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**INVESTIGATING TREATMENT STRATEGIES FOR ADOLESCENT
RAPE SURVIVORS:
A Grounded Theory Analysis**

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**A minor dissertation submitted in partial fulfilment of the requirements for
the award of the degree of MA in Clinical Psychology**

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COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature

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Date: 18 June 2009.

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ABSTRACT

An evaluation conducted by the Rape Crisis Cape Town Trust (RCCTT) revealed that over 43% of their clients were teenagers, and a preliminary search of the current literature revealed a dearth of studies on the interplay between the developmental stage of adolescence and treatment of the adolescent rape survivor. This study therefore aimed to explore factors to consider when devising treatment strategies for this unique client group. Individual and focus group interviews with clinical practitioners, Rape Crisis staff members, and lay counsellors from each of the Rape Crisis Centres in the Western Cape, who had worked with rape survivors in this age group, were conducted, using an open-ended, semi-structured interview schedule. A grounded theory analysis of participants' experiences of working with adolescent rape survivors was then carried out. Patterns that emerged from this data tended to focus on basic guidelines that the practitioners' followed, the influence of the family and social systems on the therapeutic process, and the challenges that practitioners experienced in working therapeutically with these adolescents. This data was then combined with literature in the areas of trauma, adolescent development, and treatment strategies. The findings demonstrated that victimization in the stage of adolescence is a complex phenomenon that calls for maintaining a 'paradoxical position' by the practitioner, and that requires a multi-dimensional approach to treatment. On the basis of the findings, four broad categories, including 1) the stage of recovery of the client, 2) symptoms and behaviours present, 3) level of development the adolescent is functioning at, and 4) the influence of the system on the adolescent's healing, were suggested as starting points for planning interventions, and a number of treatment strategies that materialized from the study were discerned under these categories. Recommendations for future research were then proposed to further the body of knowledge in this field.

Keywords: adolescence, rape, sexual abuse, treatment strategies.

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‘deeper, richer, context-bound understanding’ of the defined research problem that separated the qualitative approach out as the preferred method of study.

In Chapter Three a further argument for the use of the grounded theory approach for this particular study is offered, followed by an outline of the basic principles and procedures of the approach, and how they were adapted to this investigation. The main body of the research, the findings and discussion, is presented in Chapter Four. In this chapter, the various categories and themes that emerged from the participants subjective accounts of their experiences of working with adolescent rape survivors is recorded, together with specific examples as they were communicated by the participants, and this is discussed in relation to the literature in order to enrich the material and our understanding of working with adolescent rape survivors. Following from this, Chapter Five offers some ideas about the significance and limitations of the study, and concludes with a number of recommendations for working with adolescent rape survivors on the basis of the literature and findings.

The literature review that follows offers a number of factors to consider when working with adolescents. Important to note here, when considering a literature review for the grounded theory approach, is that unlike quantitative studies where a research problem usually evolves from the literature, in a qualitative study the analysis is based on “finding categories and concepts within the data, not by bringing them to the data from the literature or anywhere else... [so that] it makes sense to delay this stage of the work, at least until conceptual directions within the data have become clear” (Punch, 1998). According to Punch (1998), the purpose of the literature review is thus not to formulate specific hypotheses to be confirmed or disconfirmed, but rather to catalogue a variety of significant ideas that is fed into the

analysis at a later stage (ibid.). Thus the literature was reviewed with this basic understanding in mind, and is covered in detail in the next section.

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CHAPTER 2: LITERATURE REVIEW

A literature search into treating adolescent rape survivors revealed a dearth of studies on the interplay between the unique set of developmental tasks and needs of adolescence and the treatment of the adolescent rape trauma survivor. Instead there seems to have been a historical tendency to lump the adolescent together with children or adults, so that the specific issues of the rape trauma superimposed on the unique problems of adolescence often tends to be ignored. The other tendency is to write about trauma in general without separating out the rape trauma as a unique experience with specific effects on the life of the adolescent. The literature review is thus divided into three areas, namely: 1) a general introduction to trauma and rape; 2) the impact of rape on the developing adolescent, for the purposes of highlighting the various factors to consider when treating an adolescent rape survivor; and 3) existing therapeutic models of working with rape trauma survivors, and the literature that is available in working with adolescents, and adolescent rape survivors. These divisions reflect the need to understand each of these domains separately, and to discover the overlaps between them, in order to start thinking about relevant factors to consider in building the foundations for finding effective strategies of working with adolescent rape survivors. The rest of this chapter therefore documents the literature in more detail under the three areas described above.

2.1. Trauma and Rape

The term 'trauma' comes from the ancient Greek word meaning to 'wound' or to 'pierce', and can be understood in this context as a piercing or wounding of the person's psyche and an overwhelming of their physical and psychological defences and ways of coping (Spiers &

Harrington, 2001). According to Melzak (1997), this can lead to disconnection, where boundaries are broken between past and present, conscious and unconscious, internal and external experiences, and memories and feelings. Emotions, cognitions, memories and physiological responses thus become severed from one another, disconnected from their source, and tend to persist in an altered and exaggerated state long after the actual danger is over (Herman, 1992). This assault on the individual's internal and external worlds often shatters their basic assumptions so that their inner world is no longer able to provide a trustworthy map for negotiating daily life and the external world is now perceived as frightening, unpredictable and incomprehensible (Janoff-Bulman & McPerson Frantz, 1997). This can produce states of extreme anxiety and partial or total ego disintegration or disorganization (Rubin, 1999), and there is less energy for the present as energy is caught up with the past and extreme emotions (Herman, 1992).

According to the Diagnostic and Statistical Manual IV-TR (2000), when a person has experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; and their response involved intense fear, helplessness, or horror, symptoms of Acute Stress Disorder (ASD) or Post-Traumatic Stress Disorder (PTSD) may develop. These include the re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma, and persistent symptoms of increased arousal. The victim is diagnosed with the disorder when the disturbance causes significant distress or impairment in important areas of their functioning for at least two days for ASD, or for more than one month for PTSD (ibid). In Van der Kolk (1996), however, studies of various traumatized populations showed that the syndrome of intrusions, avoidance and hyperarousal does not adequately explain the complexity of long-term adaptations to traumatic life experiences, and fails to take into

account the variety of contributions to the genesis of these problems. Carr (2006) conceptualises the development of psychological problems as arising from risk factors which predispose people to developing problems, precipitating factors which trigger the onset or marked exacerbation of psychological difficulties, maintaining factors which perpetuate problems once they have developed, and protective factors which prevent further deterioration and have implications for prognosis and response to treatment. We should therefore not oversimplify the complex interrelationships among specific traumas, secondary adversities, relational, environmental and attachment problems, and other causal influences to the development of PTSD or other psychiatric syndromes (Van der Kolk, 1996).

Rape, following from this, is a specific kind of trauma, where some of the defining features are that it is sudden, it is a physical, sexual and psychological violation that is perceived as life threatening and is often violent, the survivor is forced to participate in the crime, and the survivor cannot prevent the assault or control the assailant so that their normal coping strategies fail and they become a victim of someone else's aggression (Burgess & Holmstrom, 1979). Rape Trauma Syndrome (RTS) was the term given by these practitioners to the cluster of symptoms they observed as a result of their crisis counselling of rape victims, but it is not categorized in the DSM IV-TR. Burgess and Holmstrom (1979) stated that although RTS is similar in profile to PTSD and ASD, there are a few symptoms that are markedly unique to the rape trauma. These include a feeling of contamination and resultant compulsive washing, self-blame and guilt for somehow having 'participated' in their rape, and feelings of shame that they were maliciously violated and rendered helpless at the hands of a perpetrator whose apparent need was to terrorise, dominate, and humiliate the victim (ibid.). RTS, according to Burgess and Holmstrom (1979), is a natural response of a psychologically healthy person to the trauma of rape, and it is only when this pattern becomes

entrenched or unlikely to change, and affects the person's functioning in a permanent way, that it is referred to as a disorder and is regarded as a mental illness. However, Rutter, Taylor and Hersov (1994) noted that when trauma is deliberately perpetrated, the ensuing distress is greater, possibly due to the public nature of most other traumatic events versus the secrecy (and sexual nature) of rape. It was also observed through clinical studies that most rape survivors suffer severe and long lasting emotional trauma, but that this could be prevented if detected early enough, if they were treated while still in the early stages as symptoms have not yet become crystallised and are thus far easier to treat, and/or if symptoms did not form part of the complex PTSD category where the person's pre-morbid functioning was already impaired (Burgess & Holmstrom, 1979).

The 'complex PTSD' (Herman, 1992) – also known as Type II trauma syndrome (Terr, 1991) - referred to above describes the often more complex symptom presentation of survivors who were exposed to severe, prolonged, or repeated trauma such as childhood sexual abuse, and is also not listed in the DSM IV-TR. In psychiatric or clinical psychology traditions, these are often the people who will receive a diagnosis of PTSD, or one of the other diagnostic categories like a Mood, Psychotic, or 'Cluster B' Personality Disorder, depending on their "often bewildering array of symptoms" (Herman, 1992). Herman notes that psychiatric hospitals are often filled with these kinds of patients, and the lack of a more accurate diagnostic concept has consequences for treatment because the connection between the patient's present symptoms and the traumatic experience is frequently lost. Terr (1991) writes that studies of mentally-ill patients with a variety of symptomatic responses were often abused or shocked in their own childhoods, and according to Van der Kolk (1996), these patients seem to organize much of their lives around repetitive patterns of reliving and warding off traumatic memories, reminders and affects. Rape victims often describe a

childhood history of sexual abuse, and Marx, Heidt and Gold (2005) propose that in cases of sexual revictimization, various forms of emotion regulation may produce symptoms or behaviours that signal vulnerability to sexual predators, and an impairment of the ability to properly process danger cues which impedes successful defensive behaviour. Van der Kolk (1996) agrees that trauma leads to problems with the regulation of affective states which makes people vulnerable to engaging in various pathological attempts at self-regulation, such as eating disorders, sexual disturbances, substance abuse or self-mutilation. Marx et al. (2005) add that extreme arousal leads to dissociation and the loss of the capacity to put feelings into words; and that failure to establish a sense of safety leads to characterological adaptations that include problems with self-efficacy, shame, and self-hatred, as well as difficulties in working through interpersonal conflicts. What these authors (Marx et al., 2005; Van der Kolk, 1996) are trying to impress is that adaptation to trauma is complex and multi-faceted, and that failure to consider all the variables will have implications for treatment.

In addition to the overwhelming nature of trauma in the lives of individuals, one also has to consider that there may be similarities as well as differences in the reaction of the young person to sexual assault (as compared to adult responses), where both may have the experience of disorganization and of having to reorganize their disrupted lifestyles, but where there could be differences in the different personality styles of adolescents, the developmental crisis still facing them, the manner in which the trauma is experienced, the reaction of family members to overwhelming feelings (e.g. to blame either themselves, the child, or the assailant), and the young person's ability to report their distress (Burgess & Holmstrom, 1979). Rubin (1999) points out that the combination of adolescence and trauma brings together two very complex areas, so that superimposing the experience and typical symptoms of the rape trauma onto the multitude of developmental challenges which already presents the

individual with varying degrees of stress implies a complex task for this group. It points to the possibility of the adolescent rape survivor becoming emotionally overwhelmed, developmentally arrested, and/or 'characterologically' or more permanently affected or functionally impaired (ibid.).

2.2. Adolescent Development and Rape

Adolescence, marking a transitional stage between childhood and adulthood, begins with the onset of puberty and brings with it a number of developmental tasks, the successful completion of which will enable the individual to function optimally as an adult.

Development is characterized by continuous, accumulated experiences as well as discrete, age-specific periods of growth in the physical, intellectual, and social dimensions (Gil, 1996).

In the first category, pre-disposing factors in early life need to be considered, as these early traumas could be re-triggered by, and compound the effects of, exposure to trauma in later life. Thus the adolescent's reaction to being raped depends on influences such as early attachment patterns, temperament, self-regulation strategies, personality characteristics, family dynamics, social environment, and so on (Carr, 2006). Rubin (1999) agrees that the notion of psychic trauma, the psychological effect of an extreme external stressor, is a relative idea based on a number of variables, such as in a vulnerable teenager who has become predisposed and sensitized to the repetition of trauma due to early distressing experiences or pre-oedipal trauma; loss of a parent or sibling; sexual over-stimulation and/or abuse; or illness or exhaustion in the adolescent. In these cases trauma can be seen as overwhelming a weak and disorganized ego that is further compromised by the state of flux and disintegration of adolescence. For a more stable personality, resistance to the impact of trauma or resilience may be stronger (ibid.).

In addition to this, it is the discrete tasks peculiar to adolescence that will form the focus of this review in the hopes that it will shed light on some of the developmental needs of the adolescent and how these might also interface with the effects of the rape trauma. In the physical dimension, one of the tasks that needs to be negotiated is that of adjusting to the impact of puberty and the changing body, which often involves the adolescent's preoccupation with self-image, as well as questions of control and adequacy, mutuality or intimacy in relationships, and negotiating sexuality and developing a sexual identity (Gil, 1996; Holmes, 1991). Another task to master is that of cognitive development, in which the expected norm is an increase in both quantitative and qualitative intellectual ability (Louw, 1995). In particular, Piaget (1958, in Louw, 1995) noted an increased ability for abstract reasoning in which the adolescent is able to think about situations hypothetically and to use logic in more elaborate ways than younger children. The adolescent development of morals and values is related to this increased ability for abstract, 'formal operational' thinking (Louw, 1995). Gaining mastery over these physical and intellectual challenges will enable the adolescent to achieve the third task in the social dimension of separation and individuation. This involves identity formation, establishing a degree of autonomy and self-resource, awareness of complex emotional cycles and thought processes, developing self-regulation coping strategies, and negotiating important role transitions like driving a car or first sexual relationships (Carr, 2006; Holmes, 1991; Leffert & Peterson, 1995; Louw, 1995). Related to this, teenagers also face the dilemma of group identity (peer, family and community) versus pursuing personal goals and individuality (Holmes, 1991). A more in-depth discussion of these discrete challenges follows; with a view to discerning at least some of the ways in which trauma might negatively impact on the attainment of these age-specific skills.

In the first task of *adjusting to the impact of puberty and the changing body*, the adolescent must, amongst other things, come to terms with their sexuality and develop a sexual identity, following a period of rapid physical growth, hormonal changes, increasing sexual drive, the development of primary and secondary sexual organs and characteristics, and the attainment of sexual maturity i.e. the ability to reproduce (Louw, 1995). Finkelhor (1995) pointed out that sexual maturation tends to make teenagers, especially girls, more vulnerable to sexually motivated crimes (barring incest and certain paedophilic preferences), and various studies have found that the effects of sexual victimization on adolescents includes disturbances in sexual identity and sexual functioning (Browne & Finkelhor, 1986), promiscuity and disturbances in sexual orientation (Burgess, Hartman, & McCormack, 1987), and distortions in body image (Straus, 1994). There is also evidence that sexual abuse and other trauma can hasten the onset of puberty (Herman-Giddens, Sandler, & Friedman, 1988; Putnam & Trickett, 1993). On the whole it was also found that adolescents are experiencing puberty at an earlier age, appearing more physically mature than previous generations, and there has been a simultaneous drop in the age of first sexual encounters (Leffert & Petersen, 1995). Personality characteristics may also affect victim targeting (Finkelhor, 1995). Related to this, early adolescence is marked by a narcissistic preoccupation with their changing bodies, where the teenager's body image is linked to their self-esteem which is, in turn, determined by other people's perceptions of them - all of which has to be integrated into their existing identities (Louw, 1995). This physical metamorphosis can thus become a source of concern and increased anxiety among many young people (Gil, 1996), making them increasingly vulnerable to psychosocial adjustment problems, emotional and psychosomatic problems, negative body image, more norm-breaking behaviour, and sensitivity to feelings of inferiority and rejection. (Leffert & Petersen, 1995). It was hypothesized in the report of these researchers that early puberty and related issues may well cut short the time needed to

consolidate the skills and tasks of this period (ibid.). Carr (2006) adds that self-devaluation and idealization of others, promiscuous acting out versus apathetic withdrawal as defences against dealing with the anxieties that puberty elicits, as well as various environmental stressors that overwhelm the adolescent, could lead to resistance, developmental arrest, and/or ultimately prevent the working through of this phase. Other potentially negative influences to these adjustments to puberty and changing needs of adolescence include socio-cultural values around issues of body image, sexuality and sexual orientation, and morally appropriate behaviour (Louw, 1995). From this brief review it is clear that the issue of having to negotiate the onset of puberty is already a complex one for adolescents, so that superimposing an external trauma like rape on top of this, as well as the various symptom presentations that result from trauma, will inevitably compound the problem in some way, and may well set the adolescent into an arrested or distorted course of physical or sexual development.

The *cognitive development* of adolescence includes a new ability for abstract thinking, as posited by Piaget, which enables more sophisticated solving of more complex problems and thus an increased ability to recognize relationships, form concepts, reason and incorporate new knowledge into existing cognitive frameworks (Louw, 1995). Alongside this is a newfound ability for idealism, for constructing hypothetical situations, and for reflective thinking. It is a different type of egocentrism to childhood in that adolescents often become preoccupied with their own thoughts in the service of developing their incomplete identities and of making sense of their external and internal worlds (Gil, 1996; Louw, 1995). This expanded ability for philosophizing also enables the adolescent to consider alternative values to his or her parents. In turn, this assists in the building of their internal psychic structure and in developing a stronger sense of self as separate from others, as well as increasing their

knowledge, understanding and trust in the workings of the external world, which enables the process of individuation to occur. Given their limited experiences, however, adolescent thoughts are not necessarily tested against reality and may thus become somewhat distorted (Gil, 1996), or their lack of experience and the emotional charge peculiar to adolescence may render them less able to use their decision-making abilities maturely (Leffert & Petersen, 1995). In addition to this the external circumstances to which the adolescent is exposed may themselves be distorted, affecting the development of their cognitive schemas and beliefs, for instance about their worthiness, what is right or wrong, their ability to control their environment, and what can be expected from the future (Gil, 1996). Thus their developing ability to reflect on and assign meaning to their life experiences may be greatly compromised by the impact of trauma. It is well documented in the psychoanalytic tradition that extreme trauma can lead to deficits in symbolic functioning and productive thinking (Boulanger, 2005; Fonagy, Gergely, Jurist & Target, 2002; Ogden, 2003), and for the teenager for whom this is still only a 'developing' ability, trauma can have dire consequences in terms of having the mental resources to cope. Sugar (1999) suggests that adolescents should therefore be given more information than is usual, along with an appeal to their cognitive abilities and experiences. Linked to cognitive development, Carey (2008) reminds us that the vast majority of brain growth occurs in childhood and adolescence, and severe stress during these developmental stages can result in lasting structural and functional damage, producing amongst other things differences in the encoding of incoming information in memory, difficulties in processing the information and in learning from the experience, enduring behavioural changes in the direction of either fight or flight [or freeze] (Van der Kolk, McFarlane & Weisaeth, 1996), and various physical or psychological symptom presentations depending on the chemical and hormonal changes incurred (Carey, 2008; Lester, 2003; Van der Kolk et al., 1996). Thus it is not only the ability to incorporate new learning into existing

experiences that is affected by trauma; basic neuropsychological functions of being able to attend and encode, retrieve or remember information, and process it in a way that can help the adolescent to solve problems are also likely to be disrupted. This of course may affect many important areas of their functioning, such as academic and social, further compromising self-esteem and self-efficacy, and ultimately the task of individuation.

In the task of *separation and individuation*, issues of identity, intimacy and of belonging become highlighted, particularly in the context of the peer group, as parental ties start to loosen and adolescents begin to seek out new objects (Holmes, 1991). Blos (1967) conceptualized adolescence as a 'second individuation process', which closely resembles the first individuation phase of infants' separations from the symbiotic relationship with their mothers, where the adolescent must deal with issues of self-differentiation that involves separation from early object ties or disengagement from parental internalizations, followed by a re-organizing of ego structures into stable patterns that firmly represent the self as different and separate from others. Ultimately the goal is to develop a greater sense of autonomy and stability that will be reflected in the individual's later adult life. Erikson (1968) stated that the 'identity crisis' of adolescence involves redefining him- or herself and his or her role in society. During this stage of 'identity development versus role confusion', the adolescent will either negotiate the crisis period successfully, resulting in a stable identity, or become developmentally arrested as a result of external demands and internal conflicts, and be left with an identity that is foreclosed (aimed at receiving parental/societal approval), negative (contrary to cultural values and expectations), or diffused (not committed to anything) (ibid.). Factors that could adversely affect the healthy individuation and development of an identity include: 1) the unsuccessful reworking and mastering of unresolved early childhood traumas during the stage of adolescence, and thus the inability to find satisfying ways to cope with the

ongoing impact of the original trauma; 2) parental/societal lack of respect and understanding for the adolescent's struggle for freedom from infantile dependencies in tension with their continued need for support and caring responsiveness; 3) lack of facilitation of the adolescent's process of differentiation through parenting or external forces that are either too restrictive of their search for freedom, or too un-boundaried and ungrounded in their need for limit-setting (so that the adolescent is unable to draw from a stable resource while their intrapsychic structures become unfastened); and 4) lack of ego continuity in which the adolescent's experiences and history is denied due to situations where the teenager is forced to accept a distorted reality in order to survive, so that development and integration are arrested (Blos, 1967). Some effects of a failure to adequately negotiate these developmental tasks are that these adolescents are unable to gain mastery over their anxieties, become restricted by internal preoccupations and conflicts, show a limited capacity to tolerate frustrations and extreme feeling states, and are compulsive and driven to engage in extreme forms of self-destructive behaviour (Holmes, 1991). According to Friedrich (1995b, in Gil, 1996), abused adolescents often have specific symptoms reflecting self-related issues, including an unstable sense of self, marked identity problems, distorted self-image, reduced self-efficacy, atypical depression, and borderline features.

In summary, this section shows that because of the variety of developmental tasks and needs of adolescence, trauma could lead to disruptions in any, or all, of these developmental processes. These multiple layers need to be borne in mind when working with teenagers, as the adolescent rape victim will more than likely present with a number of these other developmental difficulties too. The next section documents some of the theories in treating rape survivors and the challenges found in working with adolescents in general as well as in

those who have been abused, and in many cases this is supported by strategies for dealing with these issues.

2.3. Working with Rape Survivors and Adolescents

Most authors agree that survivors of rape tend to go through a number of stages of recovery that do not necessarily follow a linear sequence (e.g. Burgess & Holmstrom, 1979; Herman, 1992; Sutherland & Scherl, 1977). For example, Herman (1992) refers to the stages of establishing safety, remembering the trauma and mourning losses, and integrating the experience, reconnecting with society and reclaiming his or her world (Herman, 1992), while Sutherland and Scherl (1977) identified an acute reaction occurring immediately after the rape, followed by outward adjustment, and finally integration and resolution of the experience. Burgess and Holmstrom (1979) describe two phases of the rape trauma syndrome: the first is the acute or immediate phase of disorganization, and the second phase is the long-term process of reorganization. In a study in which preteen and teenage female survivors were asked about their treatment experiences in an attempt to enhance understanding of the sexual abuse disclosure process, researchers advocated integrating existing theories and research into a model that deals with three separate phases of disclosure (Staller & Nelson-Gardell, 2005). These include the *Self phase* in which the teenager is ready to tell about their abuse, but may not provide sufficient information to substantiate it, so that providing them with an accepting and safe emotional and physical space is necessary. In the *Confidant selection—reaction* stage, support and belief from significant others is key to further disclosing, and the way others respond to partial, accidental or indirect disclosures may be critical to the direction that their healing journey takes. In the *Consequences phase*, helping teenagers to understand and anticipate the myriad of personal and environmental consequences to disclosure may help them regain a sense of control of their own life story

and allow them to respond proactively (ibid.). The discussion that follows looks at various therapeutic factors and findings to consider when working with adolescents through these stages of recovery, but given the uniqueness of each individual's process and the likelihood of the stages overlapping, it is not possible to indicate what to focus on when. However, Auerbach, Salick and Fine (2006) found that intervention strategies used will very much be determined by what stage of the trauma and recovery process the client is in, what issues the client is dealing with within this stage, and an evaluation of the practitioner's resources and skills in providing what the client needs to deal with these issues more successfully, so it would be beneficial to keep these stages in mind. Also, since this review attempts to bring together a number of clinical experiences and research findings in work done with trauma survivors, adolescents, and abused adolescents, it cannot include all that has been written in the well-documented field of trauma itself, and may well fall short of covering all the needs of, and areas that comprise, this complex client group.

Immediately following a sexual assault, the victim's feelings may include shock, disbelief and fear, and they may be physically injured and need medical attention, still be in danger from the perpetrator and need to be relocated, want to press charges, or have other practical concerns like being pregnant (Sutherland & Scherl, 1977). Burgess and Holmstrom (1979) include the immediate impact reaction (in the form of either expressed or controlled emotion), physical reactions (injury, and/or sleeping/eating disturbances, amongst other things), and emotional reactions (in response to the threat to the person's life such as fear, degradation, shame, self-blame, anger and/or revenge). Thus authors note that the first stage is basically one of establishing safety through helping the survivor attend to practical issues, clarifying basic information, and encouraging dialogue about his or her ordeal or concerns in a warm, calm, empathic and consistent environment (Sutherland & Scherl, 1977). Sutherland

and Scherl (1977) found that once survivors resume their normal activities they may lose interest in seeking help and talking about the rape experience, and the authors reassure clinicians and counsellors that this is a healthy response of attempting to re-adjust and should be supported rather than challenged. Many rape survivors will only seek help for the first time during what they refer to as this 'phase of outward adjustment', and often it is at the urging of a friend or relative. If this is so it would be helpful, in these authors views, to explore the survivor's feelings with regards to seeking help, as well as to interview the referrer with the aim of giving them an opportunity to talk about their own feelings, and to give them information about the victim's current status and predictable future reactions (ibid.).

Once practical issues of safety have been adequately dealt with, there may be space for the adolescent to begin talking about their experiences. For Bronstein and Flanders (1998), the very first contact with young people is crucial in the development of a therapeutic alliance, and involves not only an initial assessment of the adolescent's difficulties, but already aims to address his or her anxieties through putting the survivor in touch with primarily those anxieties that are closer to consciousness (such as feeling out of control, being afraid of being deserted if people knew their secrets, or wishing to destroy themselves). Without containment through reflecting understanding, which opens the possibility for a space for thinking, there is little prospect of the adolescent being able to sustain ongoing psychotherapy (ibid.). Gil (1996) proposes a number of general principles to help build rapport and establish a therapeutic alliance with abused adolescents. Taking a non-judgmental attitude is especially important since these adolescents seem acutely sensitive to being judged, and avoiding challenging their initial statements will help them to feel respected and that they are believed. Adolescents often relate to clinicians as if they were extensions of their parents, or authority

figures who have control over their lives, or they may try to be their friend in order to loosen these perceived controls, and it is imperative to maintain firm boundaries, adopt an attitude of respect, and avoid power struggles when working with an adolescent. A strategy for addressing adolescent resistance is to communicate that they are in control of what they say, and inviting them to say what they want. Also, maintaining a positive attitude towards the rude, hostile, or passive and compliant adolescent often helps to disarm them (ibid.).

