Predictors of symptom severity and treatment attendance amongst rape and sexual assault survivors attending a Cape Town crisis counselling service

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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: Signed by candidate

Date: 14/02/2018

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To God be the glory.

ABSTRACT

Despite the prevalence of rape in South Africa and its association with a high risk of mental health difficulties, little research has examined the specific predictors of post-rape symptom severity or counselling retention rates of treatment-seeking rape survivors. This mixed methods study aimed to investigate predictors of symptom severity and treatment attendance amongst rape survivors attending a crisis counselling service in Cape Town. The quantitative phase of the research was comprised of a retrospective chart review of 482 intake files at three Rape Crisis counselling centres in Cape Town between 2012 and 2016. The qualitative phase involved four focus group interviews with 25 Rape Crisis counsellors at these three counselling centres. Quantitative data were analysed using bivariate statistics, a multiple linear regression and a zero-truncated negative binomial. Multiple linear regression analysis revealed that being English-speaking, reporting being raped (as opposed to reporting a sexual assault or attempted rape), and rape by an unknown perpetrator were associated with increased symptom severity. A zero-truncated negative binomial revealed that increased symptom severity, being male and identifying as a race other than black or coloured were associated with longer time in treatment. Counsellors perceived lower reported symptom severity to be influenced by clients' ability to identify symptoms, while poverty, poor social support, experiences of other trauma and knowing the perpetrator were perceived to increase symptom severity. Being a survivor of drug-alcohol facilitated rape/incapacitated rape and having practical obstacles to attending treatment were perceived by counsellors to result in shorter treatment attendance. Motivation for attending counselling was also perceived to influence length of attendance. There was both convergence and divergence between the quantitative and qualitative results. The implications of the findings for future research and delivering counselling to rape survivors are discussed.

Keywords: *Rape; sexual assault; symptom severity; treatment attendance.*

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ABBREVIATIONS AND ACRONYMS

ANOVA	Analysis of variance
CJS	Criminal justice system
CSA	Child sexual abuse
DAFR/IR	Drug-alcohol facilitated rape/incapacitated rape
IQR	Interquartile range
KZN	KwaZulu-Natal
PTSD	Post-traumatic stress disorder
RCCTT	Rape Crisis Cape Town Trust
RTS	Rape trauma syndrome
SAPS	South African Police Service
VoCS	Victims of Crime Survey
WHO	World Health Organization
ZTNB	Zero-truncated negative binomial

CHAPTER 1: INTRODUCTION

The incidence of rape in South Africa appears to be high compared to other countries (Jewkes & Abrahams, 2002; Jewkes, Skweyiya, Morrell, & Dunkle, 2009; Van der Spuy & Shearing, 2014). Globally, research has indicated that rape survivors are at high risk of developing post-traumatic stress disorder (PTSD), depression and other mental health difficulties. In one review of multiple studies, 94% of rape survivors who were assessed immediately after being raped met the criteria for PTSD and three months later 47% of the participants still met PTSD criteria (O'Shea, 2001). Despite the high prevalence of rape in South Africa and its association with a high risk of mental health difficulties, little research has examined the specific predictors of post-rape symptom severity or of counselling attendance by rape survivors in South Africa. Understanding which factors may predict symptom severity and treatment attendance can assist counselling services in providing targeted treatment that could improve treatment engagement and post-rape recovery.

1.1 Definition of rape and sexual assault in South Africa

In this study predictors of symptom severity and treatment attendance for survivors of two sexual offences, rape and sexual assault, were researched. Definitions of rape and sexual assault differ by country. In this study rape and sexual assault are defined according to the Republic of South Africa Criminal Law (Sexual Offences and Related Matters) Amendment Act of 2007, as amended. Rape is defined as,

> Any person ('A') who unlawfully and intentionally commits an act of sexual penetration with a complainant ('B'), without the consent of B, is guilty of the offence of rape,

and sexual assault is defined as,

> A person ('A') who unlawfully and intentionally sexually violates a complainant ('B'), without the consent of B, is guilty of the offence of sexual assault. A person ('A') who unlawfully and intentionally inspires the belief in a complainant ('B') that B will be sexually violated, is guilty of the offence of sexual assault (2013).

In this thesis, the term ‘rape survivor’ will refer to both rape and sexual assault survivors.

1.2 Prevalence of rape and sexual assault

The World Health Organisation (WHO) estimates that worldwide 35.6% of women have experienced either physical or sexual violence or both, however in Africa this was estimated above the global average, at 45.6% (World Health Organization, 2013). A survey of crime statistics based on data received from police services for the year 2002 found that South Africa had the highest rate of reported rape per capita of the countries surveyed (Van der Spuy & Shearing, 2014). Estimating the real incidence of rape and sexual assault in South Africa is difficult. Statistics released by the South African Police Service (SAPS) show that between 1 April 2016 and 31 March 2017, a total of 49 660 sexual offences were reported, with 39 828 and 6271 being incidences of rape and sexual assault, respectively (South African Police Service, 2017). However, it is unlikely that this is representative of the actual number of rapes and sexual assaults perpetrated during this time since research indicates that the prevalence of sexual violence may be four to nine times higher than what is reported to the SAPS (Jewkes & Abrahams, 2002). The findings of the 2015/16 Victims of Crime Survey (VoCS) showed that only 36% of people surveyed who admitted to having a sexual offence perpetrated against them in the year prior reported it to the police, a sharp drop from 67,3% in the 2013/14 period (Statistics South Africa, 2017a)[1]. This trend of declining reporting rates concurs with data released by the SAPS, when comparing these time periods, indicating that SAPS statistics are poor estimates of the real incidence of sexual violence in South Africa (Institute for Security Studies, 2017).

Since measuring the prevalence of sexual violence according to reported crime statistics may not be accurate, researchers have utilised survey methods to investigate the incidence of rape. In a study conducted with men in the Eastern Cape and KwaZulu-Natal, 27.6% of participants reported that they had raped a woman or girl in their lifetime, with 46.3% of these admitting to multiple perpetrations of rape (Jewkes et al., 2009). A 2010 survey of randomly selected households in Gauteng found that the lifetime incidence of sexual violence for female participants was 25.3%, while for male participants the lifetime prevalence of having perpetrated an act of sexual violence was 37.4% (Machisa, Jewkes, Lowe Morna, & Rama, 2011). This study also reported that 12.2% of women had been raped by a non-partner and 4.9% of women had experienced more than one incident of rape by a non-partner (Machisa et

[1] The 2016/2017 Victims of Crime Survey did not report findings on reporting rates of sexual offences for the period 31 March 2016 to 1 April 2017.

al., 2011). In a study of 785 women who patronised alcohol-serving venues in an informal settlement in Cape Town, 18.6% of participants reported an experience of forced sex during their lifetime (Watt et al., 2015). Another recent survey of 2600 men living in an informal settlement in Johannesburg revealed that 19% had committed an act of sexual violence and a further 19% had committed both sexual and physical violence in the previous year (Hatcher et al., 2017). Furthermore, it is concerning to note the trend revealed in the 2016/17 VoCs that the rate of sexual offence revictimisation is on the increase in South Africa (Statistics South Africa, 2017b). Collectively, these studies indicate an alarmingly high incidence of self-reported experiences and perpetration of sexual violence in South Africa. Given the high prevalence of rape and sexual assault in South Africa and the associated negative mental health consequences, having a better understanding of factors that may exacerbate symptom severity and influence treatment attendance would be beneficial in the treatment of rape survivors. Currently limited research has investigated this within the South African context.

1.3 Research objectives

This mixed methods study had two main objectives. Firstly, it aimed to investigate the association between demographic and rape incident characteristics and post-rape and sexual assault symptom severity in a treatment-seeking sample of survivors. In this study, symptom severity is defined as the number of symptoms survivors present with post-rape. Secondly, it aimed to examine whether demographic factors, rape incident characteristics, and symptom severity are associated with length of attendance of counselling at a rape crisis counselling service.

1.4 Structure of dissertation

The dissertation consists of five chapters. The second chapter provides a summary of the literature outlining the negative mental health sequelae for rape survivors as well as a summary of the current research on predictors of symptom severity and treatment attendance. Chapter Three outlines the methodology employed in this study. The findings of this research are reported in Chapter Four. The final chapter presents a summary and discussion of the findings and a consideration of the implications of these for future research and treatment planning.

CHAPTER 2: LITERATURE REVIEW

This chapter provides an overview of the literature on the impact of rape as well as the current research examining which demographic and rape incident characteristics may place rape survivors at increased risk of negative mental health sequelae. A review of research examining factors associated with counselling attendance is then presented.

2.1 Post-rape and sexual assault mental health sequelae

Posttraumatic stress disorder, anxiety, depression, obsessive-compulsive disorder and substance abuse are common mental health problems that survivors of sexual violence develop (World Health Organization, 2013). Compared with survivors of other forms of trauma, rape survivors have consistently been found to be at a significantly higher risk of developing PTSD, to experience greater PTSD severity, to have higher rates of eating and sleeping disorders, bipolar and obsessive-compulsive disorder, to be more likely to develop comorbid conditions such as depression and substance abuse and to be at higher risk of suicidal ideation and attempts (Au, Dickstein, Comer, Salters-Pedneault, & Litz, 2013; Campbell, Dworkin, & Cabral, 2009; Chen et al., 2010; Dworkin, Menon, Bystrynski, & Allen, 2017; Kelley, Weathers, McDevitt-Murphy, Eakin, & Flood, 2009; Kilpatrick & Acierno, 2003; Koss, Bailey, Yuan, Herrera, & Lichter, 2003; Zinzow et al., 2012). A United States-based prospective study investigating chronicity of PTSD in a national sample of women found that having a history of rape was a statistically significant predictor of PTSD after two years (Cougle, Resnick, & Kilpatrick, 2013). Much of the research devoted to sexual assault and rape and consequent development of PTSD and other psychological distress has focussed on the experience of women. However, a review article about the consequences of rape for men indicates that male survivors of rape experience similar mental health sequelae to female rape survivors (Peterson, Voller, Polusny, & Murdoch, 2011).

South African research concurs with international findings regarding the negative mental health sequelae associated with sexual violence. In a national prevalence study in South Africa, rape was found to be associated with the highest risk for PTSD amongst survivors of different kinds of interpersonal violence (Kaminer, Grimsrud, Myer, Stein, & Williams, 2008). A 2017 three-province study found a high prevalence of PTSD (87%) and moderate prevalence of depression (51%) amongst rape survivors (Mgoqi-Mbalo, Zhang, & Ntuli, 2017). Another recent study conducted in Cape Town examining different types of trauma experiences as predictors of

PTSD in adolescents found sexual abuse to be a significant predictor of PTSD (Nothling, Simmons, Suliman, & Seedat, 2017).

2.2 Predictors of post-rape and sexual assault symptom severity

Although research indicates that survivors of sexual violence appear to be at higher risk for developing PTSD and other psychiatric disorders than survivors of other types of trauma, not all survivors experience post-rape symptom severity equally (Campbell et al., 2009). Understanding which factors might predict increased symptom severity would assist in providing more targeted treatment for survivors of sexual assault. However, international research has found discrepant results in terms of demographic and rape incident characteristics that predict symptom severity (Campbell et al., 2009; Jordan, Campbell, & Follingstad, 2010). Further, these international findings might not be replicated within the South African context and despite consistent findings that rape victimisation is associated with an increased risk of mental health difficulties, very little research has examined specific predictors of post-rape symptom severity in South Africa.

2.2.1 Demographic factors

Currently there is limited research investigating age as a predictor of post-rape symptom severity. A review article found a dearth in research specific to the effects of rape and sexual assault on mid-life women as well as few studies that addressed age specifically in research results (Thomas, Scott Tilley, & Esquibel, 2015). An article reviewing the effects of sexual and physical trauma on elderly women cited only one study that researched post-rape symptom severity amongst older women (Cook, Dinnen, & O'Donnell, 2011). The findings indicated that elderly women showed increased depressive symptoms when compared with younger women a year after being raped (Cook et al., 2011). A local study found that age was a significant predictor of symptoms of depression (Malan, Hemmings, Kidd, Martin, & Seedat, 2011). These limited findings suggest that the older survivors are, the more susceptible they might be to developing depression. By contrast, some international research points to younger age being a predictor of increased PTSD symptoms in the aftermath of rape (Ullman, Filipas, Townsend, & Starzynski, 2007). This concurs with a local clinic study which found that adolescent rape survivors were at double the risk for developing PTSD compared with adult survivors, indicating that younger age may be a risk factor for increased PTSD amongst South African rape survivors (Van der Walt, Suliman, Martin, Lammers, & Seedat, 2014).

Similarly, and as mentioned earlier, limited research has focussed on the psychological effects of rape and sexual assault on men. A recent review article found only 24 studies examining post-rape psychological functioning in males (Peterson et al., 2011). While some studies have found that men experience similar psychological consequences to women (Cortina & Kubiak, 2006; Tolin & Foa, 2006), others have found that men experience increased symptom severity as well as higher rates of lifetime psychiatric diagnoses and hospitalisation when compared to women survivors of rape (Peterson et al., 2011). However, these findings are limited to a few studies and warrant further investigation. Although the findings are discrepant when comparing the effects of rape on male and female survivors, the review found consistent evidence that male survivors had worse overall psychological functioning than men who had not been raped (Peterson et al., 2011).

A recent study found that bisexual women reported greater symptom severity for both PTSD and depression than heterosexual women, indicating that sexual minority status may increase vulnerability to negative mental health sequelae post-rape (Sigurvinsdottir & Ullman, 2016a). Over a three-year time period, black women showed faster recovery in terms of symptom severity reported for PTSD and depression than non-black women, suggesting that race may play a role in recovery. However, women who identified as bisexual and of a black race group showed the highest PTSD and depression symptom severity indicating that one should consider intersectionality when examining predictors of post-rape symptom severity (Sigurvinsdottir & Ullman, 2016a).

In a United States study, Ullman and Najdowski (2009) found that demographic characteristics of rape survivors are significantly related to suicidal ideation post-rape. Specifically, minority ethnic groups (African American and Hispanic), younger women, and those who identified as bisexual were found to have greater suicidal ideation. Another United States study found that participants who had less education reported more severe PTSD symptoms (Ullman & Filipas, 2001). The study did not find significant differences in the PTSD severity of rape survivors of different ethnic groups, however this may be due to the fact that this study had a relatively small sample of participants who identified themselves as part of a minority ethnic group.

A South African clinic study with 140 participants from the Eastern and Western Cape provinces found that participants who identified as coloured were more likely to experience depressive symptoms four to six weeks after being raped than those who identified as black

(Abrahams, Jewkes, & Mathews, 2013). The researchers attributed this to differing social responses to the disclosure of being raped across different communities in South Africa. This suggests that sociocultural factors may mediate the psychological impact of rape on survivors. As indicated by these findings, race may be a proxy for sociocultural factors. Given the legacy of inequality due to Apartheid, race may also be a proxy for how economically resourced individuals are and this may also play a role in symptom severity as indicated by the finding in the same study that unemployment was statistically associated with increased incidence of depression (Abrahams et al., 2013). In addition, this study also found that having more than 11 years of education was associated with depression.

A recent study conducted in three South African provinces, Limpopo, KwaZulu-Natal (KZN) and the Western Cape, found that cohabitation or marriage was statistically significantly associated with decreased PSTD and depression symptom severity, while unemployment was a significant predictor of increased depressive symptom severity (Mgoqi-Mbalo et al., 2017). The study also found that living in the KZN region was statistically significantly associated with increased symptom severity. The authors suggest that this result may be mediated by a number of factors. Participants from KZN had the most reports of child sexual abuse (CSA), proportionally, lived in the province with the highest incidence of murder, were the least educated in the study sample and were mostly unemployed. The authors suggest that compounding trauma and poverty may have exacerbated their symptom severity when compared to the participants from the other provinces and suggest these factors be researched further (Mgoqi-Mbalo et al., 2017). The cumulative effects of trauma and its association with symptom severity is discussed further in section 2.2.3. No other South African studies have investigated the relationship between demographic factors and post-rape symptom severity.

2.2.2 Rape incident characteristics

Studies investigating rape incident characteristics as predictors of symptom severity have produced mixed results. Some studies have found no association between identity of the perpetrator and symptom severity (Elklit & Christiansen, 2013; Ullman et al., 2007). An older study found that not knowing the identity of the perpetrator was significantly associated with PTSD (Bownes, O'Gorman, & Sayers, 1991). Similarly, a more recent study found that knowing the identity of the perpetrator was marginally associated with a lower risk of developing PTSD and depression post-rape (Zinzow, Resnick, McCauley et al., 2010). However, an older study found that rape by a family member predicted chronicity of PTSD

one year post-rape (Darves-Bornoz et al., 1998). One study found that type of sexual offence (rape vs attempted rape) and number of perpetrators were not significantly associated with symptom severity (Elklit & Christiansen, 2013). However, other studies have found multiple perpetrator rapes to be a significantly associated with increased symptom severity (Machado, de Azevedo, Facuri, Vieira, & Fernandes, 2011; Tiihonen Möller, Bäckström, Söndergaard, & Helström, 2014; Ullman, 2007a; Ullman & Najdowski, 2009).

A few studies have focused on the role of perceived threat to life, severity of assault, physical violence and injury accompanying rape and sexual assaults. Some studies have found an association between rapes accompanied by physical violence and PTSD (Bownes et al., 1991; Darves-Bornoz et al., 1998) while another found no relationship (Ullman et al., 2007). Others have found that physical injury is a significant predictor of PTSD and depression (Tiihonen Möller et al., 2014; Zinzow et al., 2010). Further, survivors who perceived their rape as more life threatening were more likely to develop PTSD or have increased PTSD symptom severity (Ullman & Filipas, 2001; Ullman et al., 2007). Being subjected to multiple sexual acts in one attack has also been found to be significantly associated with PTSD (Tiihonen Möller et al., 2014). Overall, there appears to be an association between various indicators of severity of perceived threat to life and physical injury and the severity of PTSD symptoms.

Drug-alcohol facilitated rape and incapacitated rape (DAFR/IR) seem to be prevalent, particularly amongst university students (Walsh, DiLillo, Klanecky, & McChargue, 2013; Zinzow et al., 2010). Gilmore and colleagues (2017) define DAFR/IR as, "…non-consensual sex resulting from an inability to consent from voluntary or involuntary ingestion of drugs or alcohol" (para. 1). International studies have found that DAFR/IR survivors had lower incidences of major depression and PTSD diagnoses when compared with survivors of non-substance related rape (Gilmore et al., 2017; Zinzow, Resnick, Amstadter et al., 2010; Zinzow et al., 2012). Another study with survivors of physical assault and rape found that survivors who had been drinking alcohol at the time of the rape or assault had lower intrusive PTSD symptoms initially, but these symptoms took longer to ameliorate (Kaysen et al., 2010). Some research indicated that DAFR/IR survivors appear to be at increased risk of substance abuse in the aftermath of rape compared with survivors of non-substance related rape (Zinzow et al., 2012).

Only two South African studies have explored whether rape incident characteristics are associated with post-rape adjustment. Abrahams and colleagues (2013) examined predictors of depressive symptoms amongst rape survivors in the public hospital service in the Eastern and Western Cape. They found that survivors who were raped by a known perpetrator were more likely to develop post-rape depressive symptoms than those who were raped by an unknown perpetrator, possibly due to a lower risk of victim-blaming by others if the perpetrator was a stranger compared to a partner or acquaintance. This again suggests that sociocultural factors may mediate the impact of rape, however the correlational nature of the study does not allow for causal conclusions. Abrahams and colleagues (2013) also found that the number of perpetrators and the severity of the assault did not predict depressive symptomatology. However, another local study found that severity of the assault (weapon use or threatened weapon use) was a significant predictor of increased depressive symptoms (Mgoqi-Mbalo et al., 2017).

The literature review indicates discrepant results in both the South African and international research examining the association between rape incident characteristics and symptom severity, suggesting that rape incident characteristics may overall play a limited role in predicting post-rape symptomatology. However, given the dearth of local research, further investigation is warranted.

2.2.3 Other factors

Research indicates that prior interpersonal trauma is a significant predictor of post-rape symptom severity. A recent WHO mental health survey found that experiences of multiple incidences of trauma as well as childhood adversities were significant predictors of PTSD in rape survivors (Scott et al., 2018). This study found that previous sexual trauma, although part of the measure of overall prior trauma, was not on its own a significant predictor of PTSD. Another study found prior non-sexual trauma, but not prior sexual trauma, to be a significant predictor of PTSD symptom severity (Elklit & Christiansen, 2013). In contrast to these results, other research has found that multiple sexual traumas in adulthood as well as a history of CSA contributed to greater symptom severity in rape survivors (Sigurvinsdottir & Ullman, 2016a; Sigurvinsdottir & Ullman, 2016b; Ullman & Peter-Hagene, 2016). Exposure to two or more traumatic events prior to being raped has also been found to be a statistically significant predictor of symptom severity (Tiihonen Möller et al., 2014). A history of CSA and other trauma exposures have been found to be factors that are statistically significant predictors of

suicidality, as well as increased PTSD and depressive symptoms amongst rape survivors (Cheasty, Clare, & Collins, 2002; Schumm, Briggs-Phillips, & Hobfoll, 2006; Taft, Resick, Watkins, & Panuzio, 2009; Ullman et al., 2007; Ullman & Najdowski, 2009; Ullman, Peter-Hagene, & Relyea, 2014). A local study found that childhood trauma was not a predictor of PTSD in adult survivors of rape (Malan et al., 2011). The authors advise that this result be interpreted with caution since the result may have been mediated by resiliency, a factor that was not measured in that study and may play a protective role in preventing the development of PTSD. Due to the high incidence of childhood trauma in South Africa, this population may have been particularly resilient (Malan et al., 2011). While research overwhelmingly suggests that compounded trauma predicts increased symptom severity, there are discrepant findings regarding prior sexual victimisation as a predictor of increased symptom severity.

