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**RAPE CRISIS COUNSELLORS' EXPERIENCES OF WORKING WITH
RAPE SURVIVORS IN CAPE TOWN**

Claire Gregorowski

GRGCLA001

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University of Cape Town

Supervisor: Dr Debra Kaminer

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To the Grace of God.

This thesis is dedicated to Rape Crisis counsellors for their passion and dedication in walking with survivors of rape and childhood sexual assault on their journeys of recovery.

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University Of Cape Town

ABSTRACT

This exploratory qualitative study documents the clinical knowledges gained by Rape Crisis counsellors working with rape survivors in Cape Town. It includes a description of the demographic profile of their clients, the rape experiences that their clients report, the psychological difficulties that clients present with, the methods of treatment being offered by the Rape Crisis counsellors, and counsellors' experiences regarding the effectiveness and/or limitations of these interventions. The research is conducted from a phenomenological hermeneutic framework. A semi-structured interview was developed for the research and was administered to eight counsellors and three counselling co-ordinators across the three Rape Crisis centres in Cape Town. Data were analysed using grounded theory analysis techniques. The research found that for the survivors of rape presenting for treatment at Rape Crisis, the experience of childhood sexual assault (CSA) was common, and that many survivors have experienced multiple traumatisation, or experience multiple ongoing stressors in addition to dealing with the impact of rape or CSA. Participants reported that survivors experience similar patterns of post-rape symptomatology as described in international literature. Treatments offered by participants were guided by the principle of empowerment and closely resembled feminist counselling models. The majority of participants' counselling work focussed on the early stages of recovery from trauma described in the literature, namely establishing physical, community, interpersonal and emotional safety. Establishing physical safety required that participants draw on an extensive network of non-government and other organisations. Treatment also focused on helping survivors to talk about their traumatic experiences and facilitating their connection with others. Participants commonly reported experiencing vicarious traumatisation as a result of their work with clients. The most commonly reported barriers to treatment were clients' conditions of poverty and the limited amount of sessions participants are able to offer due to limited resources. Despite these, the participants reported observing positive change in many of their clients following treatment.

Keywords: Rape; childhood sexual assault; rape counsellors; treatment methods.

TABLE OF CONTENTS

DECLARATION

ACKNOWLEDGEMENTS

ABSTRACT

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION	1
1.1 BACKGROUND TO THE STUDY	1
1.2 THE RAPE CRISIS ORGANISATION	3
1.3 AIMS OF THE STUDY	3
1.4 STRUCTURE OF THE DISSERTATION	4
CHAPTER TWO: LITERATURE REVIEW	5
2.1 INTRODUCTION	5
2.2 DEFINING TERMS AND PARAMETERS	5
2.3 PREVALENCE OF RAPE AND CHILDHOOD SEXUAL ASSAULT IN SOUTH AFRICA	6
2.3.1 Police statistics	6
2.3.2 Epidemiological studies	7
National and provincial surveys	7
Studies of children and adolescents	8
2.4 CONTEXT OF RAPE AND CHILDHOOD SEXUAL ASSAULT IN SOUTH AFRICA	9
2.5 THE PSYCHOLOGICAL IMPACT OF RAPE AND CHILDHOOD SEXUAL ASSAULT	11
2.5.1 Rape Trauma Syndrome	11
2.5.2 Post Traumatic Stress Disorder	12
2.5.3 Other psychological responses to rape	14
2.5.4 South African studies	15
2.5.5 The psychological impact of childhood sexual assault	16
2.5.6 Mediators of adjustment to rape	18
2.5.7 Coping, resilience and post-traumatic growth	19
2.5.8 The course of adjustment and recovery	21

2.6 PSYCHOLOGICAL THEORIES OF THE IMPACT OF RAPE AND CHILDHOOD SEXUAL ASSAULT	21
2.6.1 Neurobiological theories	22
Neurobiological theories of Post Traumatic Stress Disorder	22
Neurobiological theories of developmental trauma	23
2.6.2 Cognitive behavioural theories	25
2.6.3 Psychodynamic theories	26
2.6.4 Feminist theories	29
2.7 PSYCHOLOGICAL INTERVENTIONS IN THE TREATMENT OF RAPE AND CHILDHOOD SEXUAL ASSAULT	30
2.7.1 Treatment for adult survivors of rape and childhood sexual assault	30
2.7.2 A three stage model of recovery	30
2.7.3 Treatment models	32
2.7.4 Crisis intervention	32
2.7.5 Psychodynamic psychotherapy	33
2.7.6 Cognitive-behavioural interventions	34
Comparative studies of cognitive behavioural treatments	37
Cognitive behavioural treatments for survivors of childhood sexual assault	38
2.7.7 Feminist therapeutic interventions	39
2.7.8 Pharmacotherapy	41
2.7.9 Group psychotherapy	41
2.7.10 Family or support network interventions	42
2.7.11 The South African Context	43
2.8 SOUTH AFRICAN NATIONAL POLICIES OF RESPONSE TO RAPE	43
CHAPTER THREE: METHODOLOGY	45
3.1 AIMS	45
3.2 EPISTEMOLOGICAL FRAMEWORK	45
3.2.1 Qualitative Research	45
3.2.2 Phenomenological hermeneutics	46
3.2.3 Researcher reflexivity	46
3.3 STUDY DESIGN	47

3.4 SAMPLE	48
3.4.1 Selection of participants	48
3.4.2 Counsellor demographic information	49
3.5 INSTRUMENT	50
3.5.1 Semi-structured interview	50
3.5.2 Interview schedule	51
3.5.3 Pilot interviews	51
3.6 PROCEDURE	52
3.7 DATA ANALYSIS	52
3.8 ETHICAL CONSIDERATIONS	54
CHAPTER FOUR: RESULTS AND DISCUSSION	55
4.1 INTRODUCTION	55
4.2 CLIENT DEMOGRAPHIC INFORMATION	55
4.3 TYPES OF RAPE EXPERIENCES REPORTED	56
4.4 THE PSYCHOLOGICAL IMPACT OF RAPE AND CHILDHOOD SEXUAL ASSAULT	57
4.4.1 Contextual factors impacting on Survivors' post-rape adjustment	57
Multiple traumatisation	57
The experience of ongoing stressors	57
4.4.2 The emotional impact of rape and childhood sexual assault	58
Emotional presentation	58
Feelings towards the self	59
4.4.3 Interpersonal impact of rape and childhood sexual assault	62
Social isolation	62
Negative impact on caregiver role	63
4.4.4 Cognitive impact	64
Disruption in beliefs about self and the world	64
4.4.5 Impaired ability to function	66
4.4.6 Physiological and somatic symptoms	67
4.4.7 Symptoms of Post Traumatic Stress Disorder	68
4.4.8 Other psychopathology and related symptoms	71
4.4.9 Behavioural changes	72
Substance misuse	72

Increased sexual activity	73
4.4.10 Psychological attempts at coping	73
4.4.11 Coping and resilience	74
Conscious attempts at coping	74
Survivor resilience	74
4.4.12 The extent and longevity of psychological impact	75
4.4.13 Post-rape complicating factors	76
4.5 TREATMENT	78
4.5.1 Principles of treatment	78
Empowerment	78
4.5.2 Childhood sexual assault, ongoing stressors and multiple traumatisation	79
4.5.3 The counselling process	80
4.5.4 Aims and methods of counselling	82
Ensuring safety	82
<u>Physical and community safety</u>	82
<u>Crisis containment and symptom management</u>	83
<u>Safety in the counselling space</u>	84
Increasing autonomy	87
<u>Self-awareness</u>	87
<u>Decision making skills</u>	88
<u>Fostering sustainable healing</u>	88
<u>Returning to previous levels of functioning</u>	90
Remembering the trauma	91
Facilitating access to and expression of feelings	92
Improving self-concept and reconnecting to inner strength	93
Reconnection with others	94
Providing hope and facilitating post-traumatic growth	95
4.5.5 The impact on the counsellor and counter-transference feelings	96
4.5.6 Factors impacting on treatment	99
Issues of difference	99
Barriers to treatment	99
4.5.7 Treatment outcomes	101

The link between counselling and healing	101
Observed outcomes	101
4.6 CONCLUSION	103
CHAPTER FIVE: CONCLUSION	104
5.1 SUMMARY OF RESEARCH FINDINGS	104
5.2 LIMITATIONS OF THE RESEARCH	112
5.2.1 The research setting and sample	112
5.2.2 The influence of the researcher	113
5.2.3 The scope of the research	114
5.3 RECOMMENDATIONS	115
5.4 CONCLUSION	115
REFERENCES	117
Tables and appendices	
Table 1: Contextual factors	129
Table 2: Psychological impact	129
Table 3: Treatment	132
Appendix A: Research Questionnaire	135
Appendix B: Consent form	140

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND TO THE STUDY

Exposure to violent crime and trauma is a daily reality for a vast number of South Africans (Altbekker, 2007; Norman et al., 2007; Peltzer, 2000; Williams et al., 2007). Studies have shown that during their lifetime, more than one third of the South African population experience violence of some kind (Kaminer, Grimsrud, Myer, Stein & Williams, 2008) and that nearly three quarters of South Africans experience one or more traumatic events, with the majority experiencing multiple traumas across their lifespan (Williams et al., 2007).

South Africa has also been identified as having the highest incidence of rape for economically comparable countries worldwide (Cox, Andrade, Lungelow, Schloetelburg & Rode, 2007; Jewkes, 2005; Jewkes & Abrahams, 2002; Martin & Artz, 2006; Meel, 2008; Steyn & Steyn, 2008; Walker & Louw, 2003; Williams et al., 2007). Some research studies have cited the prevalence of rape in South Africa as being approximately 3 times higher than in the United States, and higher rates of rape homicide have been found in South Africa (16.3%) compared with the United States (10 times higher) and Jamaica (3 times higher), indicating that levels of sexual violence are not only more common but also more severe in South Africa than elsewhere (Abrahams et al., 2008; Jewkes et al., 2006). According to the 1998 South African Demographic and Health Survey (SADHS), 1.6% of their sample reported having experienced some form of childhood sexual assault (CSA), and the incidence of childhood sexual assault in South Africa is rising (Department of Health, 1999; Jewkes & Abrahams, 2002). Within South Africa, the Western Cape has been identified as having amongst the highest incidence of rape (Jewkes & Abrahams, 2002).

In addition to the prevalence of rape and CSA, South African women and children face other forms of trauma and violence, as well as many ongoing stressors. For example, the 1998 SADHS reported that one fifth of married women experience "economic abuse" (Department of Health, 1999, p. 90) leading to greater levels of poverty, and that during a twelve month period prior to the study, one tenth of women reported that they had been physically assaulted at least once, with a large proportion requiring medical care following the assault (Department of Health, 1999). The high levels of poverty in the country as well as the

HIV/AIDS pandemic are likely to be experienced by women as ongoing daily stressors in addition to the impact of sexual and interpersonal violence.

The psychological effects of rape and CSA on survivors have been well documented. International literature has identified the strong association between sexual assault and Post Traumatic Stress Disorder (PTSD) (Campbell & Wasco, 2005; Resick & Schnicke, 1993), and in South Africa, rape has been identified as “the most pathogenic trauma” for PTSD among women (Kaminer et al., 2008, p. 1594). In addition to the psychological impact, rape results in co-morbid physical and social difficulties, including physical injuries, chronic health problems, HIV/AIDS, unwanted pregnancy and social isolation (Campbell & Wasco, 2005; Christofides et al., 2005a). Various treatment modalities aimed at alleviating the psychological impact of rape and CSA have been described in the international literature. However, there is a paucity of information on which treatments are being employed by South African practitioners in a context where resources are far scarcer than in economically developed countries. The South African context therefore necessitates the development and/or use of brief term interventions which are culturally appropriate and suitable for those experiencing multiple, possibly ongoing, traumatisation in a context of other socioeconomic stressors.

It is imperative that local research is undertaken which ultimately aims to reduce the incidence of rape and childhood sexual assault (CSA) and to alleviate their often devastating impacts. Historically, the majority of international research on rape has been quantitative in nature (Campbell & Wasco, 2005). However, as the high prevalence and extensive impact of rape has become increasingly recognised (Suffla, 2004), there has been a call for more in-depth qualitative research to investigate both why rape occurs and how it affects survivors (Campbell & Wasco, 2005). Researchers have also criticised the way in which traditional studies of sexual violence have not acknowledged the contextual factors and “structural dimensions” (Suffla, 2004, p. 43) impacting on both the occurrence of sexual violence and survivors' post-rape adjustment (Boonzaier & de la Rey, 2004; Herman, 1992a; Stefan, 1994; Suffla, 2004; van der Kolk, 2005; Yuan et al., 2006). It is therefore important that current research begins to investigate, describe and engage with the particular contexts in which South African survivors attempt to adjust and recover from sexual assault, in order to inform prevention strategies and aid in the development of appropriate treatment interventions.

1.2 THE RAPE CRISIS ORGANISATION

Rape Crisis is one of several non-governmental organisations providing services to rape survivors and their families in South Africa. Because of the country's overwhelmed mental health care system (Kaminer et al., 2008), non-government organisations such as Rape Crisis provide a significant amount of support to survivors of rape in South Africa. Rape Crisis as an organisation originated in America in the 1970's in the context of the feminist movement (Herman, 1992a). It was this feminist movement which redefined rape as "a crime of violence rather than a sexual act", and which first identified rape as a form of political dominance over women (Herman, 1992a, p. 30).

The Rape Crisis Cape Town Trust (RCCTT) was established in 1976 and offers legal, practical and emotional assistance and support to rape survivors, of 14 years and older, and those close to them (Rape Crisis Cape Town Trust, 2008). It also advocates for increased rights and improved care for rape survivors and for the empowerment of women (Herman, 1992a; Rape Crisis Cape Town Trust, 2008). Some staff members are employed by the organisation, but most are volunteers, many of whom are members of the communities they serve. Each of the three Rape Crisis sites has a Project Co-ordinator who participates in organisational planning and provides supervision and support to counsellors (Rape Crisis Cape Town Trust, 2008). Rape Crisis provides individual counselling for survivors of rape, survivor support groups, individual support for partners, assistance and support for court attendance, and counselling for friends or family members of survivors. The organisation has also developed links with other NGO's, as well as government agencies, including the Criminal Justice System (Rape Crisis Cape Town Trust, 2008). Counselling is located within the feminist framework in which women are empowered to engage their strengths and become active participants in their own process of recovery. In accordance with principles of feminist therapy, Rape Crisis also engages in initiatives for social change, such as an advocacy programme, community interventions and lobbying for law and policy reform (Rape Crisis Cape Town Trust, 2008).

1.3 THE AIMS OF THE STUDY

This research aims to investigate and describe Rape Crisis counsellors' experiences of treating rape survivors in Cape Town, and to document the clinical knowledge gained through their work. The study more broadly aims to contribute towards the sharing of knowledge and skills between South African practitioners working with survivors of rape and CSA and in the wider field of trauma. The research attempts to describe not only the impact

of rape and CSA on survivors, but also the contextual factors, including social attitudes, ongoing or chronic stressors and other forms of trauma, which may impact on survivors' post-rape adjustment and recovery. Given that the vast majority of literature describing treatment for the impact of sexual assault comes from economically developed countries, this research also aims to add to the current knowledge by describing the treatments offered by counsellors within the unique South African context. The knowledge gained in this research is not aimed at developing prevention initiatives, nor does it attempt to explain the specific relationships between multiple traumatisation, ongoing stressors and post-rape adjustment. It is limited to describing rape counsellors' observations of survivors' adjustment and/ or recovery following rape and CSA, the context in which this takes place, the treatments offered by counsellors within this context and their experiences of the efficacy and/or limitations of aspects of the treatment offered.

1.4 THE STRUCTURE OF THE DISSERTATION

The following chapter offers a review of the current international and South African literature on the prevalence, impact and treatment of rape and CSA, as well as an overview of the historical and current context of sexual violence in South Africa. Chapter Three presents the methodology employed in the research study. Chapter Four describes and discusses the research findings. Chapter Five provides a summary of the main research findings and their relation to the current literature before considering the limitations of the research, and concludes with recommendations for future research and practice.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter provides an outline of current local and international literature on rape and childhood sexual assault (CSA). It firstly defines the terms referred to in the chapter as well as the parameters of the research reviewed. This is followed by information on the prevalence of rape and CSA in South Africa, an outline of the South African historical, social and economic context of sexual violence, and a discussion of both international and local literature on the psychological impact of rape and CSA. The chapter then describes several psychological theories explaining the impact of rape and CSA on survivors, and their associated treatment interventions, before concluding with a brief description of South African national policies in response to rape.

2.2 DEFINING TERMS AND PARAMETERS

The study of rape is complicated by definitional variety between countries as well as discrepancies between common and legal understandings within countries. An example is the continuum of sexual coercion ranging from verbal persuasion to rape homicide in South Africa (Jewkes, 2005). Terms such as rape, sexual assault, sexual abuse and sexual violence appear throughout the literature and are not always clearly defined. While this may create methodological difficulties in some studies, lack of definitional clarity is not necessarily problematic for understanding the psychological impact of sexual assault reported by survivors. For example, Rape Trauma Syndrome (RTS) has been identified as a response to rape and attempted rape alike (Burgess & Holmstrom, 1974).

Rape has traditionally been narrowly defined in South Africa as being limited to penetration by male perpetrators of female victims (van der Bijl, 2006). However, the new Sexual Offences Bill passed in March 2007 includes a wider definition of rape, which no longer defines the sex of the victim or perpetrator and defines sexual penetration as “any act that causes penetration (to any extent) of the genital organs of one person into the genital organs, anus or mouth of another person, or any other body part, or object into the genital organs or anus of another person” (Combrinck, 2006, p. 2). The World Report on Violence and Health defines sexual violence as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality

using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work” (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002, p. 149). In South Africa, the Rape Crisis organisation similarly defines ‘rape’ as “any act of a sexual nature which has been forced onto another person” (Rape Crisis Cape Town Trust, 2008). This definition will be adopted for the current research. The literature review therefore includes research regarding sexual violence (as defined by the World Report on Violence and Health, 2002), rape and attempted rape. Review of the literature also extends to consideration of childhood sexual assault (CSA) because of the significant relationship between sexual victimisation in adulthood and a history of CSA (Cloitre, Scarvalone & Difede, 1997; Herman, 1992*a*), as well as the high number of survivors presenting to Rape Crisis who have experienced CSA. However the focus is not on the impact and treatment of CSA for children, but rather the psychological effects of a history of CSA on adolescents and adults. CSA in this study includes but is not limited to incest.

2.3 PREVALENCE OF RAPE AND CHILDHOOD SEXUAL ASSAULT IN SOUTH AFRICA

Statistics on the prevalence of rape in South Africa originate from a number of different sources, including police statistics, national and provincial surveys and research studies. Extant statistics on the prevalence of rape are notoriously unreliable, with rape statistics thought to be under-reported across all studies. What follows is an outline of the prevalence of rape reported in South African studies, including consideration of the various sources of statistics and their respective reliability.

2.3.1 Police statistics

Police statistics are often cited in the literature because they allow for comparison with other countries or contexts (Jewkes & Abrahams, 2002). Vetten et al., (2008) cite rape statistics from the South African Police Services (SAPS) indicating that between April and March 2006/2007, 52,617 people were raped in South Africa. It has been reported that in approximately 40% of rape cases reported to the police the survivor is younger than 18 years (Cox et al., 2007; Hirschowitz, Worku & Orkin al., 2000; Jewkes & Abrahams, 2002; Meel, 2008). In 1996, South Africa was found to have a higher incidence of rape reported to the police compared with economically comparative or neighbouring countries (Hirschowitz et al., 2000).

However, the under-reporting of rape to police services is well documented, with some studies reporting rates of less than 50% (Cox et al., 2007; Hirschowitz et al., 2000; Jewkes & Abrahams, 2002). The 1998 South Africa Demographic and Health Survey (SADHS) reported that only 15% of women who had been forced to engage in sex reported this to the police (Department of Health, 1999). "Barriers to reporting" (Jewkes & Abrahams, 2002, p. 1232) include fear of perpetrator retribution, economic reliance on the perpetrator, fear of secondary victimisation, such as not being believed or being blamed, as well as limited access to and lack of belief in the justice system (Cox et al., 2007; Hirschowitz et al., 2000; Jewkes & Abrahams, 2002; Krug et al., 2002). Of those rapes that are reported to the police, relatively few go to trial and even fewer result in a conviction, partly due to insufficient resources, inadequate procedures, corruption and the reported tendency of some police, medical and legal professionals to blame and disbelieve rape survivors (Jewkes & Abrahams, 2002; Meel, 2008; Vetten et al., 2008). Slightly more reliable than those reported to the police are statistics collected in national and provincial surveys.

2.3.2 Epidemiological studies

National and provincial surveys

Statistics cited in national and provincial surveys are much higher than figures reported to the police. The 1998 South Africa Demographic and Health Survey (SADHS) included a sample of 11,735 adult women (ages 15-49 years). According to this study, 4% of adult women and 7% of sexually active adult women reported having been forced or coerced to engage in sex during their lifetime (Department of Health, 1999). In the same survey, 1.6% of women reported having experienced non-consensual sex prior to age 15 years (Department of Health, 1999, as cited in Jewkes & Abrahams, 2002). A 1998 study of 1,306 women across three provinces reported lifetime prevalence rates of rape of 4.5% in the Eastern Cape, 7.2 % in Mpumalanga and 4.8% in the Northern Province, which translates to 2,070 per 100,000 (Jewkes, 2005; Jewkes & Abrahams, 2002). The 1998 National Victims of Crime Survey indicated that, of 4,000 people over the age of 16 years, 1.7% reported having been raped within the previous 5 years (as cited in Hirschowitz et al., 2000 and Jewkes, 2002). These surveys had the advantages of using randomised sampling procedures and employing face-to-face interviews but were limited to adults. Only the SADHS employed a relatively large sample size (Hirschowitz et al., 2000).

Almost a decade later, the 2007 South African Stress and Health (SASH) Study surveyed 4,351 South African adults (over the age of 18 years). This survey found that 1.5% of the

sample reported having been raped and 3.5 % reported having been sexually assaulted in their lifetime (Williams et al., 2007). Jewkes et al. (2006) also studied a sample of 1,370 rural South African males. They reported that within this sample, “16.3% had raped a non-partner, or participated in a form of gang rape; 8.4% had been sexually violent towards an intimate partner; and 79.1% had done neither” (p. 2949).

Discrepancies between prevalence rates reported in surveys may be due to methodological differences in data collection, for example the wording of questions, the definition of rape employed, or differences in levels of training for those carrying out the surveys (Altbekker, 2007; Hirschowitz et al., 2000; Jewkes, 2005; Jewkes & Abrahams, 2002; Koss, 1993). Rape survivors may also under-report due to differing conceptions of what constitutes sexual violence, fear of retribution, feelings of shame or guilt, loyalty to a partner or because they are afraid of being doubted (Altbekker, 2007; Department of Health, 1999; Hirschowitz et al., 2000; Jewkes & Abrahams, 2002). The nature of surveys may also prevent researchers from being able to build rapport and develop trust with participants in order to overcome some of these barriers (Department of Health, 1999; Jewkes & Abrahams, 2002). Under-reporting of rape is also a result of the social stigma attached to being a rape survivor (Jewkes & Abrahams, 2002; Koss, 1993; Wood, Lambert & Jewkes, 2007).

While smaller research studies allow greater opportunity for developing rapport with participants thereby improving the likelihood of disclosure, small sample sizes decrease the reliability of statistical data (Hirschowitz et al., 2000; Koss, 1993).

Studies of children and adolescents

Cox et al. (2007), in a study on the incidence of child rape seen at Red Cross Hospital in Cape Town report that since 2006 the rape of children has increased fourfold, and of child rapes reported to the police only 9% secure conviction of the perpetrator. Research studies looking specifically at the incidence of rape among adolescents provide similarly high statistics. Peltzer and Pengpid (2007) found that 17% of females in their sample of 800 16 and 17 year old South Africans reported having been raped and 13% reported having been sexually abused. Wood and Jewkes (1997) similarly found that almost 100% of their sample of teenage adolescents reported having experienced regular sexual violence in their relationships. These findings demonstrate the widespread sanction of sexual violence amongst the South African population.

Despite the unreliability of rape statistics, it is widely agreed that the enormously high incidence of rape and childhood sexual assault in South Africa warrants ongoing research into prevalence, risk factors and appropriate interventions for survivors.

2.4 CONTEXT OF RAPE AND CHILDHOOD SEXUAL ASSAULT IN SOUTH AFRICA

It is recognised that South Africa has unacceptably high levels of violence, including sexual violence, against women and children (Altbeker, 2007). Factors contributing to the endemic occurrence of rape in South Africa are multiple. They include poverty, unequal power relations between men and women and the generally high levels of violence in the country, much of which is born out of our particular political history (Altbeker, 2007; Meel, 2008; Suffla, 2004). Following international trends, rape in South Africa was initially understood as being perpetrated by monstrous strangers onto female bodies. Only with the resurrection of the feminist movement in the late 1970s did this public perception shift to acknowledge the extent to which rape is perpetrated by known and trusted male figures, including family members, as well as the extensive psychological impact of rape on the survivor (Posel, 2005a).

It is recognised that due to South Africa's particular history, the country's endemic levels of rape and childhood sexual assault cannot be adequately explained by international theoretical models (Moffet, 2006). Researchers acknowledge the ways in which a history of racial oppression and violence, from colonialism through apartheid, fed the continued oppression of women following democracy (Altbeker, 2007; Armstrong, 1994; Moffet, 2006; Moore, 2005; Wood, 2005). Emasculation and disempowerment of Black African men, the migrant labour system, the use of rape as a means of political force, a patriarchal legal system and a "culture of aggression and domination" (Armstrong, 1994, p. 35) during apartheid are among the proposed reasons for continued gender oppression throughout the population (Altbeker, 2007; Moore, 2005; Wood, 2005; Wood et al., 2007). However, Moffet (2006) also argues that narratives of racism should not be allowed to obscure the patriarchal underpinnings of the significant increase in sexual violence post 1994, the function of which is to restrict and oppress the autonomy of women across all social classes and races (Moffet, 2006). Some academics have also theorised that South Africa's particular political and social historical legacy of oppression and violence followed by transformation, has influenced the ways in which sexuality, including rape and childhood sexual assault, has been treated in the new democracy. They highlight the lack of political resistance to sexual violence, positing that

engagement with such an issue would threaten to tarnish the image and “moral character” of the new democratic South Africa (Posel, 2005*b*, p. 145), explaining the proliferation of sexual violence despite women and children’s right to safety being enshrined in South Africa’s current progressive constitution (Posel, 2005*a*; 2005*b*).

The particular ways in which masculinity and femininity are constructed in South Africa has been identified in the literature as promoting sexual violence. Examples include beliefs that men occupy and should enforce a dominant role in relation to women, including but not restricted to the realm of gender roles and sexuality, and that women’s bodies are sexual objects or commodities that legitimately serve as a form of economic currency (Altbeker, 2007; Armstrong, 1994; Boonzaier & De La Rey, 2004; Jewkes, 2005; Jewkes & Abrahams, 2002; Kalichmun et al., 2005; Meel, 2008; Norman et al., 2007; Posel, 2005*a*; Suffla, 2004; Wood, 2005; Wood & Jewkes, 1997). For example, Wood & Jewkes (1997) highlighted the almost universal acquiescence amongst teenage participants to male hegemony and violence in sexual relationships, and Wood et al., (2007) highlight the acceptance of multiple sexual partners for males and the regularity of a continuum of coercive sexual practices among youth in an Eastern Cape township. Jewkes et al. (2006) and Wood (2005) describe the ways in which men’s ability to coerce (often, but not only, through verbal means) and obtain multiple sexual partners is a recognised sign of masculinity. The prevalence of gang rape can also be considered an extreme form of expressing masculinity (Jewkes & Abrahams, 2002; Jewkes et al., 2006). Jewkes et al. (2006) identified participation in gang rape as the most common form of rape perpetrated by a group of rural South African men. However the notion of masculinity is also fluid and contextual within and between cultural groups in South Africa and therefore offers only one of various explanations for the high levels of rape and childhood sexual abuse (Wood, 2005).

In addition to the development of socio-cultural attitudes towards rape and gender relations in South Africa, our particular history has resulted in high levels of (exposure to) violent crime and poverty compared with other nations (Altbeker, 2007). These factors have an additional impact on the prevalence of rape across the country as well as the impact of rape on survivors (Altbeker, 2007; Meel, 2008; Suffla, 2004). South Africa differs from economically developed countries with regard to the lifetime prevalence of exposure to trauma and violence. Williams et al. (2007) report that approximately 75% of their nationally representative sample of 4,351 South African adults had experienced some potentially traumatic event, with 55.6% having experienced multiple traumatic events. Experience of

multiple traumas had the strongest positive correlation with levels of psychological distress (Williams et al., 2007). This indicates that South African rape survivors are more likely to experience increased levels of distress due to the potential cumulative impact of previous traumatic experiences than elsewhere. South Africa's high levels of poverty also need to be taken into account. The World Report on Violence and Health cites social factors such as poverty and unemployment (among others) as contributing towards the risk of men committing rape (Krug et al., 2002). Poverty may engender feelings of disempowerment among men in a predominantly patriarchal society (Boonzaier & de la Rey, 2004; Jewkes, 2005; Moore, 2005; Wood, 2005), has been linked with increased alcoholism and prostitution in making women more vulnerable to sexual assault (Armstrong, 1994; Jewkes & Abrahams, 2002) and has been associated with higher levels of sexual and physical violence experienced by adolescents (Peltzer & Pengpