?

R: Fine thanks and you?

A: Fine. R, as you know I have said that I would like to interview you for the purpose of the research that I am doing for my studies.

R: Mmm.... (She nods).

A: I would like to go over the rules with you as I have discussed with you in the group interventions. Confidentiality of this conversation will be kept and the tape will be erased after the data has been analysed. The question I am going to ask you is related to the three series of group interventions that you have attended. Please, I would like to encourage to speak up, because there is a lot of noise outside. I will be tape recoding so that I can listen to it afterwards. So, my question to you is: How was it for to be in the group interventions?

A: Ok, first of all I was very happy to see that it was such a large group. And also very sad to see that there is so many people that are being victimized and thirdly I’m grateful there is a group such as this to help people to get through it. To actually being able to identify ‘uhm’ what it is, who you are, whether the person is the perpetrator, and how you can lift yourself from the situation like that. I had an experience in my job, it was a change of the government, where I worked for a general. ‘Uhm’, I am in the police and we are not really protected against sexual harassment because they will always take the dominant figure, the male who generally has a higher rank in work, and ‘uhm’ this guy actually wanted to sleep with me. And I refused, and he really started harassing me. He started locking doors and I got scared every time and he could just do what he wanted to do. I just...just with the snap of his fingers, then I would almost crawl on the ground like a worm. This guy did eventually raped me, against my will, I could never tell my husband, because my husband is also very abusive. So can you imagine if I told him this has happened to me, he would never believe me. So I was just this absolute pathetic person. It became very lonely for me, so I indulged in my work. I just thought, by working my backside off, I thought I will be able to forget about this... until I reached the burnt out point. And attending these sessions, ‘uhm’, it’s not as I have said, its not a miracle cure, it’s like a first aid kit that you are carrying on your back... and the people equip you so well. You can...you recognize that you are a human being. You are unique, you are not that bad. What has happened to you... there is healing with the necessary
'uhm' professional help, which also starts here (pointing on her chest). I will eventually overcome that. From there I can start taking it step by step, day by day, and getting over the process and I can actually reach up from being the pathetic person on the ground, to be the person that I will like. In these group, I found out that I'm not rubbish 'uhm' I can love myself and I can interact with people and I feel that I can face the perpetrator 'uhm', not on the parent-child level but on the adult-adult level. And I can practice to talk to that person without degrading myself, but speak to that person in such a manner...without degrading the other person as well. Also respecting...sometimes it's not very easy... that person's dignity. But it's 'uhm' it's a lesson that one has to learn and I think that is what the society expects of us to do... to be have in a civil manner. Because to carry on degrading and fighting, feeling pathetic, feeling insecure 'uhm' you only have one life. And I learnt here dearly, it's one life and I'm going to take each day as it comes... and I'm going to leave it to the fullest. I'm not going to waste it, I'm sure that is not what we are meant to do in this world. And these sessions really assisted me in this manner. It really picked me up from the floor, I am on my feet and I was taught to walk, so I'm going to start walking.

A: How did these sessions assist you in this walking?

R: By telling you that 'uhm' you must love yourself. 'Uhm' by not lashing out, by 'uhm', realizing you also have problems and also faults and sometimes you also can be the perpetrator. By looking introspective into yourself and to actually see both sides very clearly and then to see that there is a helping hand for you.... Where you have started and as I have said...the lifting up and to give you the necessary tools to carry on. The third session 'uhm'....it was very emotional for me, because I think I had to get in touch of my feelings. I was very emotional, especially writing the letter about..... taking it all out on a letter. It was very emotional. Being able to realize that you are not alone- with the other women, what they shared about the letters, what 'uhm'...it was very emotional, but very helpful, because I felt that I am...ready to go out there to although it's going to take a lot of time. It is a process....'uhm', but I feel that I'm ready to...to face the abusive relationship and I've learnt I can not change the person, but I can change the situation that I'm living in.

A: You mentioned that the other women in the group were supportive. Tell me more about that.

R: It is hard to open up before other people, but I believe this is the only way of holding hands together, to communicate and assist each other to get help for what we have experienced in our lives. I think the group helped us to support each other and not to look down on each other.

A: Tell me more about other experiences of the groups.

R: I understand now that I need a lot of forgiving to do. I firstly need to forgive myself. 'Uhm'... I think that is what happened in the group, I was sitting there and I felt unstuck suddenly when the word o forgiveness was mentioned. It dawned on me that I need to forgive myself before I can forgive the
perpetrator. You know, A, I feel good, I feel relieved. It was good to be here, to be in this group. I think it is a real must to attend these group, women or who ever has been abused must start here. Because it would give people the courage to carry on... because a lot of people who are with me in my room are being victimised, but they are not here....they have missed out, I give them message of this... to stand against the victimization. I’m very lucky that I could attend these groups. This is a walking aid, if I could have missed this sessions, I could have not learnt to walk. You can attend all the other sessions, but I think this ‘uhm’, sessions we did for the three days is the foundation of the healing process...to realize what is involved in victimization, who the role players are...and to play the game in a civil manner. I really think highly of this sessions. I’d like to say...if these sessions were repeated on weekly basis, I would go all over again (smiles).

A: Is the any other thing that you want to share with me about the group interventions?

R: Yes, ‘uhm’ they were very much helpful... they really changed my life. Because I had to deal with my pain, and through this session I went that pain as I have never dealt with it before, I feel I still need to do more cleaning up, to become the whole person again. This group have assisted me to do just that. And I have got lots to be thankful for. I have hope for my situation.

A: We have come to the end of the interview, is the any other experience that you like to share?

R: No. I cannot think of anything in particular at this moment.

A: Thank you very much for your time.

R: Thank you.

A: Goodbye.
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<th>Observational notes</th>
<th>Theoretical notes</th>
<th>Methodological notes</th>
<th>Personal notes</th>
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<td>There was a sense of uneasiness amongst the group members during the group intervention when the facilitator explained the dynamics of abuse.</td>
<td>One of the women was totally speaking Afrikaans could further attend the group sessions. She was referred for individual therapy.</td>
<td>The focus in the groups should be on the experiences rather than on feelings.</td>
<td>I experienced a sense of “flashbacks” about own personal experiences of victimisation. I would sit there in the groups and feel like am I also receiving assistance in dealing with abuse.</td>
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<td>The first session of the group seemed to be difficult for the group members to share their experiences.</td>
<td>Some women do not easily share their stories. Others confront these women to tell their experiences.</td>
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<td>It seemed that other members of the group did not understand what victimization was all about or do not know what to do with their victimization stories.</td>
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<td>During the second sessions, the women were able to share their experiences about the theme of victimization. Even the silent members could at least nod their heads, to confirm that they also agree with what have been said.</td>
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<td>At the end of the sessions women give each other phone numbers, others cry, there is a lot of comforting.</td>
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ANNEXURE G

PROTOCOL TO THE INDEPENDENT CODER
PROTOCOL TO THE INDEPENDENT CODER

The following steps were followed during a conversation with the independent coder and the implementation is discussed as follows:

1. Read through all the seven transcriptions of the phenomenological interviews to get the sense of whole.

2. Take one interview and identify the possible main themes, remaining themes and contrast themes. Repeat this process for all the seven interviews.

3. Group the categories and identify the descriptive word for the category.

4. Use the categorised descriptive quotations from the dialogue that are overlapping.

Two consensus conversation meetings with the independent coder were scheduled and deadline dates were discussed.
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