It is important to note that adolescents, on the whole, relate differently than adults to treatment situations. According to Sugar (1999), adolescents who are traumatised may disavow or deny their symptoms of distress, and are generally not motivated for treatment. Also, they may show an intense, but fleeting attachment to the counsellor, the therapeutic relationship may be unpredictable, they will often be critical of adults and the social institutions they represent, there are often clear lines of membership in the “us” and “we” groups, and their view of adult society is typically characterized by ambivalence, uncertainty, and distrust (Kirk & Madden, 2003). Kirk and Madden (2003) noted that trauma is likely to heighten these perceptions and emotions, and propose that intervention should include intensive crisis intervention to reduce acute stress symptoms and to facilitate recovery, as well as an acknowledgement and working through of developmental processes that are likely to have been arrested as a result of disturbing traumatic events. This includes identifying pre-existing clinical signs of the varying levels of stress created by the developmental changes and tasks of adolescence (ibid.). Based on recognition of the developmental tasks in adolescence, Wexler (1991) proposed that the most important goals in adolescent treatment are to help the teenager learn to identify and label internal states, and to develop competence in the area of emotional self-management. Gil (1996) adds that adolescents’ also have to be assisted in the process of defining self and identity by providing them with new information,

asserting their strengths and resources, exploring the idiosyncratic meaning of past abuse or relational conflict, making cognitive reassessments, and making decisions and learning to distinguish between those things they can and cannot control (ibid.). A developmental focus in treatment of adolescents with sexual issues, according to Price (2003), is often lacking, and sexually vulnerable youth have special problems related to their sexual development that requires a developmental perspective in order to understand their special needs and offer effective treatment (ibid.). In the light of shifting dependency needs, where adolescents begin to see the failures of their parents and see them in a less idealized light, Frankel (1998) understood that it is important to help an adolescent discern their underlying loss or rage towards a parent, and sort out the difference between behaviours designed to elicit his parent's anger and disapproval, and what he does because he really wants to do it. Adolescent resistance can be seen as a healthy defence against the premature uncovering of the self, a self that has not yet had a chance to cohere and take shape, and launching into an investigation of their inner life without respecting this developmental need to safeguard the self may be experienced by the adolescent as intrusive and violating, and may ultimately enact a repetition of the trauma (ibid.). The unsettled state of transition and contradiction in adolescence means that the therapist has to adopt an essentially paradoxical position between inviting dialogue and actively expressing concern, without infantilizing the teenager, and holding back, keeping things open and not pressing for commitment, without rejecting him or her; two experiences to which teenagers are acutely sensitive (Holmes, 1991; Pick, 1988). Sensitivity to the adolescent state also includes understanding their suspicions that adults will take over, control or misunderstand, and that they need to experience and find out things in their own time and in their own way, whilst also wanting to be understood, cared for, guided and given boundaries (Holmes, 1991).

It was discovered early on that adolescent sexual abuse victims typically respond to their experiences with self-destructive, acting out behaviours such as substance abuse, suicide attempts, sexual promiscuity, perfectionism, isolation, or depression in attempts to alleviate stress or assert some control over their feelings of helplessness (Cavaiola & Schiff, 1988; Lindberg & Distad, 1985). On the basis of these findings, Lindberg and Distad (1985) found that therapy that viewed such adolescent behaviours as logical and predictable survival responses led to more effective treatment approaches. Symptoms seen in this way create safety and protection, and are dysfunctional only in that they represent an underdevelopment of certain skills (ibid.). Gil (1996) found it useful to communicate the helpfulness of the symptom, while simultaneously encouraging the development of less damaging ways of coping. Related to this, Hetzel-Riggin, Brausch and Montgomery (2007) concluded, in a meta-analysis of therapy modality outcomes for sexually abused youth, that the most beneficial treatment for survivors tended to be client-specific, and to rely heavily on the client's secondary problems. This understanding, as applied to rape survivors, shows that helping them develop self-awareness and understanding around their behaviours, and providing skills for reducing stress, can encourage the adolescent to better manage or discontinue inappropriate behaviours and to assert more appropriate types of control over their environment (Lindberg & Distad, 1985). A variety of symptom presentations may be pointing to individuals' attempts to adapt to severe, early childhood or chronic trauma (Van der Kolk, 1996). Psychiatric disorders do not fall within the scope of this study, but in initial interviews with rape survivors it is important to be able to distinguish them from 'normal' post-traumatic or adolescent responses, and to provide specialized treatment or refer the client on to the appropriate institutions.

A central mediating factor between the effects of trauma and the negotiating of this developmental stage is the presence of a supportive adult with whom the adolescent has a secure relationship (Melzak, 1997). It was found that young people cope better with stress when there is a strong positive attachment to family and parents continue to project a sense of stability, permanence and competence to their children (ibid.). Cohen and Mannarino (2000) found significant correlations between ratings of family cohesion, adaptability, and the intensity of parents' reactions to the abuse, and ratings of children's behaviour problems, and that parents' support was a strong predictor of positive outcome. However, not all parents can remain emotionally available to their children when under stress, and helping family members gain a better understanding about how to support the survivor and also to learn how to cope with their own vicarious traumatisation through offering some preventive education about post-traumatic disorders may be helpful (Herman, 1992). Sometimes a crisis forces a family to deal with issues that were previously denied or ignored, and although family meetings in crisis interventions are meant to foster the survivor's recovery rather than to treat the family (ibid.), practitioner's working with adolescents often find themselves faced with the dilemma of involving family in treatment depending on its influence on the survivor's recovery. In one study it was suggested that treatment be based on an assessment of the family's communication about emotions, particularly with respect to stressful events, and helping family members find ways to express themselves following exposure to traumatic events (Lutz, Hock, & Ju Kang, 2007). Adolescence is also a time in which a shift occurs in the roles and functions of parents, and parents may need help in thinking about how boundaries might need to shift and the developmental necessity of some of their child's behaviours, to emotionally release their child, and also to express their loss of this previous intimacy (Frankel, 1998). In addition, there may be a transgenerational transmission of fundamental characteristics of personality structure of parents, and also of parents' own

histories of trauma (Imbasciati, 2004), and Frankel (1998) advocates helping the parents to withdraw their projections so they can see the adolescent child in a less obscured light and provide them with the necessary support for recovery.

According to Gil (1996), the processing of the actual trauma-related material should only proceed once a strong therapeutic relationship with mutual emotional connectedness, trust and respect has been established. Equally important to this decision is an evaluation of the client's ego strength, coping strategies, and external support system (ibid.). Related to this, Shirk and Eltz (1998) warn that the process of uncovering traumatic experiences can be extremely disorganizing for a child who is in the midst of developing adaptive coping strategies, and whose capacity for affect regulation may be compromised, and adaptive emotion-regulation strategies need to be in place before uncovering traumatic memories and feelings (ibid.). Gil (1996) describes this process as a structured one in which the client is informed about what the process involves and a contract is obtained that specifies what will be done, for how long, and toward what end. The approach is focused, where facts of the abuse and their impact are acknowledged, feelings associated with the trauma are experienced and released, a range of feelings towards victimizers and non-protective parents are explored, and cognitive reassessments of the abuse are made (ibid.). Trauma narratives tend to be incomplete because the parts that make up the overall experience, through which the survivor processes and gives it meaning, are split-off (Wigren, 1993). Much of this integration phase of therapy therefore involves helping the trauma survivor to link and slowly reassemble the fragmented components of frozen imagery and sensation into an organized, detailed, coherent verbal account (Herman, 1992, Wigren, 1993). Survivors invariably also engage in efforts to find meaning in the aftermath of trauma, which generally entails searching for their own possible contribution to the outcome by trying to come up with

answers to 'Why me?' (Janoff-Bulman & McPherson Frantz, 1997). The attribution of self-blame is an extremely common response, but two types of self-blame were distinguished, where victims of crimes are believed to cope better if they do not engage in seeing uncontrollable, 'characterological' aspects of themselves (e.g. 'I am too trusting' or 'I am bad and deserve to be punished') as the cause of victimization, while 'behavioural' self-blame (e.g. 'I should have screamed') could be adaptive because it increases an adolescent's sense of being able to do something to avoid future victimization (ibid.). The therapist contributes to this reconstruction of the story and constructing a new interpretation of the event through normalizing the patient's responses, facilitating naming and the use of language, sharing in the emotional burden of the trauma, and affirming the dignity and value of the survivor (Herman, 1992).

Group work with adolescents will not be covered in detail in this review, as this study focuses mainly on individual therapy. Generally, in terms of the stages of recovery, group work is indicated only once survivor's have come to terms with their traumatic past and are ready to reconnect with life, develop their relationships, incorporate the lessons of the traumatic experience, and take concrete steps to increase a sense of power and control (Herman, 1992). Adolescence brings the added dimension of the developmental crises into the group, and where the individual may find support and clarification from individuals tackling similar uncertainties and struggles, they may also be overwhelmed by the group dynamics coupled with their internal conflicts relating to the trauma and their developmental process. Adapting the work of Yalom (1985) to the trauma survivor, the safe and unique social context of the group can offer the survivor an opportunity to relearn certain social techniques lost as a result of the trauma, to instil hope and inspiration through seeing the efficacy of others in solving and transcending similar problems, and to reduce social isolation through the receiving and

giving of support. It can also reinforce productive activities by focussing on solutions that ease stress and increase self-esteem, initiate norms of safety, and provide a forum for imparting guidance and information and for challenging the survivor's socialised self-limiting beliefs (ibid.). Phelan (1974) notes that in group work with adolescents, the therapist has to be more actively involved, occasionally filling some of the functions of a parent, often being a teacher, and always providing the analytic atmosphere which leads to insight and understanding. Through the help of the group process and facilitation techniques, the survivor may ultimately learn to reclaim ownership of his or her life and take responsibility for it (Herman, 1992).

A final topic to cover when working with adolescent rape survivors is the issue of self-care for both client and therapist. For the client, Gil (1996) includes encouraging them to use the coping skills learnt in therapy, to draw on previous self-soothing and coping strategies, and exploring options for appropriate responses to danger (ibid.). For the therapist, self-care is intricately tied up with the notion of countertransference which, according to Shubs (2008), may lead to vicarious traumatisation in those working with victims of violent crimes, followed by a breach in empathy, or 'empathic strain'. Typical countertransference reactions to look out for are those reactions experienced in response to the personality, behaviour and trauma story of the client, and those that originate from the therapist's own personal conflicts and unresolved issues. These reactions are broken down further according to the therapist's characteristic defensive style, namely empathic withdrawal (e.g. the therapist is a 'blank screen', experiencing affective and cognitive reactions in a detached way), empathic repression (e.g. transference issues reactivate conflicts and unresolved personal concerns in the therapist), empathic disequilibrium (e.g. empathic overarousal, associated with somatic discomfort, feelings of insecurity and vulnerability, powerful affective reactions, and

intrusive or disturbing thoughts, continue long after the session which the therapist feels a need to dispel), and empathic enmeshment (e.g. clinicians become over-involved or over-identified often due to a personal history of trauma). In addition, specific roles taken up by the therapist as a result of countertransferences were identified, such as protector, rescuer, comforter, perpetrator, or significant figure involved in the traumatic event. Recognizing countertransference allows the practitioner to not merely react, but to use these responses therapeutically in the working through of the traumatic experience (ibid.). Supervisors need to be especially alert for symptoms of trauma in the counsellor, giving close and careful supervision to help alleviate vicarious traumatization (Adams & Riggs, 2008).

Countertransference thus needs to be acknowledged and addressed in the service of helping both the therapist and the trauma survivor (Dalenberg, 2004).

In summary, this review shows that the adolescent rape survivor presents practitioners with a myriad of interlocking factors to consider in therapeutic work. These factors, broadly speaking, include: research and theorizing about trauma itself, including early childhood experiences and the effects that the rape trauma has on the survivor; the developmental tasks of adolescence and related issues that adolescents bring into the therapeutic space, including on an intrapsychic, interpersonal, and systems-based level; the specific stages in the recovery process that will inform the choice of appropriate interventions; and that counsellors themselves can have an effect on the survivor's healing process, and thinking about ways of working with this. The aim of this investigation was to examine the experiences of clinicians and counsellors working with adolescent rape survivors to determine what challenges they found themselves being presented with, how they worked with these challenges, and to see if they could shed more light on this complex field and unique client group. A discussion about

the methodology used to gather and analyse this information follows, after which the findings and their implications will be considered.

University of Cape Town

CHAPTER 3: METHODOLOGY

3.1. Study Aims and Choice of Design

As mentioned throughout the report, the general aim of this study was to explore the factors to consider when working with adolescent rape survivors for the purposes of devising appropriate treatment strategies. Although not an entirely new focus of research, literature dealing specifically with adolescent rape survivors was found to be somewhat lacking. Following from this, a study that combines a number of ideas from a variety of different sources could ultimately be useful to professionals and lay counsellors working in this field. One way of producing a rich repertoire of information that could extend the existing body of knowledge in this area is through qualitative research, which developed from the postmodernist and feminist principles that meaning is constructed intersubjectively and within a specific context, and which is based on "... the search for detailed description, seeking to represent reality through the eyes of participants" (Henwood & Pidgeon, 1994). The main task of qualitative research is thus to elucidate the ways in which the research participants understand, account for, take action, and generally manage the defined research problem and context (Punch, 1998). Grounded theory is one kind of qualitative approach that aims to generate new theory through information that is firmly grounded in participants' accounts (ibid.), and since this study hoped to develop a conceptual understanding around working with adolescent rape survivors, it was chosen as the preferred method of research. This approach is concerned with reflecting participants' accounts and naturalistic contexts as realistically as possible, while simultaneously encouraging the researcher's active involvement in a creative and interpretative process of generating new understandings (Henwood & Pidgeon, 1994). This produces a tension that inevitably leads to questions around the researcher's particular biases and values, as well as the value-laden nature of the

information gathered. In response to the first question, the researcher acknowledges a particular bias towards a psychodynamic understanding of human problems which more than likely affected the general approach to the study, and to the second question the researcher admits that the information was not always recorded in the order in which it was presented, but that she was committed to reflecting the meanings of the participants as accurately as possible. The overall objective was to draw from the wealth of experiences of the participants, and the patterns and categories that emerged from their accounts, in order to better understand the issues that are involved when working with this population group, particularly in the context of the Western Cape. In keeping with the grounded theory approach, existing literature was then fed into the analysis with a view to building a more complex, holistic picture that could further explain the issues and methods of working with adolescent survivors.

3.2. Sample

The use of non-probability 'theoretical' sampling peculiar to the grounded theory approach was used, which involved choosing the sample on the basis of participants' potential contribution to theory development, and in which "... new samples of data may be specified as the analysis proceeds, in order to elaborate and build up emerging insights and theory" (Breakwell, Hammond, Fife-Shaw & Smith, 2006). The sampling procedure for this study initially included sourcing practitioners in the mental health profession who have worked with adolescent rape survivors, as well as searching the Rape Crisis databases for counsellors who have worked specifically with teenage rape survivors with a view to building up a focus group with these counsellors. Three focus groups were conducted at three of the Rape Crisis centres in the greater Cape Town area, and a permanent staff member from each of these centres was also interviewed in a one-to-one interview. The criteria for selection was simply

that participants had experienced working with adolescent rape survivors, that it had been fairly recent, and that counselling was conducted over at least three sessions so that information about the person's progress was more likely to be included. It was hoped that the focus groups would comprise at least five to six members each, but the availability (and attendance) of counsellors meant that in the end two of the groups had only three participants, and the third group comprised four counsellors. In addition to the focus groups, there were a total of eight individual interviews: five with mental health practitioners from the clinical psychology, psychiatric nursing, and clinical social work professions, and three with permanent staff members from each of the Rape Crisis centres. The sample frame was thus thought to be comprehensive and inclusive, and requirements for diversity and 'symbolic representation' (i.e. together they hold characteristics that are seen to be salient to the study) were satisfactory.

3.3. Data Collection

A semi-structured interview schedule, informed by the requirements of RCCTT report, discussions with the supervisor for the study, and an initial inquiry into the literature, was designed for both the focus groups (see Appendix A) and the individual practitioners (see Appendix B), with the aim of encouraging disclosure about their experiences of working with adolescent rape survivors. The three focus group interviews were conducted on location i.e. at the Rape Crisis centres where the participants volunteered as lay counsellors. These focus group interviews were audio-recorded, transcribed and analysed. One-to-one interviews with the five practitioners from the mental health professions and with the three permanent staff members from each of the Rape Crisis centres were also undertaken. These were also audio-recorded, transcribed, and analysed.

3.4. Procedures and Ethical Considerations

Approval for the study was obtained from the University of Cape Town, Department of Psychology Research Ethics Committee, and from the Rape Crisis Cape Town Trust to conduct the study and source counsellors for the focus groups, before selecting a sample for analysis. Potential participants were then contacted telephonically, informed of the purpose of the study, and those who agreed to participate negotiated dates and times for the interviews. Before the interviews started, informed consent (see Appendix C for the prototype) was obtained from all participants in the study after the purpose of the study was again explained. It was made clear to participants at the outset of the study that they had a right to withdraw from the research at any time, as well as to withdraw any consent which they may have given previously to participate. After the data was collected, the participants were given an opportunity to ask any questions they still had concerning the nature of the study, and to debrief in which the researcher discussed with the participants their experience of the research process, so that if there were any unintended or unanticipated effects, these could be monitored and intervention provided before they left the research setting. It was also explained that all information obtained during the investigation was confidential, and that stored, recorded data would be kept in a safe and private place. The interviews and focus groups were then conducted and audio-recorded and later transcribed. These transcriptions were analysed using the grounded theory approach, and themes were discerned that could help to throw light on working with adolescent rape survivors. The method for analysing the data is discussed in the next paragraph.

3.5. Data Analysis

The procedure of the grounded theory method, described by Henwood and Pidgeon (1994), was the basic method used to analyse the data in this study. The first step in this process is to

develop an open-coding scheme to capture the detail, variation and complexity of the observations made by the participants (ibid.). In this study this involved highlighting the transcriptions from the interviews, selecting core categories from the data, and transferring these onto file cards. This part of the process describes a focussed selection and labelling of concepts that the researcher considered of potential relevance to the problem being studied (ibid.), with the purpose of finding meaningful patterns upon which to build a conceptual understanding of working therapeutically with adolescent rape survivors. These cards were then used as an indexing system from which the data was constantly compared for conceptual similarities and differences, and reordered as themes developed. Examples from the transcriptions that linked with the initial categories in the file cards were then coded and transcribed to computer under the basic headings selected. During this process further themes emerged, and existing ones were refined along the way. Once the themes reached 'theoretical saturation', that is that no new insights were being reached, the next part of the process was to link the themes and accounts given by participants to the reviewed literature, and to any new literature that emerged as relevant to the study. From here, a conceptual understanding was developed and offered as recommendations for working with adolescent rape survivors, and as a foundation for further study. In Chapter Four the results of this study are mapped out in detail for the reader, and in Chapter Five this is discussed further and conclusions are made on the basis of the analysis.

CHAPTER 4: FINDINGS AND DISCUSSION

On the whole, the themes that emerged as relevant to the participants when working therapeutically with adolescents could be grouped into three main categories, where the practitioners tended to focus on 1) the basic guidelines that they kept in mind when working with traumatised adolescents, including their personal countertransference responses; 2) the influence of the system on the traumatised adolescent; and 3) the specific challenges that adolescents brought into the therapeutic space and ways that these practitioners had found to work with these challenges. The various themes will thus be organized around these three categories.

In the first category, basic guidelines that were found to be relevant included: 1) working at the client's pace; 2) working with, rather than against, defences; 3) keeping firm boundaries; 4) meeting adolescents 'at their level'; 5) the importance of a clinical assessment; and 6) working with countertransference. In the second category of the influence of the system, practitioners mentioned the following as being important: 1) the adolescent is immersed in their family context; 2) mother-daughter issues; 3) a history of childhood trauma; 4) the re-enactments of trauma; and 5) a lack of social services. With category three, practitioners found the following to be relevant or challenging when working with adolescents: 1) basic differences to working with adults; 2) trust and sensitivity; 3) struggle with self-expression; 4) self-blame; 5) a need for information and help with problem-solving; 6) resistance to therapy; and 7) interrupted developmental processes. Each theme will be discussed separately, under their individual headings, and where participants all had something to say on a particular point, only a few examples are given to avoid repetition. Any identifying features that could breach confidentiality have been changed, but in the interests of ease of

recording, interviewees are coded as MHP 1 to 5 for the Mental Health Professionals, RC 1 to 3 for the staff members, and FA, FB or FC 1 to 4 for the focus groups. A discussion of the results follows.

4.1. Basic Guidelines that Practitioners' Follow

4.1.1. Working at the client's pace

Rape is an assault on the person's physical and psychological integrity, and can produce extreme emotional turmoil, heightened anxiety, distrust in self and others, shattered assumptions, and distortions of cognitive schemas that have helped them to cope in the past (Gil, 1996; Herman, 1992; Janoff-Bulman & McPherson Frantz, 1997; Melzak, 1997, Rubin, 1999). However, even before exposure to rape the adolescent state may already be one of 'inner turmoil', where feelings of misery, self-depreciation, ideas of reference, and general personal suffering among this age group were found to be common (Rutter, Graham, Chadwick & Yule, 1976). This turmoil is more than likely linked to the innumerable emotional injuries experienced earlier in their lives, even in the "... kindest of childhood fates" (Kroger, 1989), as well as to the adolescent's efforts to separate from their parents and the conflict this causes (ibid.). These complex experiences imply great sensitivity, skill and care on the part of the counsellor to prevent re-traumatisation, while still engaging with the adolescent experience. Respondents identified the need to allow adolescents a space to express their difficulties in a way that is not reminiscent of a home environment that is controlling or restrictive, or of their traumatic experience. For example:

MHP2: "... our role is to provide a safe space, a space that's not intruded on by anything or anyone... [adolescents] can have a lot of invasions in many different forms... the client is very vulnerable, scared, fragile, s/he needs to be handled with care, and how

they're handled in their first contact can make the difference... care is watching your own reactions as well".

RC1: "... listening, of course, is the biggest thing, especially with teenagers. They just want you to listen, they don't want advice... they're getting so much advice at home or being told so many things... [So] try to build up trust to talk about the deeper issues... tune in that listening skill... and let her push the conversation forward".

Despite these basic principles of respecting the adolescent state and avoiding re-traumatisation, practitioners expressed concerns, or acknowledged tendencies, around wanting to apply more pressure in the uncovering of traumatic material:

FC2: "... they've lost something and sometimes we don't allow them to mourn the loss... we need to give them space..."

FA1: "... but for me as a counsellor I do want to make her aware that something bad did happen and it wasn't okay... it's difficult with the youth because it's make or break with them..."

Another issue that could influence the pace of the therapy, as observed by some counsellors, is if the rape was reported and the survivor has to appear as a witness in court. The potential for re-traumatisation in court is huge, which is one of the reasons why members of the Rape Crisis organization are involved in preparing their clients for the hearing and in supporting them through the legal process. In sum, it seems that while working at the client's pace is the 'ideal' approach, this is continually threatened by the countertransference that is elicited in

counsellors, and the legal and social requirements for articulating the experience of the rape trauma in detail. So according to Van der Kolk et al. (1996), any intervention must be tailored to the needs of the traumatised individual, and it must be flexible and based on common-sense.

This is summed up in the following statement:

FA2: “I think it all happens in a developmental context and you have to look at it through that lens, you know it’s always identity issues, and issues of sexuality... Also, it’s usually their experience that they’re extremely individual and no-one else has gone through what they’ve gone through, so they don’t respond well to being told that others have felt the same way... you’re denying their experiences... and they’re such dynamic people at that age, counselling would work better for them if it’s very much more adaptable and flexible, taking their lead and just being willing to work differently... however they need it”

4.1.2. Working with, rather than against, defences

Defence mechanisms temper the severity of the emotional experience of violence by distorting, distancing and filtering it (Straus, 1994). These are the reactions of fight, flight and freeze that are typically expressed through the behavioural responses of the adolescent (Sugar, 1999; Van der Kolk et al., 1996), such as self-destructive ‘acting out’ or emotional or social withdrawal (Cavaiola & Schiff, 1988; Lindberg & Distad, 1985). In the therapy room they might present as erupting with rage, becoming paralysed with despair, or ‘spacing out’ or dissociating, which are common adolescent responses to overwhelming events (Straus, 1994). Thus close attention must always be paid to the shifting or worsening of symptoms as markers for slowing down or reconsidering the course of the therapy (Herman, 1992). The following account expresses this well:

MHP1: "... defences are really useful, so for a child to have to face that again before they're ready, or in that period where actually the normal shock and numbing is quite good and normal, to mess with this is inappropriate, it's almost like penetrating or violating someone again by forcing your way into something that might be wanting to close... with any therapeutic task there is the question of the right temperature of what happens between you and the person in the room. So I'm not saying that if a child comes in post rape and I can sense that they keep avoiding that I would never put on some heat, but it's about the amount of heat that you need, and I think that if you follow a sort of fanatical model of 'just going for it', you're putting on too much heat. On the other hand one could be so gentle and almost afraid yourself of where this might go, or whatever your own countertransference is that you don't put on enough heat, and the child's also not helped to confront something that they're scared of. So it's about adjusting temperature all the time".

This analogy of 'adjusting the temperature' means that applying too much 'heat' to adolescent emotions or behaviours, through challenging too much or pressurising the adolescent to disclose, could cause them to 'boil' over with destructive acting out or loss of control over symptoms. For example, wanting to 'parent' adolescents was a common response in these therapists, either to protect the adolescent from the wrongdoings of others, to protect them from their own destructiveness, shame and suffering, or to protect the counsellors themselves from the onslaught of 'adolescent negativity', and in this regard Pick (1988) warns that infantilizing, rejecting, or being a 'blank screen' in the face of the expression of adolescent distress could lead to "... vengeance in the form of acting out [that] may be swift, serious and overwhelming" (ibid.). This is especially important in the case of adolescents with a fragile sense of self due to earlier or ongoing traumas or emotional

injuries. On the other hand, doing nothing or not applying enough 'heat' could lead to a lack of change in problematic symptoms and behaviours. The implication then is to maintain a delicate balance; to engage sensitively and respectfully with the defensiveness of adolescents and not give in to the urge to be punitive, to rescue, to act out on countertransference reactions by, for example, giving 'adult' advice, or to try to prematurely 'replace' the defensive strategies adopted by the adolescent before they are ready to let go of them. Instead, viewing such symptoms and behaviours as logical survival responses and exploring how these behaviours are an attempt to adapt to trauma, to help teenagers develop self-awareness and understanding around their behaviours, and providing skills for reducing stress alongside this, was found to be useful for adolescents in distress (Gil, 1996; Hetzel-Riggin et al., 2007; Lindberg & Distad, 1985). In the views of some of the participants, one way of developing awareness in the adolescent is to simply reflect on and express to the client what you are experiencing and observing, and to offer a tentative interpretation. On the issue of avoiding, for example, practitioners recommended acknowledging the avoidance and that it may be "hard for them to go there", and also to give the client "permission to disagree" with your interpretation, as adolescents "want to be in control". This last statement also implies sensitivity to the adolescent search for personal power in their struggle for individuation, and allowing them this in the therapy space, but the therapist still has to hold in mind the need to regulate interventions in ways that are going to be useful to the client. This is expanded on in the next section.

4.1.3. Keeping firm boundaries

In addition to their defensive responses in the face of trauma is the typical adolescent propensity for being seen as rebellious or moody as ways of asserting and testing boundaries, getting their needs met, and exerting some control in ways that were previously denied to

them (Gil, 1996). Practitioners experienced adolescents as testing the boundaries “all the time”, especially in the first few sessions, for example through saying things “to shock you”, to “test your reactions” and on the basis of this, deciding whether you are trustworthy. One practitioner said it is “like seeing a Borderline personality”, and another referred to adolescent emotions as “wild and crazy and intense”. In the light of this, it is important to know when practitioners are responding on the basis of how the adolescent is presenting to them, and when their actions are informed by a generally accepted social construction of adolescence. Nevertheless, Gil (1996) points out that with traumatised adolescents it is critical to remain calm and respectful while at the same time setting limits, addressing problematic behaviours directly by reflecting what you observe, and maintaining the therapeutic boundaries:

MHP4: “... I see myself as a ‘parent therapist’, so I hold that aspect of what is parenting supposed to be about, healthy parenting, which often they haven’t had, and that also coincides with things like boundaries, limits, containment”.

MHP3: “... it’s very important for counsellors not to get as uncontained as the patient. It’s our job to remain calm and contained”.

Modelling ‘good parenting’ in therapy may thus be a useful way of providing the boundaries or a secure base in which the traumatised adolescent can begin to feel contained. Of particular importance in dealing with adolescents was also the issue of confidentiality, where practitioners found parents pressing for more information of what had been disclosed because adolescents “don’t talk to their parents” or because the parents themselves were “vicariously traumatised”. Most respondents agreed that establishing a contract of confidentiality in the

first session was crucial, and that disclosure would only occur with the adolescent's permission, as this "sets up the space to allow stuff out that maybe they haven't allowed before". On top of their developmental struggle to become less dependent on their parents, these young people have experienced an extreme form of trauma, coupled often with childhoods that speak of boundary confusion in their families, and it is likely that they lack an internal sense of structure or organization (Holmes, 1991). Thus, providing an atmosphere of respect, clarity about what is expected of them in therapy, and laying down ground rules in the beginning sets the tone for the building of their internal sense of security and adaptive psychic organization (ibid.).

4.1.4. Meeting adolescents at 'their level'

Frankel (1998) explained therapeutic work with adolescents as an ability to tolerate a sense of not yet being formed, or a 'borderline state', and here the 'paradoxical position' is relevant in which the transition from child- to adulthood requires that practitioners do not treat adolescents as children, and that they also should not prematurely force the burden of adult responsibilities onto them (Holmes, 1991; Pick, 1988). So according to the counsellors, "don't be like a teacher or parent", and also "don't be their friend"; it is important to "maintain the authority of your role". Respondents noted that "a huge part is really just trying to understand what their life is like and acknowledging that you don't know", and "not being judgemental to their ways and norms and values". Participants observed that adolescents are "scanning you all the time" and that if they "feel you are not being real", they may terminate the therapy, shut down or withdraw, or become oppositional and rude. It was also noted that one way of understanding and engaging with the adolescent is through the things that they enjoy doing or are involved in, including "what drugs are on the market, how it's being used", fashion trends, popular music, and so on, and through exploring the meanings that

these activities have for them. On this, Frankel (1998) describes adolescence as a period of emergence, where something "... is awakened... that is hungry for experience and seeks extreme states of being... and to comprehend this we must attend to how the adolescent's imagination is fed through the music, movies, television, literature and poetry that they are attracted to and actively seek out". One practitioner used her understanding in therapy in the following way:

MHP3: "I use things that are accessible to the adolescent, you listen to music; who do you like, do you have a volume control, well that volume control is about you deciding where you want your emotional volume, or what level of stuff you want to bring... I find this kind of analogy useful... because it establishes a locus of control... so the rebellious teenager doesn't have to be so oppositional, or the over-compliant, over-obedient one... her locus of control is honoured, even if she hasn't practiced using it yet, and then we can start the work".

This theme alludes to the idea that adolescents are largely preoccupied with themselves, their bodies, families, prohibitions, friendships, fantasies, and so on; areas of enquiry that for them are new, intense, and frequently bewildering (Holmes, 1991), and they are eager for us to engage honestly and in a straightforward manner with them in a real conversation in which they feel they are being taken seriously (Frankel, 1998). A prohibitive or too-familiar approach can lead to feelings of being rejected or infantilized (Pick, 1988), or can freeze the adolescents imagination (Frankel, 1998), with the consequence of disrupting the adolescent's tenuous feelings of containment or their natural processes of discovery.

4.1.5. The importance of a clinical assessment

Anna Freud (1958, in Rutter et al., 1976) wrote that "... adolescence resembles in appearance a variety of other emotional upsets and structural upheavals... and adolescent manifestations merge almost imperceptibly into... almost all the mental illnesses", but in and of itself adolescence is not an affliction but a normal phase of increased conflict (Rutter et al., 1976). Given that adolescents may already have features of what an unsuspecting practitioner might describe as 'psychopathology', it becomes really important for those working with them to familiarise themselves with what is 'normal' adolescent behaviour. For example, Blos (1967) divides adolescence into early adolescence, adolescence proper, late adolescence and post adolescence, each with a different set of tasks, including: the onset of puberty and the beginnings of the separation process; a reworking of early oedipal conflicts, formation of stable extra-familial relationships and consolidation of sexual identity; consolidation of previous stages and developing a greater sense of autonomy; and ego-integration, actual separation from parents, autonomy, and a new capacity for intimacy (ibid.). This describes a normative process, but in reality the counsellor may find a fourteen year old adolescent who is fixated at an earlier age of development, or a 'parentified' child who comes across as older than his or her age. For example:

MPH1: "It depends on the child, on level of development, on intellectual capacity, on ego strength. So some children I've worked with have had multiple abuses and are intellectually not that well functioning, so you almost have to help them work a little bit, to learn to close it off, because they can't, there's almost too much there and you almost need to strengthen the ego a bit... and with other children you can gently help them go through what they're remembering, what's there, with a witness who can hold it and metabolize it".

MPH3: "...also, you may have a very intelligent adolescent who's got a great verbal IQ, and it's easy to fall into the trap of thinking that that indicates a good grasp of process-related or even of deeper issues. Very often it's not... and one has to be careful not to collude with that and end up doing damage, because one's not fully aware that they're actually not grasping stuff".

So the adolescent may be arrested at an earlier stage of development, with all the behavioural and defensive manifestations of that stage, which may describe a normative crisis with its 'neurotic, psychotic or borderline manifestations', but there are also those adolescents who are truly psychologically disturbed, and to miss this or try to work with it without the proper training and skills could lead to increased disturbance and self-harming or destructive behaviours:

MHP1: "... what I really worry about is [if] counsellors don't do a clinical evaluation of the child that they're working with. So if the child's intellectually disabled, they often don't notice... or if the child has had a history of Borderline stuff or old trauma...you're working with a different kettle of fish. So rape is rape, but the person has to endure it, and their psyches are very different".

The subject of assessment was one of the areas in which a clear distinction between lay counsellors and trained clinicians could be discerned from their accounts. For example, a lay counsellor recounted an instance when she became plagued with feelings that the adolescent client was lying (after the client withdrew her accusation in court and the prosecutor found the perpetrator not guilty). In the sessions that followed, this counsellor found it difficult to maintain an empathic connection with her client, and to believe the story of her rape. There

might well have been deeper issues going on for this child, and the doubt and uncertainty of the counsellor could have impacted on the child. Although this is only one example, it is not unlikely that other lay counsellors have come across similar difficulties, or cases of borderline personality or intellectual disability that have slipped through the initial assessment process, and the countertransference they are left with, on top of being filled to overflowing with stories of trauma, may well lead to the 'empathic strain' and 'vicarious traumatisation' discussed by Shubs (2008), and negative consequences for both the counsellor and the client.

This highlights the need for training and skills in identifying underlying psychopathology, as well as an understanding, as one practitioner put it, of "all the potential routes that the adolescent might take to overcome this that may be healthy or normal, or more detrimental". The idea of 'acting out', for example, is often seen as 'wrong' or 'rebellious' in teenagers, and having an understanding of how adolescents work and that acting out is "a very real, painful and terrible thing for them" is crucial to our dealings with them. Clinicians warned that opening psychologically fragile children up to remember things when they do not have the skills to cope, and then sending them home to an uncontained space, could lead, for example, to "flashbacks that we in fact stimulated", and then to running away, slitting their wrists, overdosing on drugs, shooting themselves, or other self-harming behaviours. The implication is that counsellors need to have an idea of who they are working with before uncovering traumatic material, because in those adolescents with a history of trauma, borderline features or other psychiatric conditions, the consequences could be extremely harmful, and it is the practitioners responsibility to 'do no harm'. If a counsellor is faced with something they do not have the skills to work with, then they should not work with it. Suggestions to lay counsellors by clinicians were to refer such individuals on for specialised

treatment, or to support and contain them without doing any uncovering work in the event that the client cannot be seen immediately by the appropriate institution or practitioner.

4.1.6. Working with countertransference

Dalenberg (2004) argues that traumatised patients have good reason to fear countertransference in the therapist, as these reactions may replicate features that led to the original emotional injuries that made coping difficult, and have the potential to confirm the patient's trauma-related beliefs or simply frighten the patient by virtue of its existence. Satisfaction with treatment and perceived positive outcome by traumatised patients in one study was strongly correlated with the perception that the therapist struggled to maintain a connection to the patient, engaged in internal battle on the patient's behalf, and self-analysed in an effort to achieve these ends (ibid.). Shubs (2008) helps us in this respect by mapping out the various kinds of countertransference responses and where they might stem from, so that we can engage in this process of self-analysis in the interests of maintaining a safe and effective therapeutic relationship.

Most respondents mentioned that they become 'angry' and 'protective' as their primary countertransference responses, followed by a sense of sadness and loss. Anger was understood to be a good emotion by one clinician, who explained that this indicated a "sense of agency and that something could be done". Sometimes there was frustration that was understood as stemming from the adolescent's dissatisfaction in their relationships as a consequence of their status and lack of choice in their families, dysfunctional interactional styles in their family contexts, or because their symptoms were interfering with their functioning or peer relationships. These feelings often made counsellors "want to hold children", or "become an activist", and they said they had to watch that they did not

“overreact” or become “too involved”. One practitioner referred to times when split off feelings are “projected into you”, where the counsellor comes to embody the trauma and the client seems ‘vacant’ and ‘empty’. Another spoke about “feeling responsible for every breath they take” in the case of those adolescents “who are extremely lost and unformed” and who become dependent, and this clinician “worried all the time” and had to “find ways not to push them to attend therapy more often”. Most of these reactions are not peculiar to adolescents, but describe common experiences when faced with traumatised individuals who were victims of violence. More specifically they may describe disbelief and anger in women (all the respondents were women) to other females (who represent a greater percentage of rape victims) who continue to be violated by males. On top of this, the clients they were reminiscing about were adolescents, still children in many respects, and it seems quite normal to want to protect them from an iniquitous and threatening world. One also has to reflect on one’s own experience of adolescence and that being in the presence of distressed young people might bring up one’s own unresolved emotional injuries from that period. In relation to this, Shubs (2008) reflects that recognising characteristic defensive styles and the roles taken up in response to countertransferences, and working through them, might help practitioners to respond in ways that are useful to the therapeutic process of their clients. Most participants advocated a good supervision structure and personal reflective process as essential in processing their left-over feelings from sessions, in developing awareness around their own behaviours and contributions to the therapy, and in planning future interventions. Literature and ongoing in-service training were also regarded as essential to the personal growth and development of consciousness of practitioners. Otherwise, according to one respondent, “we can lose perspective”. In the crisis counselling organization, support, supervision and in-service training are available for the lay counsellors, but sometimes counsellors do not make use of this for various reasons. For example, some participants in the

FB group felt a need for a more private space in which they could unload their personal struggles, and also found it difficult at times to attend the in-service training when it was held at night and in another location and they were unable to get there for logistical reasons. With this group in particular there was an overwhelming feeling of exhaustion in the interview room, and a plea for outside support.

Perhaps in relation to supervision it is prudent at this point to write a few notes that were found to be relevant to good supervision for the benefit of those who are struggling in their supervision processes. Barnett, Erickson Cornish, Goodyear and Lichtenberg (2007) suggest that on the whole a trusting and collaborative relationship must be present, an agreement must be reached between both parties on the nature and course of the supervision process and relationship, and appropriate boundaries must be maintained. Positive qualities in supervisors are that they have empathy and respect for the supervisee; provide constructive feedback in a supportive, non-judgemental and validating environment; are approachable, open and available; and are able to adjust the intensity, style and mode of the supervision as supervisees needs change. The environment is felt to be a safe space in which supervisees can openly discuss their work, address their insecurities and concerns, and have the freedom to try out new therapeutic strategies and techniques. If supervisees are overly worried about being evaluated, pleasing the supervisor, or 'not messing up', they will be less likely to share their negative experiences and failures, which will limit their growth and learning.

Supervisees also need to be invested in their supervision and be open to feedback (ibid.).

4.2. The Influence of the System

4.2.1. Adolescents are immersed in their family context

This theme is of particular importance as it shows that working with adolescents implies working with their families too, since they are still very much under the control and charge of their parents. Herman (1992) states that the fundamental principle of recovery is the empowerment of the survivor, which means that s/he must be the author and arbiter of his or her own recovery, and linked to this is the question of how empowerment is applied to therapy with an adolescent. In the case of adolescents, empowerment has to be understood in relation to the interactional system in which they are immersed, as was observed in the following statements:

RC1: “... many of the problems that they’re experiencing are actually not problems they have as much control over because they’re teens – they’re in a household where there are adults who dictate how things are going to happen, so in terms of her healing process there are certain factors that can inhibit the way in which you can work with them... quite often it’s the parent that needs counselling... [and this] needs to be quite non-threatening because people are intimidated, they don’t understand what the process is about”.

RC2: “... our idea of empowerment only goes so far, because how much can she assert that within her home context... how does she stand up against them, because that might just have negative consequences for her...”

‘Empowerment’ may be understood from a therapeutic perspective as a redirecting of clients miscarried, self-limiting or problem-maintaining efforts to cope with their problems (Coyne,

1987). The reframing of problematic behaviours is a critical tool in achieving this, and the assumption is that the appropriate application of resources that were previously unrecognised or misapplied will help to resolve these problematic coping behaviours (ibid.). In the case of adolescents, empowerment can only be applied within the parameters and limitations of the family and social context within which they are immersed.

The adolescent's healing process is dependent on things like family cohesion, the presence of a secure relationship with a significant adult, the intensity of the parents' reactions to the abuse, parents' emotional availability to their children in the face of the trauma, and the family's ability to express their emotions in relation to stressful events (Cohen & Mannarino, 2000; Lutz et al., 2007; Melzak, 1997). Practitioners reported that often the parents are "harsh to their kids", they may overtly blame them for the rape or say, for example, that "she was raped because she was running around at night". At times parents "don't believe the child was raped", or there is "no communication between the parents and the child", and practitioners also noted that sometimes the parents are "not in a position to support their child" because of their own unresolved childhood traumas or emotional injuries. Other examples given were of removing a pregnant teenager from school to protect the perpetrator, a family member and father of the unborn child, from questioning teachers or peers, or preventing the adolescent from reporting the rape because the perpetrator is the main breadwinner in the family. The consequences of an unsupportive family may be that guilt and shame are intensified, feelings of helplessness are reinforced, or the adolescents' sense of insecurity is increased, because they are not provided with the necessary containment or protection from those people that they are meant to be able to rely on and trust. In the words of one respondent, "it's not always the trauma that hurts the child; it's when it's not

metabolized [by the context]”. The implication then is that treating the adolescent can not be done in isolation from their family system.

Caregivers are also at risk for elevated levels of stress and vicarious traumatization when their children become victims of violent crimes, and intervention strategies for non-offending caregivers include: 1) information to educate parents about the problem; 2) parenting skills training to improve parenting behaviours and responses to children; 3) parental coping strategies such as relaxation exercises to help them reduce their stress levels; and 4) opportunities for social support and parental empowerment, for example through a parent support group (Banyard, Englund & Rozelle, 2001). In relation to working with the family, practitioners advocated parenting skills training because, as one respondent put it, this is “less threatening than pointing out all the ways in which they are dysfunctional”; which may alienate the parents. Basic psychoeducation around the impact and predictable consequences of trauma was also found to be useful, especially in the case of parents who are vicariously traumatised, as this might help them to understand their own and their child’s behaviours better. Since adolescents’ recovery is dependent on parental support, attending to the needs of the caregiver will promote positive adjustment in children after exposure to rape or any other trauma.

In terms of working with the adolescent with various family-related problems, practitioners agreed that it is important “not to collude with them against the system”, but rather “to help the client reality test in terms of the home environment”. It is also important not to “unpack stuff in your room and then send somebody out into an uncontained space and expect them to cope”. Another respondent noted that adolescents “need a space where they won’t feel judged or where they can feel free to talk about the details of the rape without traumatising the

family”. On the whole, practitioners suggested working with adolescents separately from their parents, and having joint sessions further down the line in which the client and family members are helped to communicate and express themselves clearly and directly, to set boundaries and limits and clarify roles, and to assist parents in regulating their affective involvement in the child’s activities. On this last point of affective involvement, counsellors found that mothers often tended to be “over-involved and domineering”, as is discussed in more detail in the next section.

4.2.2. Mother-daughter issues

As mentioned, mothers were often experienced by counsellors and their female adolescent clients as “over-involved and domineering”, for example when the mother pressed for details of what had been disclosed in therapy, or when she was over-controlling of the child’s activities after the rape. Other examples of mother-related problems included that sometimes, when mothers know about the rape, “quite often it has been spoken about too openly for the child’s liking”, or when daughters choose to disclose to a peer before disclosing to their mothers, the mother may feel “very left out and angry”. A respondent explained that mothers may be supportive in a practical way, but that emotionally the adolescent feels “like she is walking this path alone”. In these cases, it was suggested that mothers be approached in a supportive way “without blaming and judging”, because then they might “be able to hear and see and shift”, whilst also persuading them that their daughters may need “a little bit extra” in terms of support, and helping them with this. Possible interventions are listed in the previous section.

Charles, Frank, Jacobson and Grossman (2001) gave a possible explanation for these mother-daughter issues. They found that mother-daughter dyads tend to be more intense and less

differentiated than other parent-child dyads, and can lead to difficulties in individuating from mothers and strong emotional conflict. Mothers may repeat their own past experiences of difficult separations, or infantilize or ignore their daughters' appropriate demands for autonomy because they are unable to access their own past. On the basis of this it was suggested that therapists need to attend to themes associated with separation in order to avoid premature or unilateral terminations (ibid.). There may also be a transgenerational transmission of fundamental characteristics of personality structure of parents, as well as of their own histories of and reactions to trauma (Imbasciati, 2004). For example, many participants reported that often when the child had been raped, mothers own histories of rape or incest, and their unresolved issues, were triggered. In practitioners' views, this may present mother and daughter with an opportunity to heal their relationship, because it is "something that they share", but it also means that she frequently "puts those feelings onto the child", and may be the reason why the mother becomes so involved. In these cases therapists are urged to work with the mothers separately, and help them to withdraw their projections so they can provide the adolescent with the necessary support for recovery (Frankel, 1998).

The father-child relationship was non-existent in the accounts of participants and their clients, which may point to instances in which the father is under-involved or absent in the adolescent's life. It could also relate to the secondary role assigned to fathers in traditional family structures in which the father is valued for his material contributions rather than for his capacity to provide emotional nurturance within the home. Recent psychoanalytic literature (Liebman & Abell, 2000) describes the father's role in the developing adolescent as a mediator in the mother-child dyad, as facilitator of separation-individuation, and as a significant contributor to the development of a healthy sense of self and core gender identity. The father who adequately relates to his daughter/son through appropriate nurturing

behaviour will be internalised by his adolescent child as a benign, realistic and whole object, or the opposite will hold true because of his absence or inappropriate way of relating. Two consequences of this include that adolescents will either remain locked in the pre-oedipal mother-child dyad, and/or carry a fragmented, idealised or devalued image of their father into their adult relationships with men (ibid.). The father's role is thus an important component of adolescents' growth, and where they have been a victim of rape it can be inferred that their perceptions of men as perpetrators could be healed through healthy relationships with their fathers.

4.2.3. A history of childhood trauma

Many psychiatric patients were found to have histories of trauma, but those with Borderline Personality Disorder (BPD) stood out as having the most severe abuse histories, usually starting before the age of six (whereas with other diagnoses the abuse tended to start later, near puberty). (Herman, 1992; Terr, 1991; Van der Kolk, 1996). The idea that people become fixated at the emotional and cognitive levels at which they were traumatised means that they will be using the same means to deal with current stressors that they used at the stage of development at which the trauma occurred, and ultimately these patients are unable to tolerate ambivalence and are compelled to repeat the trauma (ibid.). Personality disorders usually become manifest in adolescence or early adulthood, and a thorough assessment or screening process helps to discern who one is dealing with. Despite this, at the crisis counselling centres these individuals slip through the cracks and land in the laps of lay counsellors unprepared for the extreme negative transference of these patients. Thus, a thorough working knowledge of clinical practice is required when working therapeutically with adolescent sexual abuse survivors (Van der Kolk, 1996).

Repeated trauma that starts in childhood, often at the hands of a significant family member, characteristically includes features of denial and psychic numbing, dissociation, rage, somatisation, poor emotional regulation, pathological attempts at self-regulation, relationship problems, a compulsion to repeat the trauma, and a confusing mixture of co-morbid diagnoses (e.g. Herman, 1992; Marx et al., 2005; Shirk & Eltz, 1998; Terr, 1991; Van der Kolk, 1996). Shirk and Eltz (1998) suggest an integrated approach to the treatment of multiply-victimised adolescents, including the establishment of a safe relationship; the development of the adolescent's coping and emotion regulation resources; the uncovering of traumatic material; and the facilitation of adaptive interpersonal skills. While on the surface this does not look very different from the stages of recovery described by Herman (1992), repeated trauma involves greater difficulty in engaging these individuals in the process of therapy, a lengthier treatment process with one therapist, and a larger number of tools and techniques to be used in a more comprehensive treatment program (Shirk & Eltz, 1998). According to one therapist, when adolescents have rape in their histories "it's covered over with so much anger and blunting and numbing and cynicism, or it comes with egos that have just been worn down over the years, and now they fall apart about anything all the time". On the whole, practitioners reminded us that "we must be able to absorb the horror", and that "our job is to be as non-judgemental, firm and grounded as possible" in these cases so that the adolescent feels secure enough to be able to begin to process his or her distress.

Lay counsellors often find themselves insufficiently trained to work at this level and the period of their intervention is usually too short, and yet they are repeatedly faced with these clients:

RC1: "...one of the most terrible things about rape is that you often find that a rape survivor hasn't been raped once, she's been raped several times, and sometimes you'll find that the survivors are also survivors of child sexual abuse, and that doesn't come out straight away..."

One practitioner's understanding of this was that "trauma creates the real self going into hiding", which "could stay hidden for a very long time, and if you're not aware of the hidden stuff you could just treat the presenting rape without ever going further". With adolescents it was also noted that the process of uncovering these hidden levels may be much harder because "they are steeped in the multiple unwritten covert laws of society that they don't know how to decode", and so they are trapped in trying to live and negotiate their lives and the many things they do not yet understand. In other words, there are so many things that the adolescent is trying to come to terms with, because this stage of development demands it, that the trauma might well have gone 'underground', influencing their thoughts and actions from a repressed, unconscious place. This refers to the theory of the 'compulsion to repeat' the trauma that comes from earlier harmful experiences and patterns of coping that have become maladaptive and entrenched over time. The following example illustrates this:

RC2: "Generally there are a huge number of adult survivors who've also been sexually abused. I had a client, when I first saw her she was 23, and she'd been raped four times already, and every single case was different, not the same scenario, not the same perpetrator, not the same location... she was saying, I don't know when the next one is going to happen, and what about her was attracting these rapes..."

This perception, that it was ‘something about them’ that caused the rape(s) or ongoing incest, is associated with the shame response common in sexual abuse survivors, not only because of the sexual nature of the crime and self-blame and guilt for having ‘somehow participated in their rape’ (Burgess & Holmstrom, 1979), but also obviously because of the repetitive nature of trauma and the internalised belief that these things keep happening because ‘I am bad’ and ‘I deserve to be punished’. It also links to the idea that in cases of revictimization, emotional dysregulation may produce symptoms and behaviours that signal vulnerability to predators, as well as an impairment in the ability to properly process danger cues which impedes successful defensive behaviour (Marx et al., 2005). It may not be that the individual is raped over and over again; it may be that they become involved in abusive relationships or unwholesome peer groups and destructive behaviours, or that their lives never seem to get on track and they feel stuck. Whatever the case, shame results from perceived or real ‘attacks on the self’, and an inability to regulate shame and its associated debilitating feelings, often triggered in response to perceived rejection or separation, has been inferred to be at the roots of trauma re-enactments and most psychiatric conditions (Van Vliet, 2008). This has implications for treatment in the sense that recovery necessarily involves a rebuilding of a ‘resilient self’: through moving away from withdrawal and isolation towards connecting with others; refocusing energy and attention on goals, interests and positive behaviours that enhance the self; moving away from avoidance towards facing and addressing the shameful event(s); understanding external factors, developing insight into oneself, separating from the shame and creating meaning; and resisting against attacks on the self through direct actions and attitudes aimed at protecting the individual and decreasing vulnerability to future attack (Van Vliet, 2008).

4.2.4. The re-enactments of trauma

Similar to the ‘repetition compulsion’ of childhood trauma, acute trauma also has the potential to re-trigger earlier emotional injuries incurred as a result of everyday experience or of dysfunctional patterns of relating in families, particularly those that remind the adolescent of states of helplessness (e.g. the lack of power in the parent-adolescent relationship and that between the perpetrator-victim), impingement (e.g. where parents project their own disavowed aspects of themselves into the adolescent versus the violation of being raped), loss (e.g. the loss of the safety of childhood and the loss of control, dignity and integrity at the hands of the rapist), and uncertainty (e.g. the vulnerability and contradictory states of adolescence and the insecurity and confusion experienced when being raped). Superimposed on this is the adolescent’s ‘agitation of inexperience’ where the changes that are taking place in their lives, of which they have no first-hand knowledge, may be feared and avoided (Copley, 1993). Thus practitioners found adolescents talking ‘around’ their experiences, unable to face problems directly, and still in a state of exploration and incoherence in their meaning-making, as was illustrated in the following account:

RC1: “It’s more about how it’s affected their lives, how the symptoms are affecting them, and how it’s affecting their social support... and often you find that if there’ve been any relationship problems before within the family, or a partner relationship, these seem to be more pronounced when the rape occurs... they really cause people quite a lot of anxiety... so they don’t always talk about the rape straight away; it takes time to build up that trust... even though a lot of the problems that teenagers come with are problems that don’t seem to be focussing on the rape, it’s all related, it’s all affecting her life, so we need to be patient because it will happen, she will come up with the stuff”.

In relation to this, Frankel (1998) notes that the one-to-one nature of individual therapy can create a stillness which can aid the adolescent in sorting through all the various challenges and demands on the adolescent's being, it is where the therapist can act as a kind of mentor in the development of the adolescent's psyche and emotional coping skills (Shirk & Eltz, 1998), and where the therapist can help the adolescent make links between his or her current stressors and past traumas (Van der Kolk, 1996), in the service of gaining mastery and resolution (Kroger, 1989).

4.2.5. A lack of social services

Sometimes the survivor's natural support systems cannot be mobilised and are detrimental to the adolescent's welfare, and as a last resort, formal institutions of mental health, social welfare, and justice have to be called on for the purpose of establishing safety (Herman, 1992), but as was indicated by the interviewees, these facilities are often lacking or are inappropriate for this age group:

RC1: "One issue that's really become problematic for us is the new law, that if you have knowledge, suspicion or information that an adolescent is being abused, then you are obligated to report. Now if you turn that around and ask what does the adolescent need in terms of how is her world going to change if we do report... you're removing the child from her environment where she has a roof over her head, has food in her stomach, she's able to access her school, but the perpetrator's also able to access her... and social services can't do anything because there's nowhere for the child to go, there are no places of safety... So we've had a case where the survivor decided to report, the police fetched her, she went to lay a charge, and then she was placed back in the home where the perpetrator was... Or we often get

referrals from [a place of safety] where there are rape survivors and youngsters who are up for juvenile cases and are awaiting trial living in the same context: somebody who's removed from society because it's unsafe for her, and somebody that's removed because they're unsafe for the community... the cycle just continues... We need facilities, we need drug rehab centres, we need so many different types of facilities and there are none; no places of safety”.

This clearly describes an unsafe situation for the adolescent, and in the experience of helpers, therefore, there is a desperate need for social services for this age group and for communication between the organisations, for the provision of better services for adolescents.

4.3. The Challenges of Working Therapeutically with Adolescents

4.3.1. Basic differences to working with adults

Linking to the discussion on the influence of the system on the adolescents healing, a characteristic feature that makes it challenging to work with adolescents (as compared to adults) is the restrictions that are imposed on them by their caregivers and how this limits the choices that are available to them:

RC1: “... adults have greater control over their lives, they're in a position, as disempowered as they are or might be... to take ownership and be responsible for their lives, whereas with teenagers they don't have as much power and control... they have caregivers imposing the kinds of restrictions that parents need to... so sometimes I feel those frustrations from my clients, the younger ones in particular... but every person that you meet has particular limitations on themselves, whether it's

self-imposed, whether it's their circumstances... so you need to work within those parameters, that's their reality".

Working within the parameters of parental, institutional or self-imposed restrictions means that empowerment, when working one-to-one with the adolescent survivor, happens in relation to the individual and, according to counsellors, "is here in this room". So while there may be a need to work with family members, or to relocate the child, this might not always be possible, and empowerment thus means helping the adolescent with things like improving their social skills, building trust and self-esteem, developing self-soothing coping skills, reality-testing around distorted beliefs, and so on, but it "doesn't extend to changing socio-economic status", or encouraging changes that are not within their control. Adolescent choices are limited; they cannot change their circumstances, and this was sometimes frustrating for counsellors. On the other hand, despite the limitations one encounters, some participants experienced the inherent developmental need for exploration, expansion and development in adolescents (Copley, 1993; Frankel, 1998; Gil, 1996). For example:

MHP3: "What is easier working with adolescents, as opposed to adults, is they haven't accumulated a huge amount of baggage in blocking and distorting and repressing stuff... the shadow side is still there, but the light side, that sense of hope regardless of how hopeless a person feels is just under the surface... there's a natural adventurousness, a natural need to go through this and come out a victor... even if they don't see it, I can feel it so it helps me find it for them more easily".

Reflecting on this, it could happen that counsellors get caught up in one of these extremes, where feeling the limitations only, or exclusively seeing adolescents as hopeful pioneers,

could negatively impact on practitioners attitudes, observations, and the actions they take. The conception of adolescence as a contradictory state, holding both limitations and growth, again points to a 'delicate balance' (Frankel, 1998; Pick, 1988) that practitioners' need to maintain, in this case of working within the parameters and limitations, while simultaneously enabling personal growth to take place. The adolescent is caught between two worlds, between childhood and adulthood; limitations and growth; group identity and pursuing personal goals; inexperience and a desire to know, and this 'in-between' state may present in an assortment of contradictory feelings too. The following statement illustrates how one practitioner holds this balance:

MPH1: "Adolescents are quite afraid of their own limits, it's a stage of needing transcendence, and they're quite scared of vulnerability and rape is something that makes them very vulnerable... in my experience, if you go in with too much openness to that vulnerability it frightens them, they don't want to see themselves reflected in your eyes as weak or hurt until they are really ready to tell you that themselves, so that's a big thing, watching that space, that when they break they need to be met, but you can't mirror that too quickly... whereas adults almost come with more readiness to be met somewhere vulnerable...".

4.3.2. Trust and sensitivity

The capacity to trust in self and others is severely damaged by the traumatic experience, so that the survivor finds it difficult to rely on others and tries to guard against, and prevent the recurrence of, past betrayals through keeping others at a safe distance (Brothers, 1995).

Participants observed how difficult it is to build a trusting relationship with the adolescent trauma survivor:

MPH1: "... a lot of them have been so hurt by adults that they're not necessarily going to think that you as the helper are going to understand and help them... it's a lot more tricky... that sense of having to sit in the seat where you are not necessarily trusted as a given".

MHP3: "... with adolescents you have to be very careful not to offend them... if you don't find the connection early it's much harder than with adults or children to recapture it because you've got a child who's rebelling and who needs to protect themselves, if you cut them off at the beginning it's almost impossible to ever get them back again..."

With trauma there may be expectations of danger, betrayal and malevolent intent (Herman, 1992; Shirk & Eltz, 1998). Along with this comes the adolescent's typically considerable anxiety about coping as a separate individual in the perplexing and incongruous world that they have become increasingly open to by virtue of their increased awareness, attunement and sensitivity (Frankel, 1998; Pick, 1988). With this as the backdrop, establishing and maintaining a therapeutic alliance becomes subject to repeated testing, disruption, and rebuilding of the therapeutic relationship (Brothers, 1995; Herman, 1992). Not recognising and acknowledging when one has failed these tests of trustworthiness can lead to 'sadosomachistic rescriptings' or re-enactments of past trauma both within and outside of the therapeutic relationship (Brothers, 1995). Counsellors noted that these adolescents are "very on edge", and that in their lives, and in therapy, trust with adolescents can be swiftly and unwittingly broken:

RC1: "... trust is a really important thing, and you can break it just like that with a teenager and you won't even know it at the time, it might be something really benign and tiny, that you might smile at her mom in a certain way..."

Practitioners reported that although joking and laughing or commenting on their appearance may seem to be natural social ways of engaging with them, some adolescents might be "offended and find this invasive", or the exposure may feel excruciatingly traumatic for them. In the views of the respondents, adolescents can be "very tender" about various things, and "we need to be aware of just how open or sensitive they are", and also to "be as transparent and obvious as possible". In addition, the existence of both providing 'corrective' experiences and of repeating past betrayals will inevitably exist within the same relational context and the therapists' task is to work through these disruptions in connectedness and failures in empathic responsiveness. According to Brothers (1995), this can be achieved by investigating and interpreting what it was that the therapist did that produced the disruption, the meaning this has for the client, its impact on the bond between the therapist and client, the early developmental trauma or acute traumatic experience that it replicates, and the clients expectations and fears of how the therapist will respond to the expression of the painful feelings that follow in its wake.

4.3.3. Struggle with self-expression

Participants found that adolescents often "don't say anything", "struggle to express themselves", or "don't have the words to name their feelings". This theme may link to Frankel's (1998) comment that resistance in adolescence is a healthy defence of safeguarding against a premature uncovering of the as yet unformed self of the adolescent, so that too much poking and prodding to get them to disclose could have dire consequences. On the

other hand, Rose (1991) points out that silence in the therapist is also not appropriate, especially early in treatment as the survivor is traumatised, regressed and mistrustful. Rose (1991) explains that silence can intensify the negative transference in which the therapist may be experienced as failing to protect, betraying, abandoning or assaultive, and can lead to a stalemate in the therapy or to premature termination. The idea of holding a delicate balance again emerges as an important concept in working with the traumatised adolescent, this time in moderating silences with the therapists own input, while at the same time encouraging communication in the adolescent.

Participants found that working with other modalities, such as drawing, journaling or working with clay, helped them to resolve this problem. The general idea was that it helps to take the trauma “outside of the person”, where therapist and client could reflect on the drawings, mind-maps, genograms, mandalas, or whatever they chose to do, in a way that is “not too threatening or too sore”. Sometimes, one respondent said, “you have to hold onto interpretations and only reflect what is observed at a later time”, depending on how the adolescent responds. Within these exercises, participants noticed that it then became possible to engage the adolescent in exploring things like self-perceptions, relationships, future goals, or naming feelings, and that ultimately this helped the adolescent to open up to a point where they could develop insight and awareness and start making links between their current stressors and the impact of the rape trauma. This of course only applies to the adolescent who is willing to engage in these modalities; for those who were resistant, participants suggested talking about things like bereavement or loss so that “they can have things to grab onto and identify with”, or as Gil (1996) pointed out, to communicate that they are in control of what they say, and inviting them to say what they want. Another counsellor reminded us that the adolescent may be quiet because “s/he’s told the story to so many people already” - the

police, the prosecutor, family - and s/he may simply be feeling overwhelmed. So sometimes the adolescent just needs to be given time to open up, or permission to not say anything.

Every now and then, rather than being mistrustful and guarded, the adolescent may indiscriminately share too much too soon, and as a consequence become overwhelmed with fear, shame and self-loathing (Brothers, 1995):

FC2: "... sometimes they open up so much and then they feel vulnerable, they feel shy afterwards, she thinks: now she thinks differently of me, I cannot face her again, you know when I walked in I was this but when I walked out I'm less... but some people feel better because they've given it to you, they've shared it with somebody, and after a year or two they share it with somebody else, almost like they're taking it drop by drop".

In relation to this, a conversation took place in this focus group that ultimately led to the conclusion that adolescent management should be different to the empowerment policies adopted with adults, and that if they did seem vulnerable after a session, or even just because they are adolescents, they should be followed up to see how they are doing in between sessions.

4.3.4. Self-blame

Shame and the attribution of self-blame is a common response in the aftermath of rape (Burgess & Holmstrom., 1979; Janoff-Bulman & McPherson Frantz, 1997). In the case of adolescents this is superimposed on their 'emotional turmoil', self-depreciation, and ideas of reference (Rutter et al., 1976), and their shame may thus be intensified or more complex.

Their emerging sexuality can also be stimulated by sexual attention from an adult and according to Copley (1993), it is important to recognise and work with feelings the adolescent may have about being sullied or worthless, and acknowledge any sense of complicity on his or her part, or the repercussions could be that the adolescent is left with something ‘bad’ inside that no-one can bear to recognise. As discussed in section 4.2.3, shame is often at the roots of trauma re-enactments (Van Vliet, 2008), as was observed in the following statement:

MPH4: “... the guilt, you know blaming themselves, maybe it’s something I did, maybe it’s a punishment, maybe I’ll be judged... and then the vacillation between acting out more of the same, or feeling guilty and almost lashing out or shutting out people that are close to her...”

Practitioners highlighted the importance of allowing survivors the space to express their shame, while at the same time helping them to “re-attribute blame to the perpetrator” of the crime. The literature adds that adolescents may also need to be helped to explore shifts in attribution from ‘characterological’ to ‘behavioural’ self-blame (Janoff-Bulman & McPherson Frantz, 1997), and sometimes, if required, to shift blame to the interactional systems of which they form a part (Coyne, 1987).

4.3.5. A need for information and help with problem-solving

For Winnicott (1963, in Frankel, 1998), therapy is about gently nudging the adolescent, who has been knocked off the path of development for whatever reason, back into a state of self-correcting growth. Sometimes, counsellors observed, “it’s almost as if they feel their life’s over” and that adolescent trauma survivors “stop seeing themselves as important” or worthy,

and so they have been knocked off their path of adolescent development. For instance, a large percentage “have left school”, or they “stop doing the things they did before”, and practitioners found it helpful to “explore what their plans were before this happened”, or to “ally with their strengths, even if it’s a little thing”, to help to bring them back. The journey, according to one respondent, is about “how far you’ve come from who you are and finding your way back”.

But adolescents are inexperienced in the ways of the world (Copley, 1993), and practitioners found that they often needed basic information, for example around sex and their bodies, pregnancy, how to access resources, and so on, and also help with problem-solving through their issues, to help them back onto their path. This was often the case with adolescents who have not received this kind of assistance from their families, where parents themselves were abused and were “not in a position to support their children”, or where families found it acceptable to leave school to go out and work “because this brings in another income”. So for these respondents, part of the counsellors role when working with adolescents is to provide them with information, to facilitate their working through of issues, to help them to find options, to model appropriate behaviours, and to “help them think through the practical things that they can’t access themselves”, because as one practitioner pointed out, “how will they know unless you tell them”. So in sum, practitioners must remember that the adolescent is an ‘emerging being’ (Frankel, 1998), who is basically inexperienced in the ways of the world (Copley, 1993), and who therapists can assist in their striving for growth by being informative mentors and appropriate models of experience.

4.3.6. Resistance to therapy

Many counsellors experienced doubt and frustration with adolescent non-attendance, and ended up wondering if lack of attendance was because of something the counsellor did.

While it is important to ask this question as part of a reflective process, traumatised adolescents, as discussed in the literature, are also generally not motivated for treatment or may show an intense but fleeting attachment to the counsellor because of their ambivalence, uncertainty and distrust of adults (Kirk & Madden, 2003), denial of their distress (Sugar, 1999), or because they were referred and were not attending out of choice (Gil, 1996).

Practitioners also pointed out other reasons for erratic attendance, for example that the adolescent “couldn’t work on things before”, and later, when a new relationship starts or they have to write exams, for example, their anxiety re-triggers the trauma and they return for therapy. Occasionally clients in the crisis stage “haven’t always heard everything or understood about our services”, or people from disadvantaged backgrounds do not return simply because “they don’t have the money for transport”. Sometimes, according to respondents, adolescents “have so many other things to focus on in their lives” that attending therapy may not be their first priority, or “a lot of the time it’s around their own identity issues, that they don’t want to be different and rape makes them think that they are perceived as different”. Also, the continual threat when the “perpetrator lives within the family or community” may affect the adolescent’s attendance. Mostly, however, practitioners found that adolescent resistance often resulted from being forced to attend therapy:

FC1: “Often it’s the parents that feel the child needs counselling, and most of the time the adolescents are not ready to come or to talk about it...”

So it may be that when parents experience ‘acting out’ in adolescents after trauma, they send the child for counselling with someone who is ‘more equipped’ to handle their ‘difficult’ child, but identifying the child as the ‘problem’ may have the consequence of reinforcing that they are somehow to blame for what happened to them, or negatively impact on their expectations of caregivers, and as a result obstruct the formation of a positive therapeutic alliance (Shirk & Eltz, 1998). As Holmes (1991) put it, the adolescent needs to feel reassured by the counsellor’s manner and level of understanding, that they are being taken seriously, and that the gist of what is worrying them is grasped right from the start, without the therapist presuming to ‘know’ too much about them or trying to ‘take them over’ (Bronstein & Flanders, 1998; Holmes, 1991). To illustrate:

MPH1: “...if you’ve worked with them with integrity and trust, they will come back to you... instead of bombarding them with all the healing that you’re now going to be doing, and penetrate them and freak them out, and when they do actually need to come back they don’t want to come to you... so create something good with the child, and as things happen and suddenly they’re afraid... so they can come back... they need to be able to explore and come back to a trusted base”.

Thus it is the task of the therapist to establish a connection with the mistrustful, frightened and resistant adolescent, and this has to happen in the very first contact with them (Bronstein & Flanders, 1998). Some respondents, for example, observed that the moment the adolescent’s feelings and resistance are acknowledged, and they are given the option of returning “when they are ready”, this often makes it possible for the adolescent to open up.

4.3.7 Interrupted developmental processes

Adolescents must come to terms with their developing sexuality and develop a sexual identity (Louw, 1995), developing their understanding of their internal and external worlds (Gil, 1996; Louw, 1995), and separate and individuate from early object ties (Kroger, 1989).

Sexual victimization can disrupt these processes, leading for example to disturbances in sexual functioning, (Browne & Finkelhor, 1986; Price, 2003), distortions in body image (Straus, 1994), distorted cognitive schemas and beliefs (Gil, 1996), heightened anxiety and emotional turmoil (Kroger, 1989; Rutter et al., 1976), impulsivity and self-destructive behaviours (Cavaiola et al., 1988; Lindberg & Distad, 1985), a fear of intimacy, poor interpersonal relationships and isolation (Holmes, 1991; Straus, 1994), a breakdown in moral development (Straus, 1994), and an unstable sense of self (Friedrich, 1995, in Gil, 1996).

Practitioners focused mainly on disturbances in sexuality and body image; for example

FA2: "...their feelings about their body... she used to be told she was beautiful all the time, and now she's concealed and ashamed... some have mentioned that they don't like to look at themselves in the mirror anymore... beauty is something that's their fault, it's because they're beautiful that this happened to them".

In other words, adolescents are often in the beginning stages of trying to understand their bodies and to integrate their sexualities, and practitioners noted that usually there is a healthy transition from childhood to adulthood where there will be a time when the adolescent will make the decision to have a sexual relationship, but rape is forced on them and it can change the course of this process. In participants views, rape "exposes adolescents to an adult activity", and their "sexual awareness is prematurely awoken". They may then become sexually promiscuous because the adolescent "wanted to see if it's going to be the same as

that time or whether it can be different” or as another respondent put it, they close off to the world because adolescent girls, constantly faced with “symbolic penetration by the world, by masculinity, and by consciousness”, may find the additional concrete penetration of rape so overwhelming that “using their minds” or being open to growth, to knowing or to consciousness “may be too scary”.

Unless there is an understanding of the developmental needs of adolescents, practitioners may find them difficult to understand, they may respond on the basis of what they see but miss crucial dimensions, or they might see some behaviours, emotions or thought processes as seemingly inappropriate when in fact they are developmentally typical, or the other way around where behaviours they think are typical are actually inappropriate (Gil, 1996). On the other hand, viewing the adolescent in the context of their life stage, and their level of functioning, may prevent misunderstandings that could hinder the therapeutic process, and may provide the therapist with identifiable and feasible goals when devising treatment plans (ibid.). It is thus important to be as non-judgemental, accepting and as sensitive as possible to enable the adolescent to talk freely about these things, and to have a thorough knowledge of adolescent developmental process, so that the therapist is in a better position to act appropriately and therapeutically.

Overall these findings show a myriad of factors to be important when considering working with adolescent rape survivors. The themes that emerged from these practitioners’ accounts thus have implications for therapeutic practice, which will be discussed in the next section, after which possible future directions for research will be considered.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1. Implications for Counselling Practice

The literature and subjective accounts of participants demonstrates that adolescent rape survivors bring with them a number of complex and interlocking dimensions that need to be considered when devising appropriate therapeutic strategies for working with them. Emergent findings from the accounts of the participants, as seen in relation to the literature, shows a number of broad categories to be significant in planning interventions, including: 1) the specific stages in the recovery process; 2) conceptualising trauma and understanding symptoms; 3) developmental tasks of adolescence and related therapeutic challenges; and 4) the influence of the system on the traumatised adolescent. Within these categories specific themes were discerned from which therapeutic guidelines for working with adolescent rape survivors can be drawn. By changing these categories and themes into questions, that do not necessarily follow a linear sequence but may be asked concurrently throughout the therapeutic process, suggestions for helping adolescent rape survivors overcome their trauma may be illustrated as follows:

1) What stage of the recovery process is the client in? For example:

Is the adolescent's context detrimental to the child's welfare, and does social welfare need to be called on for the purpose of establishing safety? What are the pros and cons of involving social services, and what is going to be the best course of action for the adolescent? Does s/he need medical attention, has s/he been tested for STD's or HIV, or in the case of girls for pregnancy, does s/he need help with reporting the rape? This stage may involve:

- clarifying basic information,
- helping adolescents to access the relevant resources,
- supporting them through these processes if necessary, and
- providing them with basic containment through a warm, calm, empathic and consistent environment.

In Herman's (1992) stages of remembrance and mourning, and reconnection, the following questions might help in devising treatment strategies.

2) What symptoms and behaviours is the adolescent presenting with? Questions under this category include:

- If symptoms and behaviours are typical of the adolescent stage of development, how can the counsellor help the adolescent to develop self-awareness around their behaviours and in so doing, establish a sense of mastery over the anxieties elicited by the stage of adolescence?
- If the symptoms/behaviours pertain to the rape itself, how can the counsellor, for instance, assist the adolescent to regain control over basic physical and health needs such as regulating their sleeping and eating, managing post-traumatic symptoms (e.g. intrusive memories, hyperarousal, and avoidance), or controlling self-destructive behaviours?
- If symptoms are proving to be resistant to change, or there are other symptoms that do not describe typical adolescent behaviour or post-traumatic responses, does the client need specialized treatment for PTSD, substance abuse/dependence, depression/suicidality, self-mutilating behaviours, eating disorders, or other behaviours that put the adolescent at risk, before they can deal with the rape trauma?

- If there is a childhood history of physical or sexual abuse, do the symptoms/behaviours describe a more complex syndrome of disorders such as complex PTSD, borderline personality disorder, borderline intellectual functioning or intellectual disability, or another clinical diagnostic category that requires specialized treatment?

On the basis of their assessment, if the practitioner decides that they can continue to work with the adolescent, the questions and therapeutic guidelines that follow may be useful in guiding treatment.

3) What level of development is the adolescent functioning at, and on the basis of this, what issues are they dealing with and what are their specific needs? Questions that could be asked include:

- If the adolescent survivor appears to be acting according to what you would expect for their age group, what are the specific issues they are dealing with in relation to: changing body and emerging sexuality; beliefs and understanding about him/herself and the world; increasing separation from parents and attempts to be independent; peer, family or intimate relationships; or self-esteem or self-confidence?
- If the adolescent is fixated at an earlier stage of development, how does this affect what issues they bring and what their needs are, what are the issues (e.g. the rape trauma, early childhood trauma, and/or other emotional injuries incurred during development) that caused this arrested development, what earlier or more primitive defences is the adolescent using to prevent unwanted or unconscious material from entering into consciousness?

The following strategies for assisting adolescent rape survivors back onto their path of 'self-correcting' growth materialized from the study:

- providing an atmosphere of respect, clarity about what is expected in therapy, and laying down ground rules in the beginning;
- respecting the adolescent's need for privacy and working at their pace;
- holding the therapeutic boundaries;
- normalising the adolescents experiences while still recognising their narcissistic preoccupations and need to be treated as unique individuals;
- helping adolescents to name feelings and to reframe their distorted perceptions;
- meeting the adolescent 'at their level': being non-judgemental of their choices, attempting to understand their world, maintaining a 'delicate balance' by neither infantilising nor expecting too much of them, and respecting the generation gap;
- communicating that s/he is in control of how much s/he wants to disclose and encouraging self-expression through the use of other modalities such as drawing or journaling;
- helping adolescents to understand their defences, symptoms and behaviours as adaptation strategies to feeling overwhelmed, and continually monitoring these to adjust the 'temperature' of the therapy;
- providing the adolescent with emotional regulation, adaptive interpersonal and positive coping strategies;
- assisting adolescents through processes of problem-solving and decision-making and providing them with information in ways that they can relate to;
- helping them re-attribute blame from self to perpetrator and exploring ways of shifting attribution from 'characterological' to 'behavioural' self-blame;

- helping adolescents to re-establish a connection to previous goals or asserting their strengths and resources;
- always checking ego strength by asking about school, peer relationships, substance use, etc. in order to discern any shifts that might require reconsidering the direction of the therapy;
- helping adolescents to make links between current stressors or re-enactments and past traumas or relational conflicts; but being careful of colluding with them against the system, and also helping them to understand their parents responses without taking the parents side;
- attending to themes of separation and termination to avoid re-enactments of previous conflicts;
- working through 'tests of trustworthiness' by recognising and acknowledging failures in empathic responsiveness;
- monitoring countertransference responses and use of too much silence or pressure to disclose, and adjusting these accordingly; and
- supporting their non-attendance as attempts to re-adjust to their world, following-up if necessary, and communicating an open-door policy.

4) Is the family and community context negatively impacting on the healing and developmental processes of the adolescent? To illustrate:

Is the adolescent unsupported by his or her context, for example because family members are showing signs of secondary traumatisation, family interactional and communication styles are dysfunctional, fathers and mothers are absent or over-controlling, or there are family

members with a history of rape or childhood sexual or physical abuse? What follows is a list of possible options for working with the family:

- Psychoeducation: providing the parents with information about trauma and its effects on the child and on the child's context.
- Parenting skills training to improve parenting behaviours and responses to children.
- Parental coping and self-soothing strategies such as relaxation exercise to help them reduce their stress levels.
- Counselling mothers or the 'over-involved' parent: e.g. supporting traumatised mothers; providing counselling if there is a history of trauma; helping them to understand the shifting needs of adolescent e.g. for separation/individuation, need for privacy/confidentiality; helping her to withdraw her projections so she can provide the necessary support for recovery; helping mothers who are colluding with the perpetrator to understand the impact this has on their adolescent child.
- Counselling fathers or the 'absent, under-involved parent': e.g. (same as above), and helping fathers to understand their role in facilitating separation-individuation, to model 'good' and appropriate male nurturing behaviour and to develop a healthy and supportive relationship with their child.
- Joint family sessions: e.g. to help improve communication between members, set boundaries and clarify roles, and regulate their affective involvement in the child's activities.
- Opportunities for social support and parental empowerment: e.g. through a parent support group.

In sum, the findings and outline provided above demonstrates that victimization in the stage of adolescence is a complex phenomenon that calls for maintaining a 'paradoxical position', and that requires a multi-dimensional approach to treatment. As such, rape crisis counsellors working with adolescent survivors expressed a need for further training in the areas of adolescent development, and the study shows that there may also be a need for training in assessment of mental disorders typically associated with childhood abuse such as borderline personality disorder or complex PTSD. Also, since adolescents are very much still immersed in their family context, counsellors may also need further input in working with parents and families. In the event that these dimensions are already a part of practitioners' training, the research findings highlight the need to view the adolescent survivor from a multi-dimensional perspective, and to draw from many different therapeutic techniques and theoretical understandings in their approach to devising treatment plans, in order to attend to the shifting needs of adolescents during their process of healing from the rape trauma.

5.2. Future Directions

By focusing on the subjective accounts of practitioners, as well as drawing from literature dealing with trauma, adolescent development, and treatment strategies, this study provides a conceptual framework for understanding the variety of factors that inform our therapeutic work with adolescents recovering from the rape trauma. Among its strengths is the fact that a review of the literature, which revealed a dearth of studies that specifically dealt with the rape trauma in adolescence, means that this is a relatively new area of research, and that a study bringing together a number of ideas from a variety of different sources could ultimately be useful to professionals and lay counsellors working in this field. The qualitative nature of the study, however, means that the responses of the interviewees were not necessarily representative of the views of the majority of practitioners working in this area, and that the

subjective nature of the participants accounts cannot be validated. Thus, a survey of the views of practitioners may broaden or tighten the scope of the dimensions that emerged in this study as significant in trauma therapy with adolescents. In addition, research into the efficacy of existing models as they are applied to adolescents could help to develop a therapeutic model that is appropriate and relevant to this stage of development, where the results from this study could be used as a benchmark for further investigations. This includes an investigation into the differences between male and female rape victims, as well as longitudinal case studies that follow individuals' recovery processes over time. It may also be useful to research perceptions from traumatised adolescents' perspectives of what constitutes helpful and unhelpful interventions, attitudes and approaches of therapists. Post-rape trauma responses as they manifest in adolescents may also add to our understanding of working with adolescent rape survivors. From this study there seemed to be a difference between how adolescents from diverse cultures and communities presented, so that therapeutic interventions for adolescents from different backgrounds and with different customs also need to be explored, as well as the impact that practitioners from different cultures have on their adolescent clients. Working with unsupportive family members also emerged as an important category and it may help to conduct further research into the effectiveness of family-based therapy on the healing process of the adolescent. Finally, an investigation into the lack of social services, particularly of places of safety, may help to increase the number and improve the appropriateness of services for this age group. In sum, this study shows that adolescent rape survivors are a unique client group whose numbers are escalating, and that the way in which adolescents can be helped to recover from the rape trauma is an under-studied area. As such, the findings from this research may prove useful not only in providing practitioners with a point of reference for devising treatment strategies, but also in providing a foundation and impetus for future studies in this area.

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APPENDIX A:

Interview schedule (semi-structured) for focus groups, investigating effective treatment strategies for working with adolescent rape survivors:- (these questions serve mainly as a guide to focus the discussion around the research topic)

Question 1

Can you describe your experiences of working with adolescent rape survivors?

Question 2

What are the guidelines for working with adolescent rape survivors at Rape Crisis?

Question 3

Are there things that you have found to be particularly useful or problematic about this way of working with your adolescent clients? Describe.

Question 4

What have you found are the challenges of working with teenagers? Are these different to working with adults?

Question 5

How do you deal with these issues when they come up (and what are the outcomes)?

Question 6

What counselling techniques and strategies, in your experiences, work and don't work when counselling adolescent rape survivors?

Question 7

What criteria do you use to determine whether your intervention has worked or not?

APPENDIX B:

Interview schedule (semi-structured) for one-to-one interviews, investigating treatment strategies for working with adolescent rape survivors:- (these questions serve mainly as a guide to focus the participant's narration around the research topic)

Question 1

What current therapeutic model do you employ to deal with adolescent rape survivors?

Question 2

What are the things that you think are particularly useful or problematic about this model when working with your adolescent clients? Describe.

Question 3

Can you describe your experiences of working with adolescent rape survivors?

Question 4

What transference and/or counter-transference issues, major themes, defences and/or anxieties have come up for you when working with adolescents?

Question 5

How do you deal with these issues when they come up (and what are the outcomes)?

Question 6

What other therapeutic techniques and strategies, in your experiences, work and don't work with adolescent rape survivors?

Question 7

What criteria do you use to determine whether your intervention has worked or not on?

APPENDIX C:

Consent form for participants in the research study 'Investigating Treatment Strategies for Adolescent Rape Survivors':

Instructions to participants: Please print and then sign your name in the spaces provided in Section A before you participate in the study. Once the study is over and you have been debriefed, you will be asked to initial the three statements listed in Section B to indicate your agreement.

Section A

I, _____, voluntarily give my consent to participate in this project. I have been informed about, and feel that I understand, the basic nature of the project.

I understand that I may leave at any time and that my anonymity will be protected.

Signature of Research Participant

Date

Section B

Please initial each of the following statements once the study has been completed and you have been debriefed:

_____ I have been debriefed.

_____ I was not forced to stay to complete the study.

_____ All my questions have been answered satisfactorily.

Thank you for your participation.