While some studies have found that social support is not a statistically significant predictor of PTSD (Elklit & Christiansen, 2013), others have found that it is an important mediating factor when considering predictors of increased post-rape symptomatology (Sigurvinsdottir & Ullman, 2016b). A review of international literature shows strong evidence for social support as a protective factor reducing post-rape symptom severity (Borja, Callahan, & Long, 2006; Dworkin, Ojalehto, Bedard-Gilligan, Cadigan, & Kaysen, 2017; Schumm et al., 2006). This finding was confirmed by two local studies (Abrahams et al., 2013; Wyatt et al., 2017). However, another South African study found that social support was significantly associated with increased depressive symptoms post-rape, although no significant relationship with PTSD was found (Mgoqi-Mbalo et al., 2017). The authors suggest that not all support that is offered to survivors may be protective and further research into what kind of support survivors in the South African context will benefit from is warranted. A South African study conducted in two provinces found that social undermining (conceptualised as feeling criticised by others) was significantly associated with increased symptoms of depression suggesting that unsupportive responses from a social support network may be a deleterious factor in the recovery of rape survivors in South Africa (Wyatt et al., 2017).

Evidence suggests that survivors who are responded to negatively after disclosure of rape exhibit increased symptom severity, making this an important measure of how supported survivors feel (Hakimi, Bryant-Davis, Ullman, & Gobin, 2016; Relyea & Ullman, 2013; Ullman et al., 2007; Ullman & Peter-Hagene, 2016). An older international study found that negative social reaction after disclosure - being responded to in a stigmatising way or being

told to, “get on with their lives,” - was statistically significantly related to increased PTSD symptom severity (Ullman & Filipas, 2001, p. 383). Some United States studies have shown that minority racial and sexual orientation groups are more likely to experience negative social reactions when disclosing having been raped, indicating that social response may be embedded in cultural values associated with different racial and religious groups. (Hakimi et al., 2016; Sigurvinsdottir & Ullman, 2016b; Ullman & Filipas, 2001). This may place survivors of certain racial or religious groups at increased risk of negative mental health consequences post-rape. Survivors of certain types of rape, such as gang rape, may also be at increased risk to receive negative social reaction to disclosure (Ullman, 2007a).

A history of psychopathology has also been found to be a significant predictor of symptom severity, six months post-rape (Machado et al., 2011). Two studies have found the presence of comorbid depression to be significantly associated with PTSD symptom severity (Machado et al., 2011; Tiihonen Möller et al., 2014). Some limited research has examined the role of personality traits, coping mechanisms, cognitive and genetic factors as predictors of symptom severity in rape survivors. Amongst these negative affectivity (measuring how well people cope with stress); a negative change in outlook on life (reappraising one’s circumstances and future as negative post-trauma); distorted trauma-related beliefs (changes in how survivors view the world); disruption in beliefs (discrepancy between how they view themselves presently versus their ideal future self); diminished generalised perception of control; self-stigma; tonic immobility (a temporary paralysis in response to a fearful situation) and dissociation have been found to be statistically significant predictors of increased post-rape symptom severity (Beck Hansen, Hansen, Hjort Nielsen, & Elklit, 2017; Boeschen, Koss, Figueredo, & Coan, 2001; Bolstad & Zinbarg, 1997; Deitz, Williams, Rife, & Cantrell, 2015; Elklit & Christiansen, 2013; Möller, Söndergaard, & Helström, 2017; Taft et al., 2009). Conversely, perceived control over recovery was found to ameliorate symptoms (Ullman et al., 2007; Ullman & Najdowski, 2009).

A local study also found that dissociation at two weeks post-rape was a significant predictor of both PTSD and depression soon after being raped suggesting that identifying dissociative symptoms early on may be useful in screening survivors at high risk of developing mental health difficulties (Malan et al., 2011). As mentioned earlier, resilience may be a protective factor preventing the development of PTSD. One Cape Town-based study has examined the role of resilience and found that it was not a predictor of PTSD symptom severity post-rape (Van der Walt et al., 2014). However, the study noted some limitations and indicated that

further research is warranted to better understand the association between resilience and post-rape PTSD (Van der Walt et al., 2014). Another local study found that relative shortening of leukocyte telomere length (a protective nucleoprotein that caps the ends of chromosomes) was associated with the development of PTSD in a sample of Cape Town rape survivors (Malan et al., 2011). These findings suggest that certain genetic factors may increase risk of developing PTSD in rape survivors, however due to the small sample more investigation is required to test replication of this result.

2.3 Alternative models of assessing symptom severity

In a study conducted in 1974, rape trauma syndrome (RTS) was first described as the unique physical, psychological, sexual and/or social responses that rape survivors experience (Burgess & Holmstrom, 1974; Burgess, 1983). RTS is an early conceptualisation of PTSD with wider symptoms commonly experienced by survivors of rape and sexual assault including depressive and physical symptoms (Burgess & Holmstrom, 1974). A literature review reveals that RTS has been used infrequently in research in recent years, in favour of describing survivors' symptomatology in terms of PTSD (Campbell et al., 2009; Darves-Bornoz et al., 1998). However, a recent study shows that rape survivors consistently reported symptoms of both depression and PTSD and that a diagnosis of one of these disorders, exclusively, was rare (Au et al., 2013). Au and colleagues (2013) suggest that this may mean that a combination of depression and PTSD symptoms is a pervasive manifestation of post-trauma symptomatology in rape survivors. This study indicates that a broader model of assessing symptoms than PTSD, such as RTS, may be appropriate for survivors of sexual violence; however most previous research on predictors of post-rape symptom severity has focused only on one diagnostic area.

2.4 Treatment engagement of rape and sexual assault survivors

As rape survivors are at high risk for developing mental health difficulties, engaging rape survivors in treatment is important for their recovery. Identifying whether demographic factors and rape incident characteristics may influence treatment retention would be useful for enhancing the planning of services to increase treatment engagement of rape survivors. However, both in South Africa and internationally, there has been limited research on the factors that predict counselling attrition or retention of treatment-seeking rape survivors.

2.4.1 Overview of research on treatment engagement of rape survivors

Different types of treatment for rape survivors with PTSD have been researched from an efficacy perspective (Markowitz, Neria, Lovell, Van Meter, & Petkova, 2017; Nixon et al., 2016; Russell & Davis, 2007), while other research has identified strategies that survivors employ to find help as well as formal versus informal treatment avenues (Campbell, Greeson, Fehler-Cabral, & Kennedy, 2015; Kennedy et al., 2012; Lewis et al., 2005; Ullman, 2007). Some studies have examined what factors predict delayed versus immediate treatment-seeking behaviour amongst rape survivors (Millar, Stermac, & Addison, 2002; Stewart et al., 1987). With regards to factors that may influence post-rape mental health help-seeking, Alvidrez and colleagues (2011) found that white women were more likely than black women to seek counselling treatment post-rape, whilst alcohol abuse and having been in counselling before also predicted engagement of mental health services in another study (Price, Davidson, Ruggiero, Acierno, & Resnick, 2014). Other research found that survivors of DAFR/IR were less likely to engage medical services post-rape than survivors of non-substance related rape (Walsh et al., 2016).

To identify studies that have examined predictors of treatment attrition amongst rape survivors who do access treatment, a systematic literature search was conducted using Academic Search Premier, Africa-Wide Information, Health Source: Nursing/Academic Edition, Humanities International Complete, MasterFILE Premier, MEDLINE, PsycARTICLES, PsycINFO, SocINDEX based on the following search terms: Rape and (clinic or treatment or patient or counselling or service or help) and (SU visit* or SU attend* or SU drop-out or SU "drop out" or SU dropout or SU attrition or SU laps*); ("Rape Victim*" or "Rape survivor*") and (contin*or persever*); Rape and (clinic or treatment or patient or counselling or service or help) and (visit* or attend* or drop-out or "drop out" or dropout or attrition or laps*); Duration or sessions Rape and (treatment or counselling) and (engagement or refusal or avoidance) engagement or help-seeking "treatment refusal" or "treatment avoidance". The search yielded six studies: four that examined predictors for treatment length of post-rape combined medical and counselling/psychotherapy services (Ackerman, Sugar, Fine, & Eckert, 2006; Darnell et al., 2015; Holmes, Resnick, & Frampton, 1998; Richer et al., 2017), one that examined predictors of counselling/psychotherapy attendance amongst rape survivors (Rizvi, Vogt, & Resick, 2009) and one amongst adult survivors of CSA (Fletcher, Elklit, Shevlin, & Armour,

2017). In addition, one review article looking at predictors of length of counselling/psychotherapy post-rape was found (Matthieu & Ivanoff, 2006).

2.4.2 Predictors of treatment attendance

Some studies have focussed on factors that predict length of treatment of combined medical and counselling support services at forensic hospitals. A recent study examining factors that were predictive of follow-up medical/counselling treatment of rape survivors after the initial visit to a forensic medical unit, found that history of mental health disorder and social support were associated with more sessions, while disability, being assaulted in public and current mental health disorder predicted dropout (Darnell et al., 2015). Another found younger age, amnesia, alcohol-related rape and being raped at home to be associated with greater attendance while homelessness, mental health disorder and rape by a partner were associated with earlier attrition (Ackerman et al., 2006). A third study found that survivors of drug-assisted sexual assault or rape were more likely to continue medical and mental health treatment than survivors of rapes with no drug involvement (Richer et al., 2017). However, an earlier study found no demographic or rape incident variables predicted treatment retention or attrition rates (Holmes et al., 1998).

A 2006 review article reported on treatment dropout amongst adults who had engaged in treatment for PTSD (Matthieu & Ivanoff, 2006). The review found few - only 13 - studies that met its inclusion criteria and attributed this to the fact that researchers are hesitant to report attrition in their studies since it may negatively impact the perception of study robustness (Matthieu & Ivanoff, 2006). Amongst the studies reviewed, only two focussed on the treatment of adult survivors of rape (Foa, Rothbaum, Riggs, & Murdock, 1991; Foa et al., 1999; Resick & Schnicke, 1992), one focussed on CSA (Zlotnick et al., 1997) and two on a mixed sample of sexual and non-sexual assault survivors (Foa, Hearst-Ikeda, & Perry, 1995; Foa et al., 1999). In spite of the few articles available, the review found some commonalities between participants who dropped out: they were more likely to be unemployed, have less income, a history of past counselling and show greater symptom severity for PTSD and other symptom measures than participants who completed treatment (Matthieu & Ivanoff, 2006).

The literature search yielded one study that investigated predictors of treatment dropout for two types of intervention, Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) for sexual assault-related PTSD (Rizvi et al., 2009). Findings indicated that participants who

were younger, had less education and lower intelligence were more likely to drop out of both types of therapy (Rizvi et al., 2009). A recent study examining predictors of treatment attendance amongst survivors of CSA that found that more education and being male were associated with increased attendance of psychotherapy (Fletcher et al., 2017).

Matthieu and Ivanoff (2006) make a strong case for the need for more research about treatment dropout: "What we learn about participants who leave can help shape recruitment, pretreatment, and adjunct services that may improve retention" (p. 1663). Rizvi and colleagues (2009) argue that few studies have focussed on treatment attrition and the predictors thereof, and that such studies are important for the enhancement of treatment engagement amongst rape survivors with PTSD. Furthermore, the literature search indicated no South African research in this area and that no research has specifically looked at the relationship between rape incident characteristics and counselling treatment attendance. Given the limited studies available, predictors of treatment attendance of rape survivors is an area that warrants further research.

2.5 Summary

While several studies have examined the role of demographic and rape incident characteristics in predicting symptom severity among rape survivors, findings have been mixed and there is a dearth of South African research despite our country's high prevalence of rape. Few studies examining predictors of counselling or psychotherapy attendance of rape survivors were found, and the vast majority of existing research is international and may not be replicated in the South African setting, highlighting the need for further research. The next chapter presents the aims and methodology of the current study.

CHAPTER 3: METHODOLOGY

This chapter presents the research aims and the methods employed in conducting this research. This study used a mixed methods approach and a description of the procedure followed for both the quantitative and qualitative phases is provided. The chapter ends with a description of the ethical procedures that were followed in this study.

3.1 Research Aims

The review of the literature indicated that rape survivors fall into a high-risk category for the development of mental health difficulties and that the demographics of the survivor as well as characteristics of the rape may influence post-rape adjustment. In South Africa, there is a dearth of research investigating these factors as predictors of the mental health difficulties among rape survivors, and the diverse sociocultural context of South Africa suggests that international findings may not be replicated locally. Further, both internationally and in South Africa little is known about the factors that may influence retention of rape survivors in treatment. The current study aimed to contribute to the limited global body of literature on predictors of treatment attendance amongst rape survivors and to add to the research regarding predictors of symptom severity. The study aimed firstly to investigate the association between demographic and rape incident characteristics and the severity of post-rape symptomatology in a treatment-seeking sample of rape survivors at the Rape Crisis Cape Town Trust (RCCTT); and secondly to investigate whether demographic factors, rape incident characteristics, and symptom severity are associated with length of attendance of counselling. In addition to contributing to research on the treatment needs of rape survivors, the study aimed to assist planning of services and training of RCCTT counsellors to enhance treatment delivery and the engagement of rape survivors in treatment.

3.2 Study design

This project made use of a mixed methods research approach. Mixed methods is a relatively new approach to research that has in recent years gained popularity due to the advantages of combining both quantitative and qualitative data in answering a research question (Creswell & Plano Clark, 2007; Creswell & Zhang, 2009). The merging of quantitative and qualitative approaches makes the mixed methods research methodology particularly appropriate for use in trauma research: the strengths of combining data that is quantifiable with the subjective experience of human beings leads to a richer understanding of the trauma-related research question (Creswell & Plano Clark, 2007; Creswell & Zhang, 2009). Furthermore, the use of

both research approaches together offsets the individual limitations of each, since quantitative and qualitative research have very different strengths and weaknesses (Creswell & Plano Clark, 2007). The study made use of a concurrent triangulation approach, whereby the qualitative phase of the study ran simultaneously with the quantitative. Collecting the data sets at the same time decreases the chance of one of the sets of data influencing the findings of the other (Creswell, 2009).

The quantitative phase of the research was comprised of a retrospective chart review of intake files at the three RCCTT counselling centres in Cape Town: Athlone, Khayelitsha and Observatory. Gearing and colleagues (2006) argue that historical records are an easily accessible data source because the data has already been collected, often in areas that are difficult to research. This data collection method does have limitations, such as the fact that the medical charts or information sheets used in retrospective research are often incomplete, not filled out with research in mind, and frequently riddled with jargon that leads to problems in understanding and interpreting the data (Gearing et al., 2006). However, in this case, the information gathered on the intake forms has been collected with research in mind. The researcher, having undergone the RCCTT counselling training, had been trained in the proper administration of the RCCTT intake form and was thus very familiar with how to interpret the data contained in these forms. Thus far, RCCTT has had no formal research analysis of predictors of client symptomatology or counselling attendance.

In addition to the data in the intake files, the RCCTT counsellors are themselves well-placed to comment on the factors that predict both symptom severity and treatment attendance amongst the rape survivors that they counsel. Counsellors may be able to elaborate on how and why certain factors influence symptomatology and attendance, and identify relevant factors not included on the intake form. Interviewing therapists and counsellors working with survivors of sexual violence has been shown to be an effective way of gathering rich data about the experiences of survivors of sexual assault (Ullman, 2005; 2014). The qualitative phase thus involved focus group interviews with RCCTT counsellors who were willing to participate in the study.

3.3 Participants

The study was conducted at the RCCTT, a volunteer-based organisation that offers various services to male and female survivors of rape over the age of 14 years. Services include counselling, court support and pre-trial consultations. The organisation also has an advocacy arm that creates awareness in the Cape Town area about rape and gender-based violence and lobbies for greater government support in providing services to rape survivors. RCCTT has three counselling centres situated in Athlone, Khayelitsha and Observatory that offer services to a racially diverse population comprised mostly of women.

RCCTT has had different iterations of the intake form they use and for the purposes of uniformly coding data, the form that was introduced in January 2011 at Observatory and January 2012 at the Athlone and Khayelitsha office was coded and analysed. In January 2016, RCCTT introduced the latest version of their intake form. Thus, intake forms over a 5-year period from January 2011 to January 2016 from the Observatory office and from January 2012 to January 2016 for the Athlone and Khayelitsha offices were included in the quantitative phase of the study.

A total of 1885 clients accessed RCCTT's counselling services during this period, however 33 of the case files were missing resulting in 1852 files being available for inclusion in the study. One of the major criticisms against the validity of retrospective chart reviews is a lack of clear inclusion and exclusion criteria (Vassar & Holzmann, 2013). In the early stages of the research, the researcher reviewed the intake forms to firstly assess the viability of the study (i.e. is the sample of intake forms large enough to produce statistically relevant data?) and secondly to develop clear guidelines for the inclusion and exclusion of files. After the review of the files the following inclusion criteria were determined:

1. Those where clients had reported a single incidence of rape, attempted rape or sexual assault.
2. Those who had presented for counselling within two years of experiencing the sexual offence.
3. Those who met the counselling criteria of the organisation i.e. were 14 years or older when the sexual offence was committed and had sought rape-related counselling.
4. Those that were complete.

Regarding the first criterion, in files where there was reference to more than one incident of sexual violence perpetrated against the client, it was not clear which rape incident characteristics recorded in the intake form refer to which sexual offence, or which symptoms are associated with which incident. Therefore, it was decided to restrict the research to the files of clients reporting a single incidence of a sexual offence. In the case of criterion two, there was wide variance in the length of time between being raped and presenting for counselling of between a few days after, to 15 or more years after the incident. It was therefore important to define a cut off time. Since 85,4% of clients presented within two years of the rape or sexual assault, it was decided to use this time frame as the inclusion criteria, to maximise the possible sample. Turning to criterion three, RCCTT has very specific parameters for clients to access their services. For example, during the period that the study focused on, the RCCTT policy was that adult survivors of child sexual abuse or clients seeking treatment for domestic violence were not eligible to access its services. Invariably screening is not always successful prior to the first counselling session. After the intake session, these clients should have been referred to other services for counselling which would then affect the number of sessions attended by that client. Since being referred would impact one of the outcome variables (treatment attendance) clients who did not meet the RCCTT counselling criteria were excluded. In one case a file was excluded even though the client did meet the RCCTT counselling criteria as the client was referred after one session to Triangle Project and not scheduled for further counselling at RCCTT.

With reference to criterion four, the researcher had to decide how to approach missing data. Statistical imputation was carefully considered as a method for accounting for missing data. Since most of the variables were categorical, it was decided that imputation was not an appropriate approach. The researcher considered using list-wise deletion but rejected this approach since many of the files had several different variables missing. The final criterion was thus informed by the decision to apply a case-wise deletion of all files that had one or more items of data missing. The consort diagram in Figure 1 shows how the sample population was established.

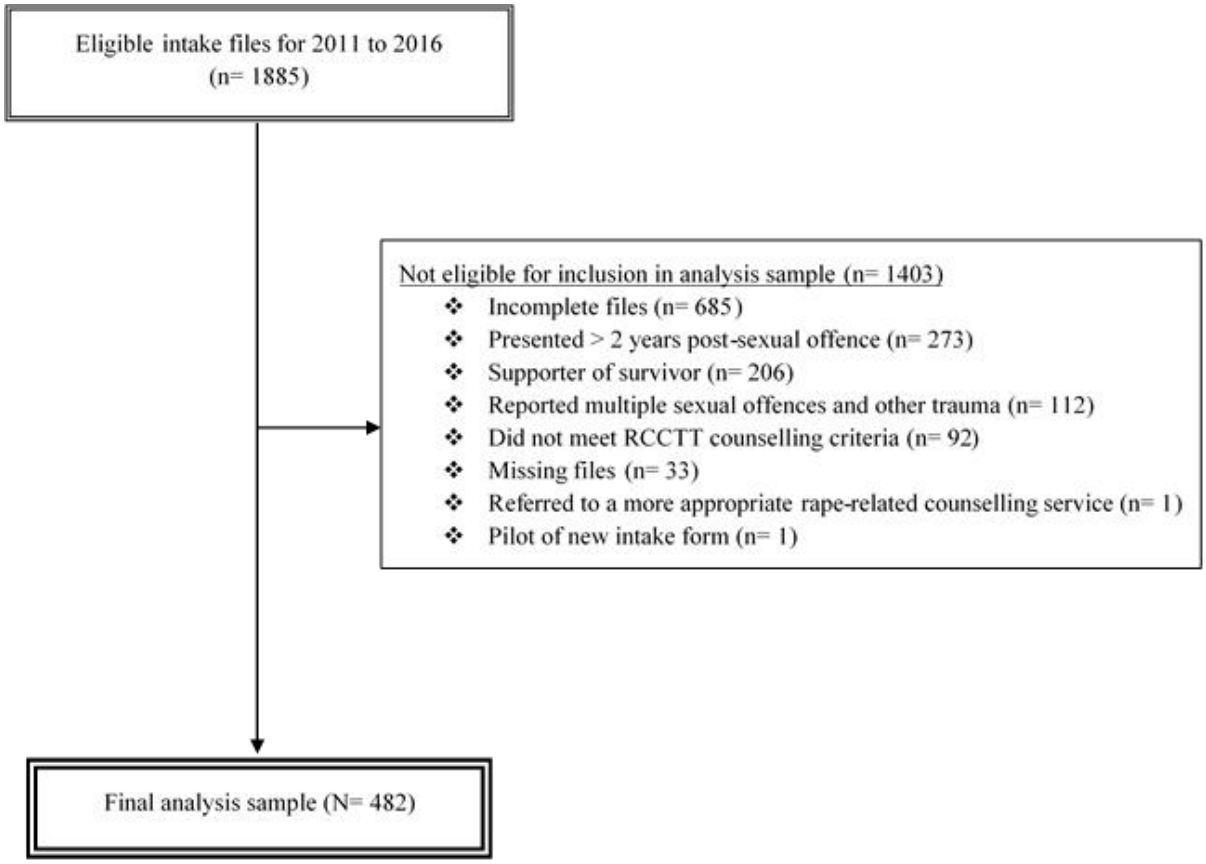

Figure 1. *A consort diagram of analysis sample (N= 482)*

In addressing the question of viability of the study, a key aspect that was considered was whether, after the exclusion of the files according to the above criteria, there would be an appropriate sample size. Gearing and colleagues (2006) argue for an average of 10 charts per variable to be used as predictors in a regression analysis. The researcher took a more conservative approach and aimed to have at least 20 cases/participants per variable. After the exclusion of the files that do not meet this study's criteria, 482 files were identified for inclusion in the study which far exceeds the standard of 20 files per variable for the 14 independent and dependent variables.

With regard to the sampling of participants for focus group interviews, Kitzinger (1995) argues that a strength of recruiting groups that occur in the natural order of community and/or work interactions is that participants already have a common experience that they are comfortable discussing. In a focus group where participants are recruited from amongst work colleagues or, in the case of RCCTT counsellors, who volunteer together in the same organisation, another strength is that they are more likely to challenge each other's viewpoints which will lead to

richer data on the subject being researched (Kitzinger, 1995). For this study it was appropriate to recruit a heterogeneous focus group in terms of race, age and particularly home language as counsellors who speak different languages would come into contact with clients of those language groups and might be able to offer different insights into relationships that might exist between the variables being researched. Selection criteria for inclusion in the focus groups were as follows:

1. Participants must have completed the RCCTT Volunteer Counselling training course.
2. Participants must have a year or more of counselling experience at RCCTT so that they would have had sufficient contact with rape survivors in order to comment on the relationships that may exist between demographic factors/rape incident factors and symptom severity/treatment attendance.

The researcher contacted the eligible counselling co-ordinators at each of the three branches to inform them about the research. The counselling co-ordinators at both the Athlone and Khayelitsha branches offered the researcher the opportunity to use an hour and a half of their monthly counselling meeting at each branch to conduct the focus group. Volunteers were informed of the research by the counselling co-ordinator. Since the focus groups were conducted during a meeting that volunteer counsellors are obliged to attend, the researcher explained the objectives of the research prior to the start of the focus group and asked volunteers verbally whether they were willing to participate to ensure that no one felt coerced. Volunteer counsellors at all three centres who agreed to participate in the focus group interview signed a consent form.

The Observatory counselling co-ordinator contacted volunteer counsellors from that office who met the inclusion criteria and asked their permission for the researcher to contact them about participation in the study. Those who agreed that they may be contacted were sent the information sheet via email informing them of the study and asked whether they would be willing to take part in the focus group interview at a mutually convenient time. Counsellors who do not have access to email but had indicated that they may be contacted, were contacted telephonically and the details of the study were explained to them.

Krueger and Casey (2000) and Litosseliti (2003) recommend recruiting between six and eight participants per focus group. Others suggest between six and 10 or up to 50 participants (Cozby, 2009; Kitzinger, 1995; Morgan, 1997). Morgan (1997) argues that while six to 10 is the norm,

there are not strict rules for the number of participants per focus group and that depending on the circumstances of the research, it can be appropriate to recruit fewer than six or more than 10. Based largely on the availability of the counsellors, four focus groups, with between three and 10 participants, were conducted. A total of 25 counsellors who had 157 years of counselling experience between them, volunteered for the study. The participants represented 81% of the volunteer counsellors who were eligible to participate in the study.

Table 1:
Description of focus group participants (N= 25)

Counselling office	Frequency	Percentage %
Athlone	10	40.0
Observatory	9	36.0
Khayelitsha	6	24.0
Language proficiency		
English and Afrikaans	13	54.0
isiXhosa	4	16.0
isiXhosa and English	4	16.0
English	3	12.0
English and Swahili	1	0.0
Counselling experience in years		
1 – 2[a]	9	36.0%
2 – 4	4	16.0%
4 – 6	1	4.0%
6 – 8	4	16.0%
8 – 10	3	12.0%
10 – 12	2	8.0%
12 – 14	1	4.0%
14 – 16	0	0.0%
16 +	1	4.0%

[a]Only counsellors with a minimum of one year of experience were eligible to participate in this study.

The number of participants per office, the extent of their counselling experience and which languages they were able to offer counselling in, are depicted in Table 1. All the participants were female with a mean age of 46.7 years (*SD* = 9.16) with the oldest being 61 and the

youngest 27 years old. The sample was relatively heterogenous in terms of language proficiency meaning that as a sample the counsellors would meet different population groups and would be able to provide insight into the post-rape experiences of clients from different cultural backgrounds. In terms of counselling experience, the sample was a fairly experienced group where 52% of the participants had between 1 and 4 years of experience while 48% of the counsellors had 4 or more years of experience. One of the participants had 19 years of counselling experience. The participants were therefore well placed to comment on the symptom severity and treatment attendance patterns of their clients.

3.4 Data collection

3.4.1 Intake forms

All clients who make use of RCCTT services are requested to provide information for a confidential intake form (see Appendix A). The data were collected from a version of the intake form that was in circulation from 2011 at the Observatory office and from 2012 at the Athlone and Khayelitsha offices until early 2016, when an updated version of the intake form was introduced. The intake form records: demographic information; information about the rape incident; experiences of the CJS; if the client reported the assault to the police; and lastly, a checklist of the symptoms that the client has experienced.

The independent variables were divided into two sections: demographic variables and rape incident variables. Demographic variables extracted from the intake forms included gender, age at first counselling session, race, religion, employment status and language. Rape incident variables included the type of sexual offence (rape, sexual assault or attempted rape), the number of perpetrators, whether the perpetrator/s' identity was/were known, whether a weapon was used, whether injuries were sustained, and whether the survivor had ingested any substance at the time of the rape. The independent variables are both continuous and categorical.

The study had two outcome variables: symptom severity and treatment attendance. Symptom severity is a continuous variable and was conceptualised as the number of psychological symptoms clients presented with on the symptom checklist upon intake. RCCTT favours the use of the RTS conceptualisation over a PTSD symptom checklist, when assessing the effects of rape on clients. RCCTT works from a feminist paradigm and rejects the DSM-5 and former versions of the manual as a symbol of the pervasive and oppressive pathologising of women

and other minority groups. RCCTT holds that the trauma that rape survivors experience is neither abnormal nor pathological – it is a normal response to sexual violence. Therefore, in their symptom checklist they favour the use of RTS over PTSD in their organisation (Shiralee McDonald, Observatory RCCTT Counselling Co-ordinator, personal communication, 23 May 2015). The checklist that RCCTT uses is based on a case study of RTS that was conducted by a clinical psychologist, Desiree Hansson (Hansson, 1993). The RTS checklist used by RCCTT includes three of the five intrusive symptoms of PTSD, one of the two avoidance symptoms of PTSD, six of the seven PTSD symptoms related to mood disturbance and negative cognition, and four of the six PTSD symptoms related to reactivity and arousal (American Psychiatric Association, 2013). There is therefore a 78% overlap with PTSD symptoms. However, the checklist also includes items that tap symptoms of depression, substance use and self-harm, amongst others, so it is broader than just PTSD.

The symptom checklist on the RCCTT intake form is divided into three sub-categories: physical, behavioural and psychological symptoms. For the purposes of this study, which focuses on severity of psychological symptoms associated with rape survivors, the physical symptoms (such as bladder infections, nausea, vaginal discharge) recorded on the intake form were excluded while the behavioural and psychological symptoms were included. There were eight files where the checklist reported only physical symptoms for these clients. Since, the physical symptoms were reported on the first page of the checklist, it was not clear whether the client did not report any emotional symptoms or if the counsellor did not complete the second and third pages of the checklist. Due to this ambiguity, these eight files were excluded from the study. Once physical symptoms were excluded, the items that were included in the study assessed eating disturbances (comfort or overeating; or loss of appetite); sleeping disturbances (insomnia or hypersomnia); tension headaches; avoidance of anything that recalls the rape; restlessness, agitation or inability to relax; changes in lifestyle; crying more than usual; denial; difficulty concentrating; increased obsessive compulsive behaviours; increased substance abuse; isolation from others; loss of interest in sex; avoiding being alone; relationship difficulties (either withdrawing or growing more clingy); self-mutilation; stuttering or stammering more than usual; confusion; constantly thinking of the rape; depression; emotional numbness; feeling alone and that nobody understands; anger; feeling constantly dirty; feeling listless or unmotivated; feeling suicidal; flashbacks; feeling helpless; humiliation and shame; increased fear and anxiety; feeling hopeless; memory loss; lowering of self-esteem; nightmares; self-blame and guilt. When symptoms were reported by clients these were coded

as present (1) on the Excel spreadsheet and then summed to provide a total score for symptom severity for each case file. A total of 15 behavioural and 18 psychological symptoms were included in the symptom check list for this study.

The second response variable, treatment attendance, is a count variable. The variable was conceptualised as the number of sessions that clients attended. When clients attend a counselling session at RCCTT, the counsellor is required to write a counselling report. The number of counselling reports per file were counted to give the attendance score. A limitation of recording attendance in this way is that the accuracy is reliant on the counsellor having recorded each session with a report. Due to human error some of the clients' session may not have been reported.

3.4.2 Focus groups

Among the strengths of a focus group is that it saves time by interviewing a number of participants at the same time, participants may be less intimidated by the researcher than they might be in a one-on-one interview and may be more likely to participate, and group dynamics often help refine participants' opinions and spark thoughts through interaction with one another (Kitzinger, 1995; Krueger & Casey, 2000). Four focus groups of three to ten participants each were conducted between the three RCCTT offices. All focus groups were run on RCCTT premises and lasted between 65 and 85 minutes. Two focus groups were offered to the Observatory counselling office to accommodate more counsellors, resulting in 69% of available counsellors attending the focus groups. The Athlone and Khayelitsha offices were each offered one focus group interview as 91% and 86 % of the counsellors, respectively, were available to attend the time offered. The first two focus groups were run at the Observatory office – six participants in the first group and three in the second. The third group was hosted at the Khayelitsha office and consisted of six counsellors. The final focus group, of 10 participants, was conducted at the Athlone office. The sample in the four focus groups was well represented as 81% (25 of 31) of eligible volunteer counsellors participated in the study. During the focus group interviews participants were asked to identify and discuss client factors and rape incident characteristics that they believed were associated with client symptomatology and with client attendance. After gaining the permission of the participants taking part in the two focus groups, the focus group interviews were audio recorded, transcribed and then analysed. Please see Appendix B for the interview schedule.

One of the significant limitations of a focus group interview is that the moderator can be biased (Teddlie & Tashakkori, 2009). Since the researcher is also a counsellor at the RCCTT Observatory office, her role as the moderator of the group could have influenced what focus group members chose to say or not say. However, the issue of having multiple relationships with a focus group is not an insurmountable problem, provided the moderator is reflexive about how this might affect the data collection (Berger, 2015; Finlay, 2003). The issue of reflexivity is discussed in section 5.3.2.

3.5 Data Analysis

3.5.1 Intake forms

The variables in the case files were coded according to a coding schedule (e.g. female = 1 and male = 2). The researcher, a fellow researcher and a research assistant worked together in coding the data. They were in close communication throughout the data collection process to ensure that the coding schedule was applied uniformly. The data contained in each file were entered into an electronic database and upon completion were transferred to statistical packages, IBM SPSS (Version 24.0) and STATA (Release 15), for data analysis. Two packages were used as neither package had the full range of statistical tests that were require to complete the analysis. The electronic database was created using Excel and predetermined drop-down options were set in the worksheets to reduce coding errors (Gearing et al., 2006).

The bivariate relationships between total symptoms and each of the independent variables were analysed using *t*-tests, correlation coefficients and one-way ANOVA. The effect size measure that will be reported is *r*. A multiple linear regression was used as it allowed the researcher to determine which demographic or rape incident characteristics may predict symptoms in rape survivors when examined simultaneously rather than just independently, as one variable (e.g. language) may act as a proxy for another (e.g. race or employment status).

Upon viewing the histogram for treatment attendance, the distribution of attendance was positively skewed. Since the distribution of attendance is positively skewed, statistical tests such as t-test and one-way ANOVA may be biased. Therefore, bivariate statistics would not be appropriate to run on this sample. Non-parametric tests were also considered but ultimately rejected as the distribution of the sample was neither normal nor the variances equal. Hence, testing whether groups differ on attendance is not possible and caution should be used when

interpreting the medians. It was decided to include all the independent variables in a count model to predict treatment attendance. Before selecting the appropriate model, three factors were considered.

Firstly, attendance is a count variable and hence a model appropriate for count variables such as a Poisson regression model and negative binomial regression model was considered (Long & Freese, 2006). Using a linear model, which is better suited to variables that satisfy the assumption of normality would not be appropriate (Long & Freese, 2006). Secondly, each client would have attended at least one session, therefore zero counts are structurally excluded from the number of sessions a client may have attended. Both Poisson and negative binomial probability functions assume the possibility of zeros (Hardin & Hilbe, 2012). In a zero-truncated model the probability function is adjusted to exclude zeros i.e. the probability function is altered to exclude zero counts in its range but still to sum up to 1 (Hardin & Hilbe, 2012; Long & Freese, 2006). Therefore, a zero-truncated model was chosen to account for the missing zero counts in the data. Thirdly, it was observed that there was overdispersion in the distribution of attendance because the value of the variance (VAR = 11.19) far exceeded the mean of 3.14 counselling sessions (Hilbe, 2007). Equidispersion - that the mean and variance are equal - is a primary assumption of the Poisson distribution (Hilbe, 2007). Consequently, a negative binomial was selected over the Poisson to correct for overdispersion (Hilbe, 2007). Considering these three factors, the zero-truncated negative binomial was selected as the model to predict treatment attendance. The fit of this model is discussed further in section 4.1.3.

3.5.2 Focus groups

The data from the focus group interviews were analysed using thematic analysis. Braun and Clarke (2006) define thematic analysis as, "a method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail" (pg. 79). This method of analysis has been chosen because of its flexibility (Braun & Clarke, 2006). The researcher aimed to identify how participants saw the relationships between the variables being studied, without pre-conceptions or making use of a pre-existing coding schedule that might have influenced the outcome of the study.

Thematic analysis is an analysis technique that has in the past been used without adequate guidelines (Braun & Clarke, 2006). Braun and Clarke (2006) suggest six steps in analysing qualitative data which the researcher used in the analysis of the focus group interviews. The

first step in thematic analysis is to become acquainted with the data (Braun & Clarke, 2006). Because the researcher was the moderator of the focus group, she was already somewhat familiar with the data (Braun & Clarke, 2006). Another way that the researcher became familiar with the content of the focus group interviews was through transcribing the interviews (Braun & Clarke, 2006). Once transcribed, the researcher read through the transcriptions of the focus group interviews several times.

After becoming familiar with the transcribed content, the second step of thematic analysis is to produce some preliminary codes. Braun and Clarke (2006) suggest that during the initial coding phase, the researcher identifies all possible codes as it is not immediately clear what will be of interest later when searching for themes in the data; pays attention to the context of the extract i.e. not to produce codes that lose the overall meaning of the extract; and keeps in mind that extracts may be allocated one code, many different codes or none. Step three moved beyond a micro analysis and is concerned with using the identified codes to find the wider themes within the data (Braun & Clarke, 2006). This phase is complete once the researcher has categorised all the extracts according to the candidate themes and sub-themes that have been identified (Braun & Clarke, 2006).

In phase four, the researcher reviews the data to ensure it supports the candidate themes identified and assesses whether all the themes are independent of each other or whether some themes can be merged together (Braun & Clarke, 2006). Overall coherency of the candidate themes are examined resulting either in a rework, discarding them or discovering new themes that have been overlooked (Braun & Clarke, 2006). The final thematic map is produced by analysing data on a micro (where coded data extracts are reviewed) and macro (looking at the data in its entirety) level (Braun & Clarke, 2006).

In the fifth step the researcher spends time defining and naming the themes (Braun & Clarke, 2006). To guarantee that there is no overlap between themes, every theme requires a detailed definition and should be reviewed on its own and in relation to the other themes to better understand how the themes contribute to the overarching 'story' revealed in the data. (Braun & Clarke, 2006). Once the researcher has a coherent 'storyline', the last phase can begin: writing the report (Braun & Clarke, 2006). The report is not simply to summarise the data but must provide an argument for why the researcher's analysis of the data is valid and answers the research question (Braun & Clarke, 2006).

This study made use of realist, inductive thematic analysis and themes were identified at a semantic level. Codes were generated progressively as the data were analysed and not through the lens of existing research or theory, thus employing an inductive approach (Braun & Clarke, 2006). The identification of themes was driven by a semantic method that looks at overt meaning (Braun & Clarke, 2006). Finally, the results of the thematic analysis is reported using an essentialist or realist paradigm where results of thematic analysis are reported at face value without interpretation of meaning through social construction because, "a simple, largely unidirectional relationship is assumed between meaning and experience and language," (Braun & Clarke, 2006).

3.6 Ethical considerations

This research was presented before the Department of Psychology's Research Ethics Committee at the University of Cape Town in February 2016 where ethics approval was awarded. In addition to this, research approval was applied for and granted by RCCTT. The paragraphs below outline the steps that were taken to ensure that risks to participants were minimal and did not infringe upon human rights (Creswell, 2009).

3.6.1 Consent

Clients who attend counselling at any of the three RCCTT centres are informed of the work that RCCTT does in the first session. Each client is made aware that the organisation has an advocacy arm that works to improve the governmental services offered to rape survivors. To facilitate the advocacy work, research about the efficacy of the CJS is necessary. This research is gathered through the intake forms that clients are asked to provide information for. Clients are asked whether they are willing to participate in providing information for the intake forms and are given the option either not to participate or to only answer the questions they feel comfortable to answer. Clients are informed that the intake forms remain confidential and will never leave the RCCTT premises. Furthermore, clients are informed that, in any research that makes use of the forms, identifying information such as names, dates of birth and identity numbers will be omitted to protect the identity of the client.

Participation in the qualitative section of the study was strictly voluntary and no counsellor at any of the centres were under any obligation to participate in the focus group interviews. Those who chose to take part in the study were asked to sign an agreement indicating their permission

for the data gathered in the focus group interviews to be recorded and used for research purposes. Participants were informed of their right to withdraw from the focus group at any time. Please see Appendix C for a copy of the consent form and Appendix D for a copy of the information questionnaire administered to participants.

3.6.2 Confidentiality

During the collection of quantitative data, identifying information such as names, dates of birth and identity numbers were omitted from the electronic database in order to protect the identity of clients. The intake files were coded on the RCCTT premises. Once data was collected it was stored in a password protected electronic file. Focus group participants were informed of their right to anonymity. All information that participants shared in the interview was kept strictly confidential by the researcher, by not publishing the names and any identifying aspects in the research report of either the participants or any clients they mentioned during the focus group interviews. Pseudonyms and the disguising of identifying details have been used where references to specific participants were made in this dissertation. Participants were informed that the researcher could not guarantee that other group members might not share information outside of the group, even though the importance of confidentiality was emphasised in all focus groups. Counsellors' names and other identifying information were kept separately from the interview data and only the researcher had access to these. After the researcher listened to the audio recordings of the focus group interviews and transcribed them, the recordings were destroyed.

3.6.3 Possible risks and benefits

Regarding the possible risks of this research, the quantitative section of the research posed minimal risks as there was no direct contact with human subjects. In the qualitative data collection, counsellors were asked to discuss patterns of symptom severity and treatment attendance amongst rape survivors who they had counselled. A possible risk for counsellors was that recounting their experiences of counselling rape survivors, may cause some emotional distress. Counsellors were informed that they could leave the study at any time and that they would be referred for further counselling if they felt distressed by the content under discussion. No counsellors indicated that they were distressed during the focus group or thereafter.

While the research will be of no direct benefit to past RCCTT clients, the study may benefit current and future clients. Through the research, RCCTT may gain a better understanding of

whether demographic and rape incident characteristics of rape survivors might predict symptom severity and treatment attendance. This knowledge may help RCCTT counsellors to better understand their clients, to develop more targeted counselling approaches for particular types of clients, and to enhance retention of RCCTT clients.

3.7 Summary

In summary, the study aimed to contribute to the currently limited global body of literature on predictors of treatment attendance and to expand on the research on predictors of symptom severity amongst rape survivors. It aimed to identify demographic and rape incident characteristics that may be associated with an increased risk of symptom severity and therefore with a higher need for treatment, and demographic and rape incident characteristics that may be associated with poor treatment attendance, in order to assist planning of services and training of counsellors to enhance engagement of rape survivors in treatment. The next chapter will report the results and analysis of the quantitative and qualitative data.

CHAPTER 4: FINDINGS

This chapter reports the findings of this mixed methods study. The quantitative analysis based on data from RCCTT case records are reported first. Descriptive statistics for the sample are presented, followed by bivariate analyses to investigate which independent variables were statistically significantly associated with symptom severity. A multiple linear regression model for predicting symptom severity is then reported followed by the results of a zero-truncated negative binomial to predict treatment attendance. Thereafter, the themes identified through thematic analysis of the focus groups with RCCTT counsellors are presented.

4.1 Quantitative results

4.1.1 Descriptive statistics

This section provides a description of the sample of 482 participants. Tables 1 and 2 depict, respectively, the number of clients surveyed at each of the three offices and a breakdown of the clients surveyed per year. Half of the participants attended the Khayelitsha counselling office, while Observatory had the next highest percentage of participants. Most participants in the study attended counselling in 2012 and 2013, while the years that had the least participants were 2011 and 2016. The iteration of the intake form the data were collected from was only in circulation at one office, Observatory, in 2011 which accounts for the few intakes for that year. RCCTT stopped using this iteration of the intake form in January 2016, thus there were only three eligible files that were included for this year.

Table 2:
Participants per office

Counselling office	Frequency	Percentage %
Khayelitsha	244	50.6
Observatory	136	28.2
Athlone	102	21.2
Total	482	100.0

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Table 3:
Participants per year

Year	Frequency	Percentage %
2011	36	7.5
2012	122	25.3
2013	123	25.5
2014	111	23.0
2015	87	18.0
2016	3	0.6
Total	482	100.0

Summaries of the demographic and rape incident characteristics for participants are shown in Tables 3 and 4, respectively. The mean age of clients in the sample was 24.3 years (SD = 9.8) with the oldest client being 75 and the youngest 14 years of age. The vast majority of the clients included in this study were females who identified with the black or coloured race group and the majority identified as Christian. The predominant languages spoken by clients were isiXhosa and English. Students (school and university) made up 43% of the sample. When not considering the number of students, there was a high rate of unemployed participants in the sample.

In terms of rape incident factors, most clients reported experiencing a completed rape by a single perpetrator. However, one in five clients had been raped or sexually assaulted by more than one perpetrator. Very few clients reported being the survivor of an attempted rape or sexual assault. Almost two-thirds of the clients knew the identity of the perpetrator(s). Two thirds of clients reported that no weapon was used or injuries sustained due to the rape or sexual assault. The majority had not partaken in any drugs or alcohol at the time of the rape, though 40% did report some substance use.

Table 4:
Demographic data of clients surveyed (N= 482)

Demographic variables	Frequency	Percentage %
Gender		
Female	464	96.3
Male	18	3.7
Race		
Black	326	67.6
Coloured	133	27.6
White	16	3.3
Asian	4	0.8
Other	3	0.6
Religion		
Christian	415	86.1
Muslim	45	9.3
Other	21	4.4
Jewish	1	0.2
Hindu	0	0.0
Language		
isiXhosa	283	58.7
English	122	25.3
Afrikaans	61	12.7
Other	16	3.3
Employment status		
Student	206	42.7
Unemployed	164	34.0
Employed	110	22.8
Retired	2	0.4

Table 5:
Rape incident characteristics of clients surveyed (N= 482)

Rape Incident Variables	Frequency	Percentage %
Sexual offence		
Rape	453	94.0
Sexual assault or attempted rape	29	6.0
Number of perpetrators		
One	380	78.9
Two or more	102	21.1
Identity		
Known	309	64.1
Unknown	173	35.9
Weapon		
No weapon	322	66.8
Weapon used	160	33.2
Injuries		
No injuries	322	66.8
Injuries reported	160	33.2
Survivor ingested drugs or alcohol at time of rape		
No substance ingested	292	60.6
Substance ingested	190	39.4

The mean symptom severity was 13.49 symptoms (*SD* = 7.87) with a median of 12 symptoms (IQR = 12). One symptom was the minimum, while 35 symptoms was the maximum number of symptoms reported. Average treatment attendance was 3.14 counselling sessions (*SD* = 3.46) with a median of two sessions (IQR = 3.00), reflecting on average very short-term treatment attendance. The minimum number of counselling sessions attended was one and the maximum 36.

4.1.2 Bivariate analyses

4.1.2.1 Symptom severity

Three types of bivariate tests – correlation coefficient, *t*-test and one-way ANOVA - were run to investigate the association between the independent variables and symptom severity.

Demographic variables

Some of the demographic categorical variables were collapsed to reduce the number of categories, especially where there were few participants per category. For race, the following categories were collapsed into a single category called 'other race': 'white' (3.3%), 'Asian' (0.8%) and 'other' (0.6%). Under religion, 'other' (4.4%), 'Jewish' (0.4%) and 'Hindu' (0.0%) were collapsed into 'other religion'. For employment status, 'retired' (0.4%) was grouped with 'employed' (22.8%) as retirement was deemed a proxy for having access to a monthly income in the form of a pension. Once these variables were collapsed they were included in a one-way ANOVA. The results are displayed in Table 6.

Table 6:
One-way ANOVAs investigating associative between in symptom severity and demographic variables

Independent variable	*n*	*M*	*SD*	*F(df, df)*	*p*	*r*
Race[a]						
Black	326	12.57	7.38	9.63(2, 57.59)	< .001	.20
Coloured	133	14.74	8.46			
Other	23	19.17	7.99			
Religion						
Christian	415	13.45	7.87	0.06(2, 479)	.942	.02
Muslim	45	13.87	7.83			
Other	22	13.36	8.32			
Employment status						
Student	206	12.98	8.13	5.13(2, 479)	.006	.14
Unemployed	164	12.72	7.20			
Employed and retired	112	15.54	8.03			
Language[a]						
isiXhosa	283	11.84	6.85	19.69(2, 170.01)	< .001	.30
English	122	17.40	8.68			
Other	77	13.31	7.97			

[a]Results based on unequal variances.

Group means for symptom severity differed at a significance level of .01 for employment status and at $p < .001$ for race and language. The one-way ANOVA was followed up by post-hoc tests using the Games-Howell procedure. For race the symptom severity mean for the black group was significantly lower compared to the coloured ($p = .028$) and 'other race' ($p = .002$) categories. For employment status, mean symptom severity for the employed group was significantly higher compared to the unemployed ($p = .009$) and student ($p = .020$) groups. For language, mean symptom severity for English-speaking clients was significantly higher compared to the isiXhosa-speaking ($p < .001$) and 'other' language ($p = .002$) categories. However, all three factors showed small effect sizes as reflected by *r*. For race and language, variances were not similar and thus the *F*-statistic was adjusted. Religion was not statistically significantly associated with symptom severity, suggesting that clients' type of religious identification was not related to their post-rape symptom levels.

With regard to gender, a two-tailed independent samples *t*-test, $t(480) = -1.91$, $p = .849$ showed that there was no statistically significant difference between mean symptom severity for females ($M = 13.47$, $SD = 7.87$) and males ($M = 13.83$, $SD = 8.09$). The sample sizes for gender were unequal as only 3.7% of the participants were male. However, the Levene's test for equal variances showed no violation of the assumption of homogeneity of variance.

With regard to age, a correlation coefficient was calculated. The scatterplot of this relationship was considered, and it showed a negative relationship. However, there were also younger clients who showed fewer symptoms and so the cloud of points does not show a typical negative relationship pattern. If the Pearson Correlation Coefficient ($r = .039$) is considered, it suggests an almost negligible relationship between age and symptom severity, while the Spearman's Correlation Coefficient (Rho = .138) indicates a weak correlation.

Rape incident characteristics

The association between symptom severity and type of sexual offence, number of perpetrators, identity of the perpetrator(s), whether a weapon was used, whether injuries were sustained or not, and whether the survivor had ingested any alcohol or drugs at the time of the rape or sexual assault, were investigated by running *t*-tests. The results are presented in Table 7. Type of sexual offence and whether the participant reported sustaining injuries from the attack were both statistically significantly associated with symptom severity. The mean symptom severity of rape survivors ($M = 13.66$) was higher at the $p < .05$ level than those who reported an

attempted rape or sexual assault ($M = 10.69$). Clients who reported injuries ($M = 15$) had higher mean symptom severity compared to those who reported no injuries ($M = 12.73$) at the $p < .01$ level. Variances for injuries were not similar, therefore the *t*-statistic was adjusted. At a significance level of .001, the identity of the perpetrator was also statistically significant for symptom severity: survivors who did not know the identity of the assailant ($M = 15.21$) had higher symptom severity compared to those who knew the perpetrator ($M = 12.52$). For identity of perpetrator(s), variances were not similar and thus the *t*-statistic was adjusted. However, as reflected by *r*, all three statistically significant variables have small effect sizes. Number of perpetrators, use of a weapon, and ingestion of drugs or alcohol were not statistically significantly associated with symptom severity.

Table 7:
Independent sample t-tests investigating differences in symptom severity by rape incident variables

Independent variable	*N*	*M*	*SD*	*df*	*t*	*p*	*r*
Sexual offence							
Rape	453	13.66	7.84	480	-1.98	.048	0.09
Sexual assault or attempted rape	29	10.69	8.01				
Number of perpetrators							
One	380	13.15	7.74	480	-1.83	.069	0.08
Two or more	102	14.75	8.26				
Identity of perpetrator(s)[a]							
Known	309	12.52	7.48	327.56	-3.55	< .001	0.19
Unknown	173	15.21	8.26				
Weapon							
No weapon	322	13.55	7.91	480	0.25	.800	0.01
Weapon used	160	13.36	7.81				
Injuries[a]							
No injuries reported	322	12.73	7.40	279.98	-2.86	.005	0.17
Injuries reported	160	15.00	8.56				
Survivor ingested drugs or alcohol at time of rape							
No substance ingested	292	13.07	7.67	480	-1.43	.153	0.07
Substance ingested	190	14.12	8.14				

[a]Results based on unequal variances.

4.1.2.2 Treatment Attendance

As discussed in section 3.5.1 it was not appropriate to run either bivariate statistics or non-parametric tests for treatment attendance by the independent variables of demographic and rape incident characteristics. Table 8 summarises descriptive statistics for treatment attendance by demographic variables, Table 9 summarises treatment attendance by age category and Table 10 summarises treatment attendance by rape incident characteristics.

Table 8:
Summary statistics for treatment attendance by demographic variables (N= 482, M = 3.14)

Demographic variables	Attendance						
	n	*M*	*SD*	Median	IQR	Minimum	Maximum
Gender							
Female	464	3.05	2.95	2.00	3.00	1	24
Male	18	5.56	8.58	2.00	5.00	1	36
Race							
Black	326	2.75	2.99	2.00	2.00	1	36
Coloured	133	3.68	3.42	2.00	4.00	1	18
Other race	23	5.57	5.69	3.00	6.00	1	24
Religion							
Christian	415	3.09	3.36	2.00	3.00	1	36
Muslim	45	3.62	3.61	2.00	4.00	1	18
Other religion	22	3.05	2.40	2.00	4.00	1	8
Employment status							
Student	206	3.45	3.79	2.00	3.00	1	36
Unemployed	164	2.91	2.67	2.00	3.00	1	13
Employed and retired	112	3.35	3.79	2.00	2.00	1	36
Language							
isiXhosa	283	2.71	3.03	2.00	2.00	1	36
English	122	4.02	4.11	3.00	4.00	1	24
Other language	77	3.34	2.84	2.00	3.00	1	13

Note. IQR = Interquartile Range.

Of note is that the mean attendance for male clients was almost double that of female clients. Participants who were identified in the ‘other race’ category and those who were English-speaking had, respectively, attendance that was on average 2.43 and 0.78 greater than mean treatment attendance. Lower mean attendance was observed in clients who identified as unemployed and with a black race group. Based on demographic factors, isiXhosa-speaking participants had the lowest mean attendance.

As shown in Table 9, clients between the ages of 14 and 19 had the highest mean treatment attendance and only one other age category (26 – 35) had an average attendance that was above the sample mean attendance. Lower mean treatment attendance was observed in the 20 to 25 and 36 to 45 age categories while clients older than 46 had the lowest mean treatment attendance.

Table 9:
Summary statistics for treatment attendance by age category

Age category	Attendance						
	n	*M*	*SD*	Median	IQR	Minimum	Maximum
14 – 19 years	188	3.44	3.965	2.00	3.00	1	36
20 – 25 years	137	2.87	2.268	2.00	3.00	1	12
26 – 35 years	92	3.18	3.074	2.00	3.00	1	13
36 – 45 years	44	2.82	3.866	2.00	2.00	1	24
46+ years	21	2.71	3.212	2.00	2.00	1	12
Total	482	3.14	3.346	2.00	3.00	1	36

Note. IQR = Interquartile Range.

As shown in Table 10, clients who reported an attempted rape or sexual assault, attended, on average, 1.18 sessions more than the mean treatment attendance of the total sample. Where there were two or more perpetrators reported, these clients had the lowest mean attendance based on rape incident factors. All other rape incident categories had means close to the sample mean of 3.14 counselling sessions. In Tables 8 and 10, the medians should be interpreted with caution as the histograms for attendance by each independent variable showed that the distributions differed i.e. they did not have the same shape and therefore have different variance.

Table 10:
Summary statistics for treatment attendance by rape incident variables (N= 482, M = 3.14)

Rape incident variables	Treatment attendance						
	n	*M*	*SD*	Median	IQR	Minimum	Maximum
Sexual offence							
Rape	453	3.07	3.19	2.00	3.00	1	36
Sexual assault or attempted rape	29	4.31	5.16	2.00	4.00	1	24
Number of perpetrators							
One	380	3.24	3.43	2.00	3.00	1	36
Two or more	102	2.78	3.01	2.00	2.00	1	24
Identity of perpetrator(s)							
Known	309	3.10	2.85	2.00	3.00	1	18
Unknown	173	3.22	4.10	2.00	2.00	1	36
Weapon							
No weapon	322	3.20	3.15	2.00	3.00	1	24
Weapon used	160	3.02	3.72	2.00	2.00	1	36
Injuries							
No reported injuries	322	3.14	3.57	2.00	3.00	1	36
Injuries reported	160	3.14	2.86	2.00	3.00	1	13
Survivor ingested drugs or alcohol at time of rape							
No substance ingested	292	3.13	2.81	2.00	3.00	1	15
Substance ingested	190	3.16	4.05	2.00	3.00	1	36

Note. IQR = Interquartile Range.

4.1.3 Multiple linear regression

The next step in the quantitative analysis was to fit the appropriate model for predicting symptom severity when considering independent variables simultaneously. The results of the model are presented in Table 11.

Table 11:
Multiple linear regression model for predicting symptom severity

Predictors	Symptom Severity							
	B	*b*	*SE*	*t*	*p*	*R*	R^2	Adjusted R^2
Constant		9.74	2.83	3.31	.001	.41	.17	.14
Female[a]	0.24	1.00	1.79	0.56	.576			
Age	-0.05	-0.04	0.04	-.87	.385			
Coloured[b]	-0.09	-1.55	1.36	-1.14	.253			
Other race[b]	0.04	1.32	1.94	0.68	.498			
Muslim[c]	-0.06	-1.66	1.27	-1.31	.192			
Other religion[c]	-0.05	-1.79	1.66	-1.08	.279			
Employed and retired[d]	0.09	1.62	0.95	1.70	.090			
Student[d]	-0.03	-0.42	0.92	-0.46	.646			
English[e]	0.36	6.46	1.27	5.10	< .001			
Other language[e]	0.13	2.67	1.45	1.84	.066			
Rape[f]	0.11	3.65	1.44	2.54	.012			
Two or more perpetrators[g]	0.03	0.51	0.89	0.58	.563			
Known perpetrator(s)[h]	-0.16	-2.60	0.77	-3.37	.001			
Weapon used[i]	-0.06	-1.02	0.79	-1.31	.193			
Injuries reported[j]	0.08	1.36	0.75	1.80	.072			
Substance ingested at time of rape[k]	0.07	1.11	0.72	1.54	.124			

[a]Reference category for gender is male. [b]Reference category for race is black. [c]Reference category for religion is Christianity. [d]Reference category for employment status is unemployed. [e]Reference category for language is isiXhosa. [f]Reference category for sexual offence is attempted rape or sexual assault. [g]Reference category is one perpetrator. [h]Reference category is an unknown perpetrator. [i]Reference category is no weapon. [j]Reference category is no injuries reported. [k]Reference category is no substance used.

The test for significance of regression indicates that the model is significant at $p < 0.05$, $F(16,465) = 5.75$. The model fit was evaluated by looking at the residual analysis. The residuals of the model do not deviate seriously from normality and show a constant variance against the standardised predicted values. Variance inflation factors were inspected and suggested no issues with multicollinearity. The model summary statistics showed that 14% of the variation in symptom severity is explained by this model, indicating a small effect size (Adjusted $R^2 = .14$). In this model three variables were statistically significant predictors of symptom severity: language, type of sexual offence and identity of the perpetrator. The model predicts at a significance level of $p < .001$ that, relative to isiXhosa speaking clients, English speaking clients will have greater symptom severity while all other variables are held constant. At $p < .05$, the model predicts that relative to attempted rape or sexual assault survivors, rape survivors will report greater symptom severity, keeping all other variables constant. Finally, at a significance of $p < .05$, the model shows that relative to participants to whom the identity of the perpetrator was unknown, participants who know the identity of the perpetrator will report fewer symptoms with all other variables constant. Based on the standardised coefficients, β in Table 10, that of the three statistically significant predictors, clients who identify as English speaking are more strongly associated with increased symptom severity than the other two predictors. Race, employment status and injuries, which were significant in the bivariate analysis, were not significant when considered together with the other variables.

4.1.4 Zero-truncated negative binomial

Turning to a model predicting treatment attendance from demographic variables, rape incident characteristics and symptom severity, as discussed in section 3.5.1 a zero-truncated negative binomial model (ZTNB) was selected. To test for goodness of fit, both the ZTNB and the zero-truncated Poisson were run. A linktest suggested the ZTNB is the preferred link function. Both Akaike's information criterion and Bayesian information criterion values also suggested that the ZTNB was a better fit than the zero-truncated Poisson. When comparing the fit of the two models the likelihood ratio test ($\chi 2 = 412.34$, $p < .001$) was further confirmation that the ZTNB is the preferred model. Results of a ZTNB are reported in Table 12.

Table 12:
Zero-truncated negative binomial predicting treatment attendance

Predictors	Treatment Attendance					
	IRR	*SE*	*z*	$p<\|z\|$	[95% Confidence Interval]	
Constant	3.72	2.43	2.01	.044	1.03	13.40
Female[a]	0.38	0.13	-2.75	.006	0.19	0.76
Age	0.99	0.01	-1.07	.288	0.97	1.01
Coloured[b]	1.39	0.38	1.22	.224	0.82	2.36
Other race[b]	2.40	0.98	2.14	.032	1.07	5.35
Muslim[c]	0.90	0.23	-0.41	.680	0.55	1.48
Other religion[c]	0.91	0.31	-0.29	.775	0.47	1.76
Unemployed[d]	1.33	0.26	1.45	.148	0.90	1.95
Student[d]	1.39	0.31	1.46	.145	0.89	2.15
isiXhosa[e]	0.89	0.24	-0.44	.660	0.52	1.52
Other language[e]	1.00	0.22	0.00	.998	0.64	1.55
Rape[f]	0.59	0.17	-1.83	.067	0.33	1.04
Two or more perpetrators[g]	0.87	0.16	-0.76	.445	0.61	1.24
Known perpetrator(s)[h]	1.07	0.18	0.40	.688	0.77	1.49
Weapon used[i]	1.07	0.18	0.39	.699	0.77	1.49
Injuries reported[j]	1.00	0.15	-0.00	1.000	0.74	1.35
Substance ingested at time of rape[k]	0.94	0.14	-0.45	.655	0.71	1.24
Symptom severity	1.03	0.01	3.75	<.001	1.02	1.05
/lnalpha	0.80	0.31			0.19	1.41
Alpha	2.22	0.69			1.21	4.10

Note. IRR = Incident Rate Ratio.
[a]Reference category for gender is male. [b]Reference category for race is black. [c]Reference category for religion is Christianity. [d]Reference category for employment status is employed. [e]Reference category for language is English. [f]Reference category for sexual offence is sexual assault or attempted rape. [g]Reference category is one perpetrator. [h]Reference category is an unknown perpetrator. [i]Reference category is no weapon. [j]Reference category is no injuries reported. [k]Reference category is no substance used.

The model for predicting treatment attendance was statistically significant ($p < .001$). Three variables were identified as statistically significant predictors: gender, race and symptom severity. The model showed that relative to male participants, female participants attended fewer sessions at significance level $p < .05$ when all other variables are held constant. When observing the incident rate ratio, the incident rate of attendance decreases by 62% for females when compared with males. At significance level $p < .05$, relative to black participants, participants in the 'other race' category attended more sessions while keeping all other variables constant. However, there was no statistically significant difference between the attendance of black and coloured clients. The incident rate ratio increases by 240% for clients of the 'other race' category when compared with black clients. Symptom severity as a predictor of attendance was statistically significant at $p < .001$ The incident rate ratio for attendance increases by 106% for each additional symptom that a participant reported experiencing.

This concludes the section reporting the quantitative findings of this mixed methods study. In the next section, the qualitative findings will be reported.

4.2 Qualitative analysis

As discussed in Chapter Three, thematic analysis was employed to analyse the qualitative data. The analysis is reported below in two parts. Firstly, the themes related to factors that influence symptom severity and thereafter the themes pertaining to factors that influence treatment attendance are outlined.

4.2.1 Counsellors' perceptions of factors that influence symptom severity

Five themes emerged from the focus group discussions regarding factors that influence symptom severity. Four of these reflected factors that are not included in the intake form and therefore did not emerge from the quantitative analysis. One theme represented a direct contrast to what emerged from the quantitative analysis.

4.2.1.1 Theme 1: Some survivors report fewer symptoms due to being less aware of or less able to identify symptoms

A theme present across all four groups was that there were some types of clients who were perceived to be less able to identify symptoms than others. Counsellors reported that these clients underreport their symptoms when counselling commences as illustrated in the following quotes:

> Whether they know it, whether they're aware of it or not, it's there. Or whether it's not, um, you know at the time that you counsel, they may not, or you may not, pick it up. But in time, you know sometimes we see clients for a while and then they come back in two or three years and then they talk about the first time they came here they didn't even think there was anything wrong. And then all those symptoms have kind of manifested later on in time. Participant 6, Focus Group 1

> For denial, at the first time some of them are like that but on the long run when you keep on giving them some sessions you find out that she was hiding something when you go back to the RTS every time she comes, you dig a lot and you find out really she was hiding something, she was scared or what… Participant 6, Focus Group 4

As suggested in the quotes above, though clients might report fewer symptoms at the start of counselling, with time they would become aware of more of the symptoms. Participants contended that these clients did not actually have lower symptom severity; they were not aware of their symptoms, were in denial or struggled to identify or articulate their symptoms when they started counselling. Three sub-themes emerged within this theme: teenagers commonly reported fewer symptoms when counselling commenced; survivors of Drug-Alcohol Facilitated Rape/Incapacitated Rape (DAFR/IR) reported fewer symptoms at the start of counselling and that the ability to identify symptoms may be rooted in cultural norms.

Sub-theme 1: Teenage survivors report fewer symptoms at the start of counselling

One of the most prevalent patterns identified within this theme was how teenagers presented in counselling. Counsellors felt that teenagers, when compared to older clients, consistently underreported symptoms when they started counselling and this was not a true reflection of their actual symptom severity:

> Participant 6: What I've noticed the age 14 to 18 they got less rape trauma symptoms but the other like from 21 they are matured those that are less than, 14 to 18, if you ask them how you feel about the rape, "I'm okay, I'm okay," but from 21 you can tick more, she is matured she knows she's been raped and the circumstances of the rape. For the teenagers, 14 - 18, "I'm right, I'm right."
>
> Participant 4: Sometimes you tick less because the client is still in denial. You see so she don't tell herself really that I have been raped. Focus Group 3

> Participant 1: It’s different to, for me, for me it’s different to say about the age because what I found most of the time with teenagers whenever I take it shows, uh, that they have less symptoms but it does not mean that they don’t experience anything.
> Participant 3: Ja, I agree. Focus Group 2

> I would say they have more but very good also at hiding it, very good, you have to dig and you have to scratch actually because from the training and the previous younger ones that you had, "Oh this is actually what you want to tell me but you can't tell in so many words." …The older clients again also will just open up.
>
> Participant 1, Focus Group 4

The difference in the way older and younger survivors presented was discussed in every focus group. Counsellors did not perceive teenagers to experience fewer symptoms, but consistently found that they were less able to self-identify their symptoms. As suggested in the quotes above, participants suggested that teenagers might be less aware of their symptoms because they were in denial or because the incident they experienced was not what they had been socialised to believe is rape.

> The younger ones generally seems to become an introvert because of the result of displaying their normal behaviour, they want to fit in so that no one must know, because sometimes they hide also, not knowingly but they symptoms don't display immediately.
>
> Participant 10, Focus Group 4

Furthermore, as illustrated in the quote above, they suggested that the developmental stage teenagers were in meant that they were more likely to feel pressure to fit in with their peer group and to conceal the rape and any associated symptoms so as not to draw attention to themselves.

> I think sometimes it feels like the symptoms are there but you can’t get them to articulate it. They’re moody or they don’t want to talk about it so they could be there but we wouldn’t really know. How to draw them out can be difficult. …Then you have them in the counselling room it’s like pulling teeth to find out what’s going on. …They just, I don’t whether they can’t find the words to describe what it is. So, you don’t know

> whether they are there or not, how intense they are, you just know that they are not okay. Participant 2, Focus Group 2

Lastly, counsellors commented on teenagers finding it difficult to articulate emotions and suggested that they may well feel many more symptoms than they reported, because they might not have the language to express what they feel. However, their perception was that if clients were to continue with counselling, the true symptom severity would become apparent.

Sub-theme 2: Survivors of DAFR/IR report fewer symptoms at the start of counselling

Counsellors across all four groups identified a trend where clients who reported experiencing DAFR/IR were more likely to report fewer symptoms when entering counselling as shown in the quotation below:

> And I think, because I've dealt with quite a few drug rapes, people don't necessarily remember the events, they awake to the after effect, if you know what I'm saying. So, a lot of the youth that I've counselled have said they recognise that perhaps later on, they'll experience symptoms, but right now, while they're sitting in the chair they don't remember anything. Participant 6, Focus Group 1

Counsellors perceived that these clients might not have fewer symptoms and may report more symptoms as time progressed – as they became more aware of the impact of the rape and the associated symptoms. They also suggested that perhaps being unconscious and not remembering being raped or sexually assaulted might protect these survivors from the feelings commonly associated with sexual trauma as illustrated in the following quote:

> Participant 3: Ok, I think those who were raped when they were drunk they don't show more symptoms than those who were sober because they don't remember exactly how did it happen, they have those flashbacks, so the other one doesn't have that much flashbacks because the other one, because it feel like he dreams sometimes…
>
> Participant 2: To add to what Participant 3 said, those who are sober they took [inaudible] they say, "I can still remember the smelling of that," they notice a lot of things but those that were drunk, maybe somebody told you that you were raped but you don't even feel there is something that has happened to you so the sober ones take long to heal. Focus Group 3

As shown above, counsellors believed that this group reported fewer symptoms because they did not remember being raped. The participant in the quotation suggests that DAFR/IR survivors might have fewer distressing memories of the rape and sexual assault, leading to reporting fewer symptoms at the start of counselling. Although DAFR/IR survivors were perceived by counsellors to report fewer symptoms, counsellors in two focus groups commented that these clients consistently reported feeling self-blame and guilt due to the rape happening while unconscious. Participants did make some comparison between teenagers and DAFR/IR and two groups mentioned these groups together, suggesting that there may be a correlation i.e. that teenagers may be more vulnerable to experiencing DAFR/IR. However, this was not explicitly explored. Like teenage survivors, this group of survivors were perceived to be in denial that they had been raped when they first came for counselling, which may impact their ability to identify their symptoms.

Sub-theme 3: Culture may influence clients' ability to identify symptoms

A smaller sub-theme that emerged in one of the Observatory branch focus groups was that clients' awareness of and ability to identify their symptoms might be dependent on the culture they were brought up in. As illustrated in the following quotation, this focus group perceived some cultural differences in the reporting of symptoms:

> Participant 2: My white clients again, they would talk about their, their um, psychological feelings, quite frank, openly. And you know, ja, my other clients, they don't, I have to like tell them what this is, where it falls under before they could identify the feeling or this is you know, it's like the angry, like *Participant 3* said. The anger that comes out but the other symptoms, no. Um, not like my other, like my coloured clients, but my white would say that out immediately.
>
> Researcher: So, are you saying there's a different awareness of the psychological symptoms?
>
> Participant 2: Well for me, that's what, that's the clients I have, I have experienced that, you know there's a difference, you know, different cultures, different interpretations if I can put it that way. They don't really feel that they, um, that this is a psychological symptom. They experience all of that, but they can't put that to the name, it's like, um, if one talks….
>
> Participant 5: The vocab is smaller.

> Participant 2: Much smaller because we as, um, coloureds don't believe back in the days going for counselling, going to talk about this. You sit and you sit and you sit with it, you sometimes just have to deal with it, you know it's a total mind game like you have to set that mind set, you have to change their mind sets about that.
>
> Participant 5: …But I agree with *Participant 2*, um, with coloured clients and sometimes with, also with black clients, there seems to be a hesitancy in naming their emotions and even with those who have a very broad English vocabulary, um, naming it is quite difficult.
>
> Researcher: So, what I'm hearing is, there isn't, in your experience, a difference amongst different cultures in terms of experiencing the psychological symptoms, but there is a difference in being able to express those symptoms.
>
> Group: Mmm, ja, yes … [agrees]
>
> Participant 5: Or self-identify them, I'm feeling funny or I'm upset, um, things aren't right. Focus Group 1

In this exchange counsellors suggest that different cultures may have different emotional languages or degrees of psychologisation and some might be more comfortable speaking about emotions and therefore more able to identify their symptoms post-rape. Naming an emotion might come more naturally to some cultures than others, even when accounting for language proficiency. There is also a perception that in some cultures, seeking counselling is stigmatised and those who are not as comfortable in the counselling space might not be able to identify symptoms as readily as those who come from cultures more accepting of mental health interventions. As with the other two sub-themes, counsellors believe that irrespective of which culture a survivor comes from, the symptom severity is similar however the awareness and therefore ability to report the symptoms at the start of counselling may differ.

4.2.1.2 Theme 2: Survivors living in poverty report increased symptom severity

Every focus group perceived poverty to predict elevated symptom severity. Participants attributed the increased symptom severity among poorer clients to the myriad of social problems people living in poverty in South Africa face due to financial deprivation:

> Because with some clients, I observe that when they have support at home, you know, where, like I said, in some homes there is poverty, there's no food, there's nothing, there's unemployment, it's like, it increases more the symptoms, you understand what

I'm saying. Because at least here they have some kind of support, but now going home, there's an imbalance in the symptoms compared to other survivors that comes, have the support and also have the support at home, things are okay at home, there's support, there's finances, it's looking good, there's more, you know, improvement in the symptoms. Participant 2, Focus Group 1

Participant 5: I think the pattern that you are talking about is the employment status.
Researcher: Ok, what do you see there?
Participant 5: Because a lot of the clients come here and it's not about the rape anymore but it's because they don't have a job or at home there is nothing to eat, that is their main focus. It's for you to explain to them, "We're here to deal with your rape," but they don't worry about the rape at that moment because it is too bad at home.
Researcher: So, do you find their symptoms are worse?
Participant 5: Yes, because they concentrate on that, right through when you tell them, "Let me speak about the rape," but that's the main important thing for them. Because I can relate to that when you don't have something in your stomach or you don't have something to go buy to eat tonight your concentration not going to be my problem that I went through, it's more on the financial situation. Focus Group 4

Counsellors postulated that not having basic physiological needs met, such as health care, food and shelter, may exacerbate symptom severity in rape and sexual assault survivors as these survivors may already be experiencing psychological distress prior to being raped, due to being economically marginalised. In the quotations above, financial support is viewed as a protective factor in recovering from trauma associated with rape. Survivors whose basic physiological needs are not met, may have reduced emotional capacity to address the symptoms they experience which may delay recovery. Furthermore, as will be discussed in section 4.2.3.3, clients living in poverty may face numerous practical challenges in accessing counselling consistently post-rape, which may place this vulnerable population at further risk of experiencing increased symptomatology.

4.2.1.3 Theme 3: Poor social support and negative social response predict increased symptom severity

Among the strongest themes that emerged from the focus groups was that poor social support and a negative response to disclosure of being raped were predictors of increased psychological distress post-rape.

> Participant 1: I think also the client has to walk alone, no one at home must know, no one at work must know, and you have to be that all alone, that's also, ja. …Ja, they don't want other people to know about it
> Researcher: And you find that their symptoms are better or worse?
> Participant 1: I think it's worse because they come here and this is the only support they get. They go back home. They so much want to speak to somebody, to tell somebody something they have maybe a bad feeling or whatever but they can't because somebody must know, because you know it's difficult.
> Participant 5: It's about the safety of the people around them, you know when there's no support and the safety of the people around them…
> Participant 1: … and the trust, you know they don't trust anyone…
> Participant 5: … then the symptoms last longer. Focus Group 1

Strong social support was viewed as a protective factor in recovery and counsellors perceived it to be factor that reduced symptom severity. Across the three groups that discussed this theme, poor social support was described as taking on multiple forms. For some clients it was that they did not have a strong family or friendship network to draw on. Others felt they could not disclose that they had been raped or sexually assaulted to their friends or family, feeling it was emotionally unsafe to do so as described above. This contributed to sense of isolation as they could not draw on the support of their family or friendship network which counsellors believed exacerbated symptomatology. Other clients did disclose and did not receive support or received a negative response to their disclosure from their support network as illustrated in the quote below:

> I also when the environment you're in, it's a very cultural thing as well, um, coloureds that I've seen, "You must make do with it," they give you a week chance and then you must be right. They don't accept a different behaviour in your environment after the rape. It's like, "You must get over it." Participant 10, Focus Group 4

Participants perceived that a reaction to disclosure from the survivor's support network that was unsupportive and lacking empathy contributed to a higher number of symptoms. In the above quote the participant refers to negative social reaction being rooted in cultural norms of responding to trauma in a stoic way, emphasising that the appropriate response is to suppress the emotion and 'move on'. The second Observatory focus group commented that negative social response was particularly prevalent amongst survivors who came from religious backgrounds leading to increased symptoms in this population.

> Participant 1: …the anxiety. You know, uh, when religions got all rules and regulations so it happened that you didn't follow one or two and that happened [the rape], the guilt and the symptoms become more severe. Question maybe this is the way God's punishing me, uh, "Why didn't I do 1, 2, 3, 4?" so they feel more ashamed, they feel more humiliated and maybe in the community which you live nobody understand you. So, all that, uh, the psychological symptoms become more severe, so, besides the gender and the uh, age, the religious plays a very strong role in how survivors feel in terms of psychological effect.
>
> Researcher: And do you find that with all religious and cultural backgrounds? Certain religious and cultural backgrounds?
>
> Participant 1: Not all. But in terms of if you are Muslim or as they call it, a staunch Christian so it's always become um, um, um, issue there or you are very cultural-based, you follow too much what the culture where you come from, how women are supposed to behave for example, how women are suppose to dress, for example and with that goes all the guilt and all the blame.
>
> Participant 3: I think *Participant 1* has brought up a good point, the cultural impact as well, um, kind of a big impact on how severe the symptoms are, across the age group.
>
> Researcher: Can you elaborate maybe a bit on your experience of that?
>
> Participant 3: Pressures from the family. If a young girl wasn't dressed appropriately for her religion whether it's a Christian, Muslim, Jewish…if there's a taboo against short skirts or…and she happened to be date raped and she was…or she was walking in a road and, um, was pulled behind the bushes or whatever, if she had a short skirt, she's getting pressured from the family and, um, that can impact how she perceives her guilt. Um, "If I stuck to my cultural or religious belief, this wouldn't have happened to me," and so it feeds into her guilt. And her family's probably thinking the same thing

> so she's probably worrying about them as well and what they're thinking of her, um, so it does impact on her symptoms. Focus Group 2

Counsellors in these two interviews perceived these survivors to be particularly vulnerable to victim blaming from their communities. They perceived religious communities to hold stances towards rape survivors that were informed by rape myths rather than empathy and understanding and that these led to increased guilt and self-blame. However, there was not a wide enough discussion on how different cultural groups in the Cape Town area respond to disclosures of rape to suggest specific patterns of poor social support or negative social response to the disclosure of rape. A more nuanced discussion may have illuminated patterns of social support amongst different groups.

In all four of the groups, participants' perception was that survivors were generally met with a negative social reaction when reporting being raped or sexually assaulted to the police:

> Maybe they wasn't treat right at the police station…maybe the anger is not yet there for the rape but how that policeman handled the situation and say maybe the person is drunk, maybe the person is under the influence of drugs and then they say, "No you can't, we can't help you because you were," and then they push them out but that person was raped. Participant 3, Focus Group 4

Being blamed for being raped while under the influence of drugs or alcohol was believed to be a common response from police officers. According to participants, clients rarely felt supported when reporting being the survivor of a sexual offence and this negative social reaction was perceived by counsellors to result in increased symptom severity.

4.2.1.4 Theme 4: Compounded trauma predicts increased symptom severity

Participants also felt that compounded trauma was a significant predictors of symptom severity. In two of the focus groups, these two themes were expressed as factors they perceived to be paramount in predicting symptoms severity:

> I think it depends on their support systems, um, and the nature of, not even the natures, basically support systems and previous trauma, I think has the biggest impact on the types and the amount of symptoms they have. Participant 5, Focus Group 1

The role of other experiences of trauma in exacerbating post-rape symptom severity was widely discussed across the four groups. Counsellors perceived rape survivors who had a history of interpersonal trauma, reported experiencing ongoing trauma and felt a secondary victimisation at the hands of the police, to experience increased symptom severity. These three different types of experiences of trauma in addition to rape or sexual assault, are linked as examples of compounded trauma that participants identified as worsening symptom severity. Two of the common types of previous trauma discussed were other incidences of rape or sexual assault as an adult or child and other experiences of extreme violence such as living in a country at war. All focus groups observed that adults who reported being survivors of CSA and were raped in adulthood, consistently showed elevated symptom severity and symptoms that are more chronic, as illustrated by this quote:

> Just also if the clients no matter what the age was now in the presenting rape, if they were abused as children, particularly sexual abuse as children, then their symptoms are far more entrenched and difficult to work with. And they tend to have, um, much more incidents or attempted suicide, cutting, um, difficulty in relationships and a lot of flashbacks. Participant 5, Focus Group 1

In this quote the participant suggests that due to the prior experience of rape or sexual assault in childhood, many of the symptoms we would expect to see in survivors of sexual assault may already be present prior to the rape in adulthood. Similarly, clients who had been raped multiple times in adulthood were a group perceived to be at high risk of increased symptom severity. The compounding effect of more than one lifetime incidence of sexual violence was believed to contribute to the high number and chronicity of symptoms observed in this group.

Refugees were also perceived to be a group at greater risk of having more than one lifetime experience of sexual violence due to coming from war-torn areas where rape is a common tactic of violence. Two of the focus groups spoke about the elevated symptom severity observed in the refugee population who access their counselling services post-rape. Two participants discuss this observation in the quote below:

> Participant 1: Well, I am not sure about the age, but I can say from the circumstances where they come from. If you deal with the refugees, their circumstances are very different. They are far from home; the rape happened quite a long and they suffer

economic social circumstances that effect more. Sometimes they was raped again here for the second or third time. So, ja, the circumstances does give a very severe, according to my experience, because I deal mostly with refugees. Also, I see, other, uh, clients but with the refugees particular.

Researcher: Oh, so you find with the refugees, just to clarify, do they have more or fewer symptoms.

Participant 1: They have more.

Researcher: More.

Participant 1: They have more.

Participant 3: That was the first thing that came to my mind as well. Not so much the age as - I haven't seen a lot of refugee clients but the ones I have seen show more distress within a session, um, have greater symptoms, um, and the symptoms more severe, I mean more of the symptoms but the symptoms are more severe.

Focus Group 2

Participants perceived refugees to be a vulnerable population in terms of presenting with more symptoms due to the violence they had been exposed to in their home countries. Counsellors observed that many of the refugee clients who accessed their services would have met the criteria for PTSD prior to being raped. Counsellors were of the opinion that rape exacerbated the pre-existing symptoms of PTSD, leading to a report of increased symptom severity when counselling commenced. As shown in the above quotation, refugees were also perceived to be an economically marginalised group, which as discussed in theme 2, was a further factor that may increase their symptom severity.

Counsellors observed that clients who were experiencing ongoing trauma as a result of living circumstances such as residing in a violent area where they felt unsafe or exposure to domestic violence showed increased symptom severity post-rape:

Participant 5: Also, people who are living under threat of violence, if they are living in a violent area…

Group: [Agrees]

Participant 5: … or if they are a refugee and there is constant threat of xenophobia or attacks from other refugee groups…

Participant 6: … or domestic abuse or domestic violence…

> Participant 5: Yes. So any of those things, there's continuous trauma happening and you get much, you can't address the rape trauma as well as you could if there's a safe environment and in those situations even though they're similar across the board, the duration is much longer, it is much harder to ease the symptoms.
>
> Focus Group 1

In the quotation above counsellors discuss the impact of living in an environment that does not feel safe. Living in constant fear of being subjected to interpersonal trauma or witnessing further violence might make survivors of sexual violence even more vulnerable to increased symptom severity when commencing treatment and result in more chronic symptoms. Exposure to ongoing trauma, was perceived to be another exacerbating factor for symptom severity.

Finally, three focus groups also commented on the role of negative experiences with the Criminal Justice System, particularly the police, in increasing symptom severity amongst rape survivors:

> To add on that some of them they are their trauma is worse because of the law, the detective inspectors because some of them especially when they were raped they were drunk because some of them they were drunk but to find out they know everything they stick on the same statement. Now the detective inspector always tell the survivor that, "You don't have a case," because all the witnesses are on the side of the perpetrator.
>
> Participant 6, Focus Group 3

Participants discussed the common experiences of survivors feeling that reporting to the police was a second trauma. In addition to the fear of being in a police station, feeling unsafe and experiences of victim blaming at the hands of the police, all of which were perceived to increase symptoms, survivors were often met with the stark realisation that justice would not be served either through lack of evidence or police incompetence and this was in and of itself a further trauma that had to be processed.

4.2.1.5 Theme 5: Survivors of known perpetrator rape report increased symptom severity

The final theme in this section addressed how symptom severity of rape survivors might be influenced by knowing the perpetrator. Counsellors perceived survivors of known perpetrator rapes to be more likely to report increased symptom severity, which contradicts the findings in the quantitative analysis.

This theme was strongly represented in all focus groups. Participants suggested that the closer the proximity to the perpetrator, the higher the symptom severity. This included both relational and physical proximity. In terms of relational proximity, clients who were raped or sexually assaulted by a family member were perceived by participants to show increased symptom severity while clients who physically lived in the same home or area, whether the perpetrator was a family member or not, were perceived to report elevated symptom severity.

> Participant 9: For me if the perpetrator's known to the survivor it's usually more traumatic because it's as if disbelief that it's actually happened because more of these symptoms actually displays that you can actually pick up on.
> Researcher: That's if the perpetrator is actually known to them?
> Participant 9: Yes.
> Researcher: And why do you think that is?
> Participant 9: I think it's because they had that trust with the person and they just didn't believe that it would ever happen, this person, would ever abuse them in that manner. You know and that is traumatic for them. Focus Group 4
>
> Because it is somebody you have trusted, this person is supposed to protect you, but he come out and do that and then you think, “Oh the world, the world is finished because this person.” Participant 6, Focus Group 3

As illustrated in the preceding quotes, survivors of known perpetrator rapes were perceived to feel high levels of betrayal. Participants postulated that the closer the relationship to the perpetrator, the worse the symptoms were due to the breach in trust and expectations of being protected, Survivors often expressed to counsellors that they had had an expectation to be protected by their family members who had raped them and that this was especially difficult to come to terms with. Being raped by a known perpetrator was perceived to be traumatic for survivors on multiple levels. In addition to the feelings of betrayal that survivors felt, participants also commented on how survivors often feel conflicted about disclosing a rape or

sexual assault by a family member as their family takes different sides for and against the survivor as shown in the quotes below:

> So sometimes the family members get torn apart because one person is taking the side of the other and so on so the person, usually the victim feels sort of like in between because they often feel like it's their fault that this whole family and everything, so when they come back here, so the symptoms kind of…it stays longer, it becomes more.
>
> Participant 4, Focus Group 1

> Destroying them, a lot, it destroying them a lot because when the rape between the family, the family will be divided: the ones that will support the survivor and the ones that will support the perpetrator. And because this person [rape survivor] ends up in between, don't know what to do because that family also has and even the one that hurts that is destroying them totally.
>
> Participant 3, Focus Group 3

Counsellors suggested that the loss of this source of social support from family members and division within the family around such a disclosure increased the trauma of the rape. Furthermore, these survivors were confronted with having to continue to see the perpetrator and in some cases, live in the same home, exacerbating the psychological distress these survivors' feel as they were constantly reminded of the violence and trauma they had experienced. Participants observed that in cases where these survivors are threatened by the perpetrator, this would add to their trauma as shown in the following quote:

> To add more to what *Participant 5* said when the survivor comes and she knows her perpetrator they become more because sometimes the perpetrator when she find that the survivor report to the police they came back and tried to hurt them, some of them even beated them so the trauma become more and more and then the perpetrator talks some bad things to him.
>
> Participant 1, Focus Group 3

Knowing their perpetrators might put survivors at further risk of violence as shown in the quotation above. Facing intimidation not to disclose being raped or to report the rape to the police, increased symptom severity according to counsellors. Linked to this was that survivors might not have the means to move to a different area or move out of their current

accommodation, if shared with the perpetrator, and participants perceived this to be another factor that increased their symptoms.

4.2.2 Counsellors' perceptions of factors that influence treatment attendance

Counsellors spent considerably less time discussing predictors of treatment attendance then they did symptom severity. Hence, only three themes were identified regarding predictors of treatment attendance amongst rape and sexual assault survivors. Client's motivation for attending counselling; being a survivor of DAFR/IR; practical obstacles to attending treatment were perceived by counsellors to influence length of attendance. Two of these were not assessed on the intake form and were therefore not included in the quantitative analysis, one theme and one sub-theme contradicted the findings of the quantitative analysis.

4.2.2.1 Theme 1: Clients' motivation for attending counselling influences treatment attendance

A theme that was prevalent across all four focus groups was that clients' motivation for attending counselling impacted their length of attendance. A trend that emerged was that clients who felt coerced to attend counselling dropped out earlier than those who felt self-motivated to attend. Participants noted that some types of clients had higher support needs and were perceived to be more motivated to stay in counselling. Clients whose motivation for attending counselling was to seek financial or other assistance that RCCTT could not offer them, attended for a shorter duration.

Sub-theme 1: Coercion versus self-motivation

One of the most frequently mentioned reasons for clients discontinuing counselling was when clients felt coerced into starting treatment and lacked self-motivation to continue the process. A few types of clients were perceived to be coerced into coming to counselling and thus remained in treatment for a short duration. All four focus groups perceived teenagers to attend counselling for a shorter duration than older clients. However, this contradicted the findings of the quantitative analysis.

> In terms of teenagers I do have those who stays a long period but the problem ones: the ones who are being sent by a school, by a relative those ones they don't last in the teenagers but those who come by their own will at least because I do have the other that

> I am going to see tomorrow we have a 15th session. I did discharge her after the 12th but then she did come back again after 4 months she want to continue again.
>
> Participant 3, Focus Group 3

> I think they young ones, the term that they come in, it's less than the older ones because the young ones some more more of them are forced to come for counselling, they're not coming free willing, come by theirself for counselling but the mother and father recommend them to come so they're not coming out of themselves so the younger ones is the one that come but the older ones will finish the sessions and have more sessions than 10 or 9 or so but the young ones is 5, 4, 3 so I think the younger ones will come very less. Participant 3, Focus Group 4

As illustrated in the quotes above, participants believed that teenagers were a group at high risk for coercion due to their age. Parents, other family members or teachers would commonly be the driving force behind them coming to counselling and participants explained that this may be why they may not remain in counselling for long. They contrasted this with the experiences they had with some teenagers who were self-motivated to attend counselling and therefore attended for a longer duration. Clients, other than teenagers, who felt they were coerced also did not attend treatment for long as shown below:

> Participant 3: I think in the case where maybe the parent wanted or the supporter phoned on behalf and the pieceworker didn't speak to the survivor, in the case where they didn't book the session themselves or maybe a parent or teacher or whoever told them to come, especially teenagers, then they only come for that one or two…
> Participant 6: Or when they're told at the forensic examination that they should go for counselling or by the court and then sometimes they're not [inaudible].
> Participant 2: I just think they're just not ready. At the court it's actually very sad because you are forced to see a counsellor – that's the only way the postpone the case, "Because you're not ready to talk so you need to…", but they don't even pitch; they don't even come for that first session.
> Participant 1: And I think they want, they want the help from the court and that is the reason they come because now they have to come for counselling; now they only come for one or two sessions, then they stay away. Focus Group 1

Participants observed that clients were often referred through the CJS: either by the police, the court, a Thuthuzela centre or a forensic medical unit at a hospital. Commonly these referrals were not well received by clients. They felt forced to come for counselling, especially those clients who were referred by the court as shown in the above quote, and felt it was difficult to refuse the referral since it came from institutions that represent authority, and therefore did not remain in counselling for long as they lacked an internal motivation to attend.

Sub-theme 2: Client support needs

Counsellors perceived that clients who had higher support needs were motivated to remain in treatment for longer:

> Participant 1: Then the one also have a very strong family support, they tend not to really take long coming.
> Researcher: So, they tend to have fewer sessions?
> Participant 1: Yes, in my experience they...because the families they make it alternative maybe healing or help whatever. Focus Group 2

> Participant 5: People with very little support at home will stay longer because their symptoms stay longer, and if there's, if it's not safe outside of the counselling they tend to stay longer.
> Participant 2: I also find that my clients that has to go to court, the court process takes forever, I mean I've got a client who's been on the court roll for four years now and I'm seeing her all the time. You know, she's anxious before she has to go to court, there's a postponement for three or six months and those clients stays longer, you know, so ja, um, that I've noticed. Focus Group 1

> And the other if it's again where a case has been made, um, and they have laid a case at the police station and, um, they're going to court, in that instance the survivor usually stays the 12 sessions because she is determined to make the best of what the situation so that's what I've found. Participant 9, Focus Group 4

> Participant 5: They [clients with pre-existing mental health difficulties] have more difficulty in reducing symptoms and some have more, um, they're more comfortable and used to being counselled. Here you get a whole hour whereas in the State system you're lucky if you get 20 minutes…

Participant 2: …ja…
Participant 5: …um, and not every week. So here there's a consistent therapeutic space.
Group: [Agrees.]
Participant 6: I agree with Participant 5. Is that they get very little attention in the public health system. Focus Group 1

Poor social support was perceived to be a motivating factor for clients to remain in counselling as they could not draw on other networks to support them through their recovery. Supportive friends and family, as discussed in section 3.2.1.4, were viewed as a protective factor in reducing symptom severity and aiding recovery. Clients with poor social support were therefore perceived to have a higher need of counselling due to their increased vulnerability. Similarly, clients going through a court process were perceived to be more motivated to remain in treatment for longer. These clients were likely to be confronted with seeing the perpetrator in court, often over a long period of time, which made them vulnerable to ongoing trauma related to the rape or sexual assault incident. They thus had a higher support need for counselling due to the long duration of a stressful and traumatic trial.

Finally, clients who had been diagnosed with a mental health disorder were perceived to need longer treatment. Two of the focus groups commented on their vulnerability as a population already experiencing various distressing symptoms prior to being raped. As illustrated above, they were perceived to be clients who found it more difficult to resolve the rape trauma symptoms which translated into having a higher need of counselling support. Participants also believed that clients with a history of mental health difficulties were generally more comfortable with the counselling process and were more reliant on the free counselling received at RCCTT since they were often neglected within the overburdened public health system. This was perceived to be the motivating factor for attending treatment for a longer period.

Sub-theme 3: Clients who are motivated to attend counselling by an expectation that cannot be met in the organisation leave counselling earlier

Clients who attended counselling motivated by an expectation that RCCTT could assist them with issues other than rape counselling, dropped out of treatment earlier as shown in the following quotations:

> Participant 3: Some of them they are coming here they think we're going to do the jail, we're going to arrest the perpetrators quick so when they come in several sessions and that is not happening they just don't come.
> Researcher: So, they don't understand what Rape Crisis does?
> Participant 3: They don't, they think [inaudible] and go and arrest the person. So, they think by coming it's magic and things will happen but when it's not happening, they stay away. Focus Group 3

> I find that I, um, a lot of the clients they don't return. Some of them think that we are like, uh, financial aid that can help them because like I said in the beginning, their financial status is severe, um, and they need money and they think we can help them so as soon as you say that we're not in a position to help them in that way then they don't come for a second session. Participant 5, Focus Group 4

Participants perceived hopes of receiving an intervention that would address physiological needs as a common motivating factor in seeking counselling, especially amongst poor clients. These survivors often wanted assistance with meeting basic needs such as food, finding accommodation or securing employment and upon learning that RCCTT does not offer these kinds of services, would not return to counselling. Due to the perceived wide dissatisfaction survivors had when reporting a sexual offence to the police, some clients were also motivated by an expectation that RCCTT would be able to assist in bringing the perpetrator to justice. Participants felt that when clients realised this expectation would not be met, this resulted in disappointment and them leaving treatment early.

4.2.2.2 Theme 2: Survivors of Drug-alcohol Facilitated Rape/Incapacitated Rape (DAFR/IR)

All focus groups perceived survivors of this type of rape to attend counselling for a shorter duration, which contradicted the findings of the quantitative analysis. A common reason that was offered was that these survivors were not conscious during the rape and could not remember what had happened and this was perceived to influence their attendance:

> Participant 1: In my experience women which have been drugged or like you say, “wake up and you find yourself in that situation,” not as my experience as a counsellor but as

> a long-term pieceworker because I piecework here for quite a long time, I'm the one who take most of the cases. They don't have a long term of coming...
> Participant 3: ...for treatment. Ja, I agree with you.
> Participant 1: Because that sense of not knowing, it's like they almost feel like they couldn't explain anything or maybe there's a question that they can't answer. So, most of the time they don't really come, once, twice... Focus Group 2

> Participant 4: Yes, like me, I've got an experience of a client who was raped when she was drunk she don't recognise can't what happened. Only just wake up near the scene and then her panty was there and then she came three times and then she said to me, "No [inaudible] informed me to come here because I, I don't feel anything about I was really raped." You see, "I don't even have a picture that I was raped," so I just tell them that, "When you realise that maybe it will come again so when you realise that you need the counselling, you will come again." Focus Group 3

As illustrated above, not being able to recount the story, in full, of how they were raped was perceived to be one of the reasons these clients terminated counselling after a few sessions. Participants suggested that clients felt awkward coming to counselling to speak about a rape they could not remember and often felt that they did not need to come to counselling as they had nothing to talk about. As discussed in section 3.2.1.1 these clients were often not as aware of their symptoms as clients who were conscious while being raped of sexually assaulted. Perhaps their symptoms may resolve faster as the memories of the traumatic event were not as entrenched, resulting in not needing treatment for long. Some participants also perceived this group to be at high risk for feeling coerced into coming to counselling by their social network, which as discussed in 3.2.2.1, might contribute to shorter treatment attendance.

Another possible reason for this group's short attendance is discussed in the following quote:

> I don't know, I think a lack of control in the rape itself seems to make them less controlled in steadily coming or saying I'm not going to come next week, I'm going to finish now, or something. They don't even have termination sessions with me which is very unusual for me. My clients normally say, "Actually we're ready to stop." We get

> to have that discussion, but with those clients, I don't get to have that discussion. …the only thing I can think of is that lack of control that happened in that space is now replayed in the counselling. We have no control over whether they come and it seems to be they don't either. Focus Group 1, Participant 5

In the above quotation, the participant suggests a psychodynamic rationale that there may be a repetition that is played out in the counselling relationship. Since these clients were incapacitated by drugs or alcohol while being raped, they may feel less in control of their recovery than those who remember being raped. This may account for their shorter attendance.

4.2.2.3 Theme 3: Practical obstacles to attending counselling

Every focus group perceived practical obstacles to attending counselling to be a consistent predictor of treatment dropout. Most often clients living in poverty faced difficulties in accessing counselling due to resource deprivation:

> …sometimes they don't have money then they only come two then they stay at home and they come 3, 4 weeks or a month and then they say they didn't have money to pitch so I think that money also play a big role. Participant 3, Focus Group 4

> Participant 2: Like you know the clients who can't get here, the clients who don't have money, the clients who don't have jobs or the clients, I don't know, who are looking after their own children or other people's children…
> Participant 1: …she doesn't have someone to take of the kids…
> Participant 2: …the children to come here. So those kinds of things can make it worse versus somebody who might be able to, who can drive, who can make it here…
> Focus Group 2

In the quotation above, the participants suggest that finances often prevent clients from being able to attend counselling. While RCCTT reimburses clients for their travelling costs to and from their offices, there were those clients who were suffering from such financial deprivation that they did not have the resources to come up with the initial transport fare, which prevented them from continuing with counselling.

> I find with the suburb, where they live, um, could also be a reason for them staying away because it is too far, for example we've had now recently lots of clients from Mitchell's Plein and, um, they're having to travel to Athlone and it's costing, even although we give them an allow, the relief, but it's just too far so they stay away and perhaps they want to, but they just don't feel like coming that far every time.
>
> Participant 9, Focus Group 4

As illustrated by the quote above survivors who lived in suburbs far away from the three RCCTT offices also dropped out of counselling early – sometimes due to the cost of travelling and sometimes because the time it took to travel to and from the counselling office was prohibitive. Clients who had access to their own vehicle or had a partner or family member to bring them to counselling were perceived to attend for a longer duration due to having access to this resource. Furthermore, clients under financial pressure to earn an income might not be able to attend counselling due to their work situations:

> Those that are working those are the most difficult ones for me, I'm not talking about anyone else, because if I'm supposed to say I can see she's very traumatised, she's very emotional, I want to see her weekly but she will tell me about work, "I can't always postpone work and come here," and I say, "No, you can come. It's only one hour and go back to work."
>
> Participant 5, Focus Group 3

Pressures of work were perceived to be a common obstacle preventing clients from attending counselling consistently. Survivors might not want to disclose to their places of work that they had been raped, making it difficult to ask for the time off work.

4.3 Summary

Findings of the quantitative and qualitative phases of this mixed method study showed little overlap in predictors of symptom severity or treatment attendance. In the next chapter the findings will be discussed considering other literature and a brief discussion of the limitations of this study and recommendations for further research and practice will be presented.

CHAPTER 5: DISCUSSION

This chapter will draw the qualitative and quantitative findings together and situate them in the relevant literature. The predictors of symptom severity will be discussed first and the predictors of treatment attendance thereafter. The limitations of this study, implications for further research as well as recommendations for counselling of rape survivors will also be discussed.

5.1 Predictors of symptom severity

5.1.1 Demographic predictors of symptom severity

The quantitative and qualitative analysis were contradictory regarding age as a predictor of symptom severity. All four focus groups had the perception that teenagers presented with fewer symptoms than older clients, however this was not reflected in the multiple linear regression. The limited previous research examining age as a predictor of symptom severity indicated that older survivors showed increased symptoms of depression while adolescents were at increased risk for developing PTSD (Cook et al., 2011; Kilpatrick & Acierno, 2003; Malan et al., 2011; Ullman et al., 2007; Van der Walt et al., 2014). Since this study used a global score for symptom severity which consisted of items that tapped for depression, PTSD and self-harm it is difficult to draw direct comparisons between these studies and the present one. It is possible that focus group participants identified a trend of increased depressive symptoms amongst older survivors, in line with the existing literature. Conversely, it is possible that focus group participants confused symptom severity and openness to counselling. Counsellors described teenagers as reticent to share while older clients were perceived to be more forthcoming. The quantitative results suggest that age in and of itself not a predictor of post-rape symptoms across RCCTT clients on average.

This study was one of the few studies that included both male and female rape survivors. Gender was not a statistically significant predictor of symptom severity, concurring with past findings that sexual violence affects men and women equally (Cortina & Kubiak, 2006; Hutchings & Dutton, 1997; Tolin & Foa, 2006). Some research has shown that male and female survivors may meet criteria for different diagnoses which suggests there may be gender differences in how survivors' symptoms present post-sexual assault (Hutchings & Dutton, 1997). Focus group participants hardly mentioned gender in the focus group interviews, indicating that they did not perceive gender to be an important factor associated with increased

symptom severity. The findings of the present study suggest that gender may play a negligible role in predicting symptom severity.

During focus group interviews few references were made to race, apart from brief comments on differing social responses, suggesting participants might not have viewed it as an important factor. The bivariate analysis showed that black survivors had lower mean symptom severity when compared to coloured and 'other race' survivors, which agreed with the findings of a previous local study (Abrahams et al., 2013). However, in the linear regression model predicting symptom severity, the race variable fell away and was not a significant predictor of symptom severity, concurring with some international research (Ullman & Filipas, 2001). The first Observatory focus group perceived black and coloured clients to be less able to self-identify symptoms than white clients due to cultural difference and different degrees of psychologisation. Counsellors explicitly stated that they did not associate this with language proficiency, but with cultural norms. However, the multiple linear regression showed that being English-speaking predicted increased symptom severity. Drawing the findings together suggests that when considering multiple variables simultaneously, the influence of race may in fact be better accounted for by another, related, variable: language.

Since the RCCTT intake form is only available in English, there may be a bias towards English-speaking clients and counsellors. Therefore, counsellors counselling in other languages translate the RTS checklist verbally for their clients. English proficiency may enable clients to report more symptoms because they have the vocabulary to do so or to recognise them more easily when presented with the RTS checklist. Similarly, the English proficiency of the counsellors and their ability to translate the checklist could also influence how many symptoms were recorded in the intake form for clients. It is possible that the symptoms of clients who are not proficient in English are underestimated due to these language challenges. No previous literature examining language as a predictor is symptom severity was found. Further research is needed to unpack race versus language in the South African context. Furthermore, further investigation into the role of culture in expression of symptoms may be illuminating as some focus groups referred to the use of somatic symptoms as means of expressing distress post-rape.

Religion was not statistically associated with symptom severity. However, the second Observatory focus group perceived clients with strong religious affiliation to have worse

overall symptoms due to experiencing an increased negative social response. This finding is similar to research indicating that survivors who relied on religious coping and social support to recover had higher PTSD than those who only relied on social support (Bryant-Davis et al., 2015). Increased symptoms post-rape amongst devout followers of religion may be mediated by negative social reactions from religious communities as was postulated by the focus group participants. The incongruent findings of the present study might be because neither degree of religious affiliation nor negative social reactions to disclosure were quantitatively measured. How strongly survivors feel affiliated with their religious beliefs and the degree to which they feel negatively responded to may be a better measure of sociocultural response and how this may be associated with symptom severity, than the categorical variable of religion that was used. Hence a more nuanced approach may have delivered different results.

Finally, the bivariate analysis showed that being employed or retired was significantly associated with increased symptom severity, contradicting past research that found unemployment to be a significant predictor when examined independently (Abrahams et al., 2013; Tiihonen Möller et al., 2014). However, in the study of Tiihonen Möller and colleagues (2014) employment status was found not to be significantly associated with PTSD in the secondary analysis, agreeing with the current study since this variable fell away in the multiple linear regression. Conversely, the finding contradicts a local study which found unemployment to be a statistically significant predictor of increased depressive symptom severity post-rape in a multivariate model (Mgoqi-Mbalo et al., 2017). Mgoqi-Mbalo (2017) suggested that poverty may be an important stressor to consider in the development of PTSD and depression post-rape and warrants further investigation. All four focus groups perceived participants living in poverty to have increased symptom severity which contradicted the bivariate analysis, if one considers unemployment as a proxy for poverty. However, it can be argued that not all participants who identified as unemployed were deprived of physiological resources and therefore this may be a weak proxy for poverty. Had other measures such as household income been included in the study the quantitative findings may have converged with the qualitative analysis.

5.1.2 Rape incident factors that predict symptom severity

This study was one of few studies that examined type of sexual offence (rape versus sexual assault/attempted rape) as a predictor of symptom severity. When compared to sexual assault/attempted rape, rape was a significant predictor of symptom severity in the regression

model. This contradicts the findings of a similar study of treatment-seeking rape survivors which found no relationship between type of sexual offence and symptom severity (Elklit & Christiansen, 2013). The finding of the current study suggests that the severity of the assault may be associated with symptom severity. As has been found in previous research, perceived threat to life is associated with increased symptom severity (Ullman & Filipas, 2001; Ullman et al., 2007) and it is possible that rape survivors perceived their life to be in more danger than survivors of sexual assault/attempted rape which contributed to the increased symptom severity. Rape may be also in some cases be associated with stronger feelings of shame and stigma which may exacerbate symptom severity.

In the focus groups, counsellors identified survivors of known perpetrator rapes as having higher symptom severity, in line with a similar local study (Abrahams et al., 2013). However, this theme contradicted the findings of the multiple linear regression which found that survivors of unknown perpetrator rapes showed increased symptom severity, in agreement with international research (Bownes et al., 1991; Zinzow et al., 2010). This contradiction may be accounted for by the measurement of type of relationship in the intake form being too crude, as has been suggested by other research (Elklit & Christiansen, 2013). Participants in the focus groups referred to different types of relationships existing within the 'known' category. Specific mention was made of rape by a family member being more traumatic due to the breach in trust which concurs with prior research (Darves-Bornoz et al., 1998). However, this was not measured by the intake form which only assessed whether the perpetrator was known versus unknown. It is possible that with a more nuanced categorisation for identity of the relationship, measuring closeness of relationship, the pattern of increased symptom severity amongst known perpetrator rapes, might emerge in the quantitative data. Conversely, it may be that RCCTT counsellors have incorrectly ascribed increased symptom severity to known perpetrator rapes given the high number (64.3%) of clients who report being raped by a known perpetrator, perhaps ignoring the trend of higher symptom severity in unknown perpetrator rape since they are likely to see comparatively fewer of these types of clients. It is important to note that a review article found mixed results regarding whether being raped by an unknown perpetrator was a predictor of increased symptom severity (Jordan et al., 2010), and the contradictory findings of the current study support the possibility that known/unknown identity of the perpetrator may have a complex relationship with post-rape symptomatology.

The finding that number of perpetrators was not significantly associated with symptom severity concurs with one study (Elklit & Christiansen, 2013), but diverges from overwhelming evidence that multiple perpetrator rape is associated with increased symptoms (Machado et al., 2011; Tiihonen Möller et al., 2014; Ullman, 2007a; Ullman & Najdowski, 2009). The present finding suggests that rape by one perpetrator may be as traumatic as rape by multiple perpetrators, given that this variable was not significant in the bivariate analysis or multiple linear regression nor was it raised by the RCCTT counsellors in focus groups. Alternatively, contrary to the findings of Ullman (2007a), survivors of multiple perpetrator rape in South Africa may be responded to with more empathy, support and less stigma than survivors of single perpetrator rape, which may negate the effects of the severity of the assault and ameliorate symptoms.

The quantitative results indicated that whether a substance such as drugs or alcohol was used by the survivor at the time of the rape was not a statistically significant predictor of symptom severity. However, lower symptom severity in survivors of rape facilitated by drugs or alcohol was a significant theme in the focus groups, a finding that concurs with other research (Gilmore et al., 2017; Kaysen et al., 2010; Zinzow et al., 2010; Zinzow et al., 2012). Furthermore, focus group participants' perception that survivors of rapes involving drugs or alcohol showed increased self-blame and guilt also corresponds with previous research (Edinburgh, Pape-Blabolil, Harpin, & Saewyc, 2014; Gilmore et al., 2017; Peter-Hagene & Ullman, 2018; Zinzow et al., 2010; Zinzow et al., 2012). Research indicates that survivors of DAFR/IR were less likely to acknowledge that they had been raped which may account for why survivors of this type of rape may present with fewer symptoms (Walsh et al., 2016; Zinzow et al., 2010).The divergence between the quantitative and qualitative might be explained by considering whether the quantitative data measured the same rape incident factor that the focus group discussed. Upon reviewing the intake form, it does not clearly measure for DAFR/IR since it asks a general question of whether the survivor had ingested drugs or alcohol at the time of rape – not whether he or she was unconscious or intoxicated at the time of the rape. Had DAFR/IR been clearly identified on the intake form, the findings may have revealed a different statistical trend.

No association between use of weapon and symptom severity was found in this study, contradicting the findings of Mgoqi-Mbalo and colleagues (2017). This suggests that perhaps severity of assault or perceived threat to life might play a limited role in predicting symptom

severity in this sample. Alternatively, it is possible that unknown perpetrators (a statistically significant predictor of symptom severity) would be more likely to make use of a weapon and thus effects of weapon use on symptom severity were better explained by perpetrator identity. While injury was statistically significantly associated with symptom severity in the bivariate analysis, in agreement with the findings of past research (Tiihonen Möller et al., 2014; Zinzow et al., 2010), it fell away in the multiple linear regression, indicating that the effects of injury may be better accounted by another related variable such as type of sexual offence since it is possible that attempted rapes/sexual assaults may be less likely to result in injury than a completed rape.

5.1.3 Other predictors of symptom severity

While the RCCTT intake form did not measure social support, the theme of social support was consistent amongst the four focus groups. Counsellors postulated that social support was a significant predictor of symptom severity. Strong family, friendship and partner support was, in their view, negatively correlated with symptom severity. This is consistent with international and local findings that social support is a predictor of symptom severity post-rape or sexual assault (Abrahams et al., 2013; Dworkin, Ullman, Stappenbeck, Brill, & Kaysen, 2018; Schumm et al., 2006; Wyatt et al., 2017).

International research points to differences in social reaction to disclosure of rape based on race, which may be a proxy for sociocultural factors. Maier (2008) found that counsellors' perception was that African American and Hispanic sexual assault survivors were more likely to experience negative social response to their disclosure and receive less emotional support from their communities than white survivors. In the present study, two participants referred to responses of distraction such as, "you must get over it" being common within the Cape Town coloured community and that these responses worsened symptom severity, which is consistent with past work in other contexts (Hakimi et al., 2016; Relyea & Ullman, 2013; Ullman & Filipas, 2001; Ullman et al., 2007; Ullman & Peter-Hagene, 2016). However, other participants did not comment on their experiences of how different cultures support or respond to rape survivors leaving it unclear as to whether certain cultural groups may be more supportive or unsupportive toward rape survivors.

Counsellors' perception that compounded trauma (including CSA, multiple experiences of rape in adulthood and other trauma) predicts increased symptom severity is overwhelmingly

supported by the literature (Cheasty et al., 2002; Koss et al., 2003; Schumm et al., 2006; Scott et al., 2018; Sigurvinsdottir & Ullman, 2016b; Taft et al., 2009; Tiihonen Möller et al., 2014; Ullman et al., 2007; Ullman & Najdowski, 2009; Ullman et al., 2014; Ullman & Peter-Hagene, 2016). The perception that refugees had increased symptom severity post-rape due to the effects of cumulative trauma seems probable given the high rates of PTSD and other mental health difficulties experienced by this population (Keller et al., 2006). Furthermore, Keller and colleagues' (2006) study found that rape was a significant predictor of PTSD in a refugee population. Interactions with the CJS were perceived to be a further trauma rape survivors have to contend with and to contribute to increased symptom severity, consistent with past research (Campbell, 2008).

5.2 Predictors of treatment attendance

5.2.1 Demographic predictors of treatment attendance

When observing mean attendance, survivors aged 14 – 19 had the highest average attendance, however younger age was not statistically significantly associated with length of treatment attendance, consistent with findings by Fletcher and colleagues (2017). Focus group participants perceived teenagers to attend fewer sessions than older clients which concurred with the findings of one study that looked at age as a predictor of psychotherapy attendance (Rizvi et al., 2009). Given the contradictory findings, it is possible that focus group participants overstated the role of coercion amongst teenagers and that many more teenage clients attend voluntarily than they perceived them to.

The model predicting treatment attendance found that males attend more counselling sessions than females, a finding that agrees with a recent study examining predictors of psychotherapy attendance amongst adult survivors of CSA (Fletcher et al., 2017). Peterson and colleagues (2011) note that men may experience more distress post-rape due to feeling emasculated through an inability to protect themselves from being raped. For this reason, it is possible that male survivors may take longer to recover, and hence remain in treatment for longer than female survivors for whom gender-based violence is, unfortunately, the norm. Since no significant difference in symptom severity was observed between male and female survivors at the start of counselling and this study did not look at subsequent measures of symptom severity as counselling progressed, further research is required to test this hypothesis.

The ZTNB model predicted that black clients had shorter treatment attendance than clients of the 'other race' category (consisting of Asian, other and white clients), while no difference between black and coloured clients' length of attendance was found. When observing the means, clients of the 'other race' category attend almost two sessions more than coloured clients. No previous research examining race as a predictor of treatment attendance was found. However, a United States study found that black women were less likely than white women to make use of a counselling service in the first year post-rape (Alvidrez et al., 2011). Alvidrez and colleagues (2011) postulated that psychosocial factors such as practical barriers (lack of child care and transportation) and stigma attached to counselling might influence treatment engagement across clients of different race categories. Similar practical obstacles to attending counselling were mentioned during focus group interviews in the current study, however no reference to race was attached to these. It is possible that given the legacy of economic inequality in South Africa due to Apartheid, many black and coloured clients would face these barriers and this may explain shorter attendance amongst these populations. Furthermore, stigma attached to counselling may deter clients from continuing with counselling as indicated by this participant's comment, "…coloureds don't believe back in the days going for counselling, going to talk about this…you have to change their mindsets about that." (Participant 2, Focus Group 1). While generalisations based on 'race' and 'culture' should be regarded cautiously, it is nevertheless important to consider whether culturally-informed beliefs and attitudes may affect attendance of post-rape counselling.

A review study found unemployment and lower income to be associated with early attrition (Matthieu & Ivanoff, 2006). However, in the present study the ZTNB found no statistical association between religion, employment status and home language with length of treatment and focus group participants made no reference to these demographic factors as possible predictors of treatment attendance. This suggests that these demographic factors may play a limited role in predicting treatment attendance amongst RCCTT clients, a finding which concurs with results from a study examining predictors of follow up attendance at a medical clinic post-rape (Holmes et al., 1998).

5.2.2 Rape incident characteristics that predict treatment attendance

Type of sexual offence, number of perpetrators, identity of the perpetrator, weapon use and injuries sustained during rape were not statistically significantly associated with treatment attendance. Similarly, these factors were either not mentioned in the focus groups or were

mentioned so sparsely that any reference to them did not constitute a theme within the data, suggesting that rape incident characteristics may play a limited role in predicting counselling attendance amongst RCCTT clients, concurring with past research (Holmes et al., 1998). The only factor that was discussed at length was the theme of shorter attendance of counselling by survivors of DAFR/IR. However, the ZTNB showed no relationship between substance ingested at the time of rape and counselling attendance. As discussed in section 5.1.2, the intake form may not have accurately assessed for DAFR/IR, possibly accounting for the discrepancy between the quantitative and qualitative findings.

Literature on treatment engagement of survivors of DAFR/IR shows mixed results. One study found that survivors of DAFR/IR were less likely to seek medical help post-rape (Walsh et al., 2016), while another found they were more likely to seek medical help and to attend subsequent psychotherapy and medical appointment than survivors of non-substance related rape (Richer et al., 2017). Focus group participants in the current study spoke at length about how survivors of this type of rape did not remember the events that took place and this may impact on whether survivors acknowledge their experience as rape. Furthermore, focus group participants also mentioned that this group may often feel coerced to attend counselling, a perception supported by research that found that adolescent survivors of DAFR/IR were less likely to disclose being raped to an adult, but that a peer would seek help on their behalf (Campbell, Greeson, Fehler-Cabral, & Kennedy, 2015). As explained by this participant, "No, [inaudible] informed me to come here because I, I don't feel anything about I was really raped." You see, "I don't even have a picture that I was raped…" (Participant 4, Focus Group 3). It appears survivors of DAFR/IR are less likely to acknowledge their experience as rape (Walsh et al., 2016; Zinzow et al., 2010). It is possible that not remembering or acknowledging the incident as a rape would mean that survivors would be hesitant to seek help (Walsh et al., 2016), but that social support networks coerce these survivors to attend counselling, resulting in them attending for one or two sessions to placate their support network and then dropping out of counselling.

5.2.3 Other predictors of treatment attendance

The findings of this study suggest that there are many factors, other than demographic and rape incident characteristics, that may influence attendance. Concurring with the perceptions of the focus group participants, studies have suggested that practical barriers such as lacking child care, transportation and work-related barriers are some reasons clients dropout of counselling (Alvidrez et al., 2011; Matthieu & Ivanoff, 2006). This suggests that poverty may be a risk

factor in early attrition, especially since poorer clients were perceived to be less motivated to attend counselling since they often had expectations that their physiological needs would be met by the organisation. The theme that lack of motivation resulted in earlier counselling termination was confirmed as a common reason offered for early attrition in a review study (Matthieu & Ivanoff, 2006). As part of this theme participants referred to clients with poor support being more motivated to remain in counselling. Social support as a predictor of attendance has only been investigated in terms of medical service or a mix of medical and counselling service engagement. Some research contradicts the qualitative findings (Darnell et al., 2015), while a review article (Ullman, 2007b) suggests social support leads to fewer symptoms and therefore a shorter medical service attendance, agreeing with the findings of the present study. Symptom severity may be an important factor associated with length of counselling engagement.

The quantitative analysis found that increased symptom severity was a significant predictor of increased treatment attendance. While this did not emerge as a theme in the qualitative analysis, it was alluded to by the participants who inferred that clients with pre-existing mental health difficulties had more difficulty reducing symptoms and therefore attended counselling for longer. Furthermore, clients with little or no social support, as discussed earlier, were perceived to have increased symptom severity. In the discussion about attendance they were also perceived to attend counselling for a shorter duration. Since themes were identified at a semantic level, the overt meaning made from the qualitative data was that participants perceived clients with poor social support and a history of mental health disorders to be more motivated to attend counselling because they had a higher support needs. One participant did suggest an association between symptom severity and treatment attendance, "People with very little support at home will stay longer because their symptoms stay longer…" (Participant 5, Focus Group 1) but this link was not explicitly explored within the focus groups. Drawing the themes about symptom severity and treatment attendance together through more latent reading of the data suggests that the increased symptom severity of survivors with poor social support and a history of psychiatric diagnoses may have been why they attended counselling for longer.

A review article contradicts this finding, showing that treatment dropout was predicted by increased symptom severity (Matthieu & Ivanoff, 2006). However, a recent study which followed up on clients who dropped out of treatment for PTSD early found that they had reduced symptom severity compared with those who completed treatment (Szafranski, Smith,

Gros, & Resick, 2017). Although this study was conducted with a general female population with PTSD, not a population with rape-related PTSD, this result suggests that perhaps clients who leave treatment early do so because their symptoms are reduced which may explain the finding in the present study.

5.3 Limitations

A limitation of the study is that the data were collected at three rape crisis centres in one city in South Africa. Generalisability to the South African population is thus limited due to the sample not being provincially or nationally representative. Furthermore, the sample is composed of treatment-seeking rape survivors – again limiting the generalisability to the South African population of rape survivors, overall. However, the aim of the study is to enhance the service offered by this particular organisation; future research with broader populations of rape survivors will be needed to assess whether the findings of this study are transferable beyond this particular setting. Especially, in light of the small effect sizes of the statistically significant findings which is another major limitation of this study.

In terms of the research design, the limitations of the chosen inclusion and exclusion criteria for the selection of intake files are worth discussing. This research focused on single incidences of rape or sexual assault. Eight percent of clients accessing RCCTT's counselling services between 2011 and 2016 reported that they had been survivors of CSA or had experienced more than one incidence of sexual violence. The symptom severity and treatment attendance of adult survivors of CSA as well as clients who had reported being raped or sexually assaulted more than once were not investigated in this study. This study may have been improved by including these files and comparing the symptom severity between single and multiple incidences of sexual trauma. The use of a two-year cut off (where clients needed to enter treatment within two years of the reported sexual offence to be eligible for this study) upon completion of the data collection, may also be a limitation. An improvement of this study would have been to have coded the time lapse between the perpetration of the sexual assault or rape and starting counselling, during the quantitative data collection. The addition of this variable could then have been used to compare the symptom severity between groups who started counselling at different times post-rape. This may have provided further insight into the profiles of survivors who are immediate or delayed help-seekers and their associated symptom severity and attendance. Furthermore, the decision to exclude the physical symptoms in the data analysis may have been another limitation as focus groups suggested that black and coloured survivors

tended to present with more somatic symptoms than white survivors and this may have been an interesting relationship to explore.

Further, the quantitative section of the study is reliant on data from the intake forms. These forms are completed by volunteer counsellors. While these counsellors have been through the RCCTT counselling training course and have received specific training on how to administer these forms, the quality of the data may at times be compromised due to human error and variable reporting skills. As discussed before, when clients mentioned another significant trauma or sexual violence in their history, these files would have been excluded. Since the intake form did not specifically require clients to answer questions about whether this was the first or only incident of sexual or other trauma they had experienced, the research relied on the client to volunteer this information and for the counsellor to record this information in the case file notes. Thus, one cannot exclude the fact that participants may have had other traumatic life experiences, not recorded in the case file, that may have influenced the severity of their symptoms.

Even in qualitative research approached from a realist paradigm, it is important for the researcher to acknowledge that qualitative analysis is exposed to a measure of subjectivity (Willig, 2001). Reflexivity is the process whereby a researcher critically assesses how his or her culture, socioeconomic status, prior knowledge and experiences might cloud the lens through which qualitative data is interpreted (Berger, 2015; Willig, 2001). Furthermore, the positionality of the researcher may elicit or silence discussions (Berger, 2015). Reflexivity assists the researcher in acknowledging the limitations of the research and considering how different meanings and realities from the data were constructed.

Berger (2015) highlights that sharing the experience of research participants has both advantages and disadvantages. As a fellow counsellor, I was aware that RCCTT counsellors felt fatigued by the requests to participate in research, as the organisation frequently undertakes and encourages research. Yet, I did not experience participants as fatigued or disinterested in the process, which may have been due to my position of being an 'insider' within the organisation. Furthermore, my position as a fellow counsellor may have encouraged focus group participants to share their experiences and be more open to the process based on a shared understanding of counselling – an advantage described by Berger (2015). Alternatively, the shared experience may have been a disservice to the research by preventing participants from

sharing certain insights, believing that my counselling experience meant that I was already aware of these patterns (Berger, 2015). It is thus possible that different discussions and narratives would have emerged in the presence of a researcher with no prior investment in the organisation. My 'insider' status may also have impacted how I identified themes since I had some knowledge of the subject matter. To limit the impact of my own experience, I made notes about where my experience of counselling converged and diverged from the focus group participants and consulted these notes frequently to ensure that my reading of the data was not overly informed by my counselling experience. I also elected to use a semantic approach in the identification of themes to limit ascribing meaning to data that may have been influenced by my own, rather than focus group participants' perceptions.

Based on other South African research, I expected some discussion around how sociocultural factors might impact the symptom severity and treatment attendance of rape survivors (Abrahams et al., 2013). However, there was very limited discussion on this topic which surprised me given that race predicted treatment attendance in the ZTNB. My being white, middle class and English-speaking, a position which represents power and privilege, might have silenced these discussions with counsellors of different races who may have felt uncomfortable discussing these factors with me, while white participants may have assumed participants of other race groups are more qualified to comment on how sociocultural factors might interplay with symptom severity and treatment attendance, or felt wary that their comments might be viewed as racist or a collusion with the researcher of the same race. Alternatively, due to spatial Apartheid in Cape Town because of the Group Areas Act, counsellors from Athlone and Khayelitsha might not have been in the position to comment on the influence of sociocultural factors on symptom severity and treatment attendance, because the clientele of their services are not multiracial and therefore not representative of different cultures within the Cape Town area. Conversely, participants might have been motivated by the belief that race does not matter in democratic South Africa – preventing a meaningful debate or discussion on how sociocultural factors, often imbedded in race, might affect survivors' symptom severity and treatment attendance. It is possible that had the focus groups been run by a researcher of a different race or conducted in other languages such as isiXhosa or Afrikaans, they may have produced different discussions about different cultures' responses to rape and how these might impact treatment attendance and symptom severity.

5.4 Recommendations for future research and practice

Despite the limitations, this study can offer recommendations to organisations such as RCCTT who offer post-rape counselling, as well as suggestions for further research. The findings indicate that thorough screening could be helpful in identifying survivors at risk of increased symptom severity. Firstly, it is recommended that survivors have symptoms assessed in their own language. The finding that English-speaking clients showed increased symptom severity may be indicative of the intake form showing bias towards those clients who were fluent in English. Organisations should consider translating any assessments tapping for symptoms into the predominant languages of the population accessing their counselling services.

Secondly, forms used for data collection or to screen for symptom severity should ask clear questions that will identify at-risk survivors. Categorisations that are binary or too crude may not thoroughly assess risk for increased symptom severity and early dropout or may not be as useful for further research. Expanding the categorisations of the identity of the perpetrator to assess for relational proximity (i.e. parent, family member, partner/spouse, former partner/spouse, friend, work colleague or fellow student, stranger) may assist in conducting further research to investigate the perception of counsellors that clients who are raped by known perpetrators, specifically family members, are at higher risk for increased symptom severity.

Similarly, it is recommended that data forms include questions that accurately identify survivors of DAFR/IR by asking whether the survivor was conscious during the rape or incapacitated due to ingestion of a substance, although this should be approached sensitively so as not to make the survivor feel judged. Since DAFR/IR survivors appear to be more prone to self-blame, treatment including psychoeducation around blame from self or others may enhance treatment engagement (Peter-Hagene & Ullman, 2015). Furthermore, gathering data upon treatment intake on the effect of this type of rape on symptomatology and tracking treatment attendance would be beneficial in building on the limited South African research on this common but under-researched type of rape.

It is suggested that multiple incidences of trauma, especially related to sexual violence, and their associated symptomatology is an area which warrants further research in the South African context since international research points to the compounding effect of multiple

traumas on mental health difficulties and some limited local as well as international research highlights the necessity of this further research (Cheasty et al., 2002; Cortina & Kubiak, 2006; Mgoqi-Mbalo et al., 2017; Schumm et al., 2006; Tiihonen Möller et al., 2014). It is important for clinicians and counsellors to enquire about survivors' trauma histories. Having this information may assist in, firstly, identifying clients who may be at increased risk for high symptom severity and, secondly, providing data for much needed further research.

The quantitative findings indicated that male clients attended counselling for longer than female clients. Further research to test replication of these results is required given the very small sub-sample of male clients. Identifying clients who may have been coerced into coming to counselling and addressing this directly with them in terms of empowerment principles - that they are in charge of their process of recovery – as well as discussing the benefits of counselling may assist in motivating these clients to remain in treatment. Evidence from this study indicated that survivors living in poverty may have increased symptoms and may be the worst affected by practical barriers to attending counselling due to financial deprivation, making them a particularly vulnerable population. They also appear to be clients at risk of being unmotivated to continue counselling as they may have hopes to have their financial needs met through the organisation. It is suggested that counselling services identify impoverished clients as well as referral networks who may offer survivors living in poverty practical assistance in meeting their physiological needs. Training counsellors in how to identify this at-risk population, how to problem-solve practical treatment barriers at the first session and to whom they might refer this population for specific needs, may enhance treatment engagement. The role that poverty might play in exacerbating symptom severity in rape survivors warrants further investigation also (Mgoqi-Mbalo et al., 2017).

Finally, social support appears to play a protective role in aiding recovery post-rape and may decrease length of treatment. It is recommended that training for counsellors includes information about the benefit of social support and that during counselling survivors are asked about their support networks and how supported they feel. Counsellors should encourage survivors to seek out support from friends and family and may need coaching in how to do this. Conversely, survivors who indicate that they have poor social support or who have encountered negative social reactions to disclosure may be vulnerable to developing more symptoms post-rape and therefore need more counselling sessions. Furthermore, psychoeducation on the detrimental effects of negative social reaction and coaching in how to respond to friends and

family who react unsupportively to disclosure of rape. This may empower survivors and assist in reducing the deleterious effects of negative social reactions when encountered. Further research examining how different communities respond to disclosures of rape may assist in a better understanding of the sociocultural factors unique to the South African context.

5.5 Conclusion

This study sought to contribute to the local and global literature on predictors of symptoms severity and the very limited research on predictors of treatment attendance amongst rape survivors. This study was unique in that it was one of the few data sets that was able to comment on risk factors that have not been widely explored such as gender and type of sexual offence. It found that symptom severity may be underestimated when symptom checklists are not available in survivors' home language, and translation of intake forms is therefore recommended. This study found that rape predicted increased symptom severity when compared with sexual assault and attempted rape. Unknown perpetrator rape was related to increased symptom severity, however it is recommended that future work focuses on proximity of relationship between survivor and perpetrator. The effects of compounded trauma, poverty and social support (including negative social reaction) on symptom severity, and the role of DAFR/IR in predicting symptom severity and treatment attendance, emerged as important factors that require further investigation. The finding that male clients attended for longer highlighted the need for a better understanding of whether men take longer to respond to treatment post-rape. Black and coloured survivors attended less counselling than survivors of other races indicating that black and coloured clients may benefit from psychoeducation about the benefits of counselling as well as exploration of the structural and attitudinal barriers to counselling attendance. Motivation for attending counselling was also perceived to influence length of attendance. Finally, this study found that the higher clients' symptom severity, the longer they remain in treatment. Overall, given the small effect sizes of the statistically significant data as well as the conflicting results of this study along with the contradictory findings in the literature review suggest that there is not strong evidence to support our understanding of the either post-rape symptom severity or treatment attendance.

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APPENDIX A

RAPE CRISIS CAPE TOWN TRUST INTAKE FORM

Rape Crisis
Cape Town Trust

COUNSELLING CONFIDENTIAL INTAKE FORM

Counsellor:		**Date**		**Case No (Year, Number, Office):**	
Referral Source:				**Referral Contact No:**	

CLIENT INFORMATION					
Name:				Female / Male	**Age**
ID No /DOB:			**Contact No:**		
Race	Black	White	Coloured	Asian	Other
Religion	Christian	Hindu	Jewish	Muslim	Other
Address:					

Employment Status:	Employed	Unemployed	Student/Learner	Retired
Language:	English	Afrikaans	Xhosa	Other
Disability	Yes / No	**If Yes, Specify:**		

PRESENTING PROBLEM									
Brief description of the event (specify sexual offence and describe):									
Date:			**Time:**						
Suburb:			**Place:**						
No. of Attackers:			**Identity:**				Known	Unknown	
Threats Used:	Yes	No	**If yes**	Verbal	Force	Weapon	Abuse of power	Other	
Weapons Used:	Yes	No	**If yes specify:**						
Injuries:	Yes	No	**If yes specify:**						
Survivor: drugs or alcohol taken at time of rape?	Yes	No	**If yes specify:**						
Perpetrator: drug assisted rape?	Yes	No	**If yes specify:**						
First report witness:									
Where did you first report the rape?	Police Station		Medical Facility				Private Doctor		
Name of Centre			**Date Reported**				YYYY/MM/DD		

POLICE CONTACT					
Reported?	Yes	No	**Who reported?**		
If Not reported, reason:					
If Not reported, do you intend to report?	Yes	No	**Reason?**		
Date:			**Case No:**		
Police Station:			**Contact No:**		
Detective:			**Contact No:**		
Can you tell me what happened at the station					
How long did the client wait at the police station?			**Reason?**		
Statement taken?			**Private Room?**		
Did you get a copy of your statement?			**Did anybody at the police station explain what would happen?**		
Who?	Police	Volunteer	Other (Specify)		
Did you have a choice about which parts of the process you wanted to participate in?			Yes	No	
Please explain					
Were you treated with respect?			Yes	No	
Please explain					
Did you feel safe?			Yes	No	
Please explain					
Were the people there helpful?			Yes	No	
Please explain					
Did the police give you a list of where to get help?	Yes	No	**Did the police offer to take you to the health facility?**	Yes	No
Did the police tell you about compulsory HIV testing for the perpetrator?	Yes	No	**Did they give you a brochure on compulsory testing for the perpetrator?**	Yes	No
Did the police inform you about PEP?	Yes	No	**Did the police give you a brochure on PEP?**	Yes	No

MEDICAL CONTACT					
Name of Centre if different to where you first reported the rape:			**Date**	YYYY/MM/DD	
Can you tell me about what happened at the centre					
How long did you wait? (hours/days)			**Reason?**		
Did the people there explain what would happen?	Yes	No	**Did you understand the process?**	Yes	No
Please explain					
Did you have a choice about which parts of the process you wanted to participate in?			Yes	No	
Please explain					
Were you treated with respect			Yes	No	
Please explain					
Did you feel safe?			Yes	No	
Please explain					
Were the people there helpful?			Yes	No	
Please explain					
Doctor's Name			**Nurse's Name**		
J88 Completed?	Yes	No	**Pregnancy Test?**	Yes	No
M/A Pill?	Yes	No	**Tested for HIV/AIDS?**	Yes	No
STI Test?	Yes	No	**STI Medication Given?**	Yes	No
Did you receive Post Exposure Prophylaxis? (PEP)	Yes	No	**If Yes, How Long After the Incident?**		
			If No, Why Not?		
Did you receive information about PEP?	Yes	No	**Did you receive a booklet on PEP?**	Yes	No
Did you receive medication for the side effects of PEP?	Yes	No	**Did you receive information about referrals?**	Yes	No

Did you receive information about the compulsory testing of the perpetrator?				Yes	No
Was a further statement taken after examination?	Yes	No	**If yes, when?**		
Did anyone tell you that you had to lay a charge to receive medical treatment?				Yes	No
Would you like to say anything about this?					

CONTRACTING					
Is contracting appropriate?	Yes	No	**How often?**		
Does the client need referral?	Yes	No	**Where did you refer the client to?**		
Is it ok to post mail to the client	Yes	No	**Did you give the client a client satisfaction card?**	Yes	No

RAPE TRAUMA SYNDROM [RTS] CHECK LIST
Please tick and circle where appropriate

TICK	**PHYSICAL SYMPTOMS –** *Usually immediately after the rape experience*
	Bladder infections
	Bleeding or infections from tears or cuts in the vagina or rectum
	Bruises, grazes or cuts
	Cold
	Comfort or overeating
	Disorientated
	Faint
	Hypersomnia
	Insomnia
	Irregular, heavy or painful periods
	Loss of appetite
	Mentally confused
	Nauseous
	Pain in the back or stomach
	Sexually transmitted infections
	Shock
	Tension headaches
	Throat irritations or soreness due to forced oral sex
	Trembling
	Vaginal discharge

TICK	**BEHAVIOURAL SYMPTOMS** – *Behavioural changes that others may also observe*
	Avoid anything that recalls the rape
	Being alert and watchful
	Being restless, agitated or unable to relax
	Changes in lifestyle such as moving house or changing jobs
	Crying more than usual
	Denial, pretending or believing that nothing bad or serious has happened
	Difficulty concentrating
	Increase in obsessive compulsive behaviours e.g. washing, bathing, checking locks **(Specify)**
	Increased substance abuse
	Isolation from others
	Loss of interest in sex
	Not wanting to be alone
	Relationship problems with family or partners, being more dependant and clingy
	Relationship problems with family or partners, withdrawing more
	Self-mutilation
	Stuttering or stammering more than usual
TICK	**PSYCHOLOGICAL SYMPTOMS –** *Emotional effects that might not be visible to others*
	Confusion
	Constantly thinking of the rape
	Depression
	Emotional numbness, not feeling anything
	Feeling alone and that nobody understands
	Feeling angry
	Feeling constantly dirty
	Feeling listless and unmotivated
	Feeling Suicidal
	Having flashbacks of the rape or reliving experiences of the rape
	Helplessness, no longer feeling in control of life
	Humiliation and shame
	Increased fear and anxiety
	Losing hope in the future
	Loss of memory
	Lowering of self-esteem
	Nightmares
	Self-blame and guilt

APPENDIX B
INTERVIEW SCHEDULE FOR FOCUS GROUP DISCUSSION

Introduction:

Hello, my name is Nicola and I am a master's student at the University of Cape Town. Welcome to the focus group and thank you for making the time to participate in this interview. This focus group is part of the research I am conducting investigating the demographic and rape incident factors that are associated with symptom severity and with counselling attendance. There are no correct or incorrect answers to any of the questions I will ask. The aim of the interview is to encourage conversation around what your experience as counsellors has been and to hear the opinions of everyone in the group.

As counsellors, you will be familiar with the confidential intake form. I have printed an amended version for you to refer to should you need a reminder of the kinds of demographic information and symptoms that are recorded in the intake forms (Appendix A).

Before we start the interview, there are a few things I must mention. As mentioned in the information sheet and consent form, the interview will be recorded so that I can remember the discussion. I must emphasise that our discussion today will be treated confidentially by me and your name will not be attached to any comments you make. However, I cannot promise that other members of the group will not share what we discuss here today. With that in mind, perhaps the group can decide on the ground rules for the group? (Each group nominates the rules that will apply to their group.)

Are there any questions before we start the interview?

Questions:

1) In your experience as counsellors, what are your thoughts about the demographics of rape survivors and how this might affect how severe their symptoms are? Have you noticed that particular kinds of rape survivors seems to have worse symptoms than others?

   Follow up: How does age influence symptom severity?

   Follow up: What are your thoughts around religious background of clients and the number of symptoms they present with?

Follow up: How do the languages clients speak and/or their race affect symptom severity?

Follow up: How does the occupation of the client (i.e. whether they are employed, unemployed, attending school or university or retired) affect the severity of symptoms experienced.

2) What are your thoughts on the demographics of rape survivors and their attendance in counselling? Have you noticed that some kinds of clients ae better at attending than others?

   Follow up: How does age influence attendance?

   Follow up: What are your thoughts around the religious background of clients and the number of counselling sessions they attend?

   Follow up: Do language or race affect counselling attendance?

   Follow up: Does the occupation of the client (i.e. whether they are employed, unemployed, attending school or university or retired) affect the number of counselling sessions attended?

3) Rape survivors usually present with three types of symptoms: physical, behavioural and psychological. What are your thoughts around the rape incident characteristics that may influence a) physical symptoms; b) behavioural symptoms and c) psychological symptoms. Do certain kinds of rape experiences seem to be related to certain kinds of symptoms or to a worse level of symptoms?

4) What is your opinion of the impact of rape incident characteristics on overall symptom severity?

   Follow up: At Rape Crisis, survivors of attempted and completed rape are counselled. What are the differences in symptom severity between these two categories of clients?

   Follow up: What about the use of weapons?

   Follow up: How do the number of perpetrators involved in the rape influence symptom severity?

5) What is your opinion of the impact of rape incident characteristics on how long clients attend counselling? Have you noticed that particular kinds of rape experience in clients lead to longer or shorter attendance of counselling?

   Follow up: At Rape Crisis, survivors of attempted and completed rape are counselled. What are the differences in attendance between these two categories of clients?

   Follow up: What about the use of weapons?

Follow up: How do the number of perpetrators involved in a client's rape influence how long he/she attends counselling for?

6) According to your own observations, are there other factors that influence clients' symptom severity or attendance of counselling, besides the ones we have already discussed?
7) Is there anything else we have not discussed that you feel is important?

Conclusion:

Thank you for your time and for sharing your thoughts on the subject of this research. I will arrange a feedback session, giving a summary of my findings, once the research is complete

APPENDIX C
CONSENT FORM

Information Sheet and Consent Form

University of Cape Town

Consent to participate in a research study:

Predictors of symptom severity and treatment attendance amongst rape and sexual assault survivors at a Cape Town crisis counselling service.

Dear Rape Crisis Counsellor

Research Purpose

You are being invited to participate in a research study being conducted by myself, a research psychology master's student from the University of Cape Town. The purpose of this study is to investigate the demographic and rape incident factors that are associated with symptom severity and with counselling attendance.

Research Procedure

If you agree to participate in this study, you will be asked to take part in a focus group interview with other Rape Crisis Counsellors which will take about 90 minutes. The focus group will take place at the Observatory Counselling office at a mutually suitable time. The interview will ask about your views and observations about the relationships that may exist between:

- demographics and the symptoms that present in rape survivors who seek counselling
- rape incident characteristics and the symptoms that present in rape survivors who seek counselling
- how the demographics of rape survivors may affect their attendance of counselling sessions
- how rape incident characteristics of rape survivors may affect their attendance of counselling sessions

The interview will be audio-recorded in order to help the researcher remember the information. After the researcher has listened to the recordings and written it down, the recordings will be destroyed. Information from the interview will be recorded anonymously.

Should you not be working at the Observatory office at the time of the focus group interview, your transport costs to and from the office will be reimbursed.

Possible Risks

A possible risk is that you may experience some emotional distress or discomfort while talking about some of your experiences as a counsellor. If this occurs you can choose whether you would like to continue with the focus group interview. Options will be made available to you if you would like some help with your worries or emotional distress.

Possible Benefits

Once the research has been completed, a group feedback session for all Rape Crisis counsellors will be arranged to provide information about the demographic and/or rape incident characteristics that may have a significant impact on clients' symptoms and attendance. This knowledge may help you to better understand your clients at Rape Crisis and improve their counselling experience. Another benefit is that the research report (which will be available to you) can be used by Rape Crisis to inform their treatment interventions.

Voluntary Participation

Your participation in this research is completely voluntary. You are free to refuse to answer any question. If you decide to participate, you are free to change your mind and withdraw from the research at any time. If you choose not to participate in this research, you will still be able to attend the group feedback session, and your status at Rape Crisis will not be affected in any way.

Confidentiality

All information you share in the interview will be kept strictly confidential by me, and your name or any identifying aspects of yourself will not appear with the information that appears in my research report. Please note that I cannot guarantee that other group members might not share information outside of the group, even though the importance of confidentiality will be emphasised in the group. Please bear this in mind when choosing what to disclose to the group. Your name and other identifying information, as well as the names and identifying information of clients, will not be kept with the interview data. These will be separated and no one but me will have access to these. Any report or publication of the study will not identify you or your clients in any way.

Questions

For any study-related questions or problems please direct them to:

Nicola Taylor (researcher) – 082 413 6591

Associate Professor Debbie Kaminer (supervisor) – (021) 650 3900

If you have any worries about how the research was conducted, please feel free to contact Mrs Rosalind Adams at the Department of Psychology at the University of Cape Town on (021) 650 3417.

I have read the above and am satisfied with my understanding of the study. My questions about the study have been answered. I hereby voluntarily consent to participate in the research study as described. I agree that the focus group interview may be recorded.

Name of participant

_____

_____ _____

Signature of participant Date

APPENDIX D

QUESTIONNAIRE FOR FOCUS GROUP PARTICIPANTS

How long have you volunteered as a counsellor at Rape Crisis?

What is your age?

Which languages can you offer counselling in?

What is the primary language you offer counselling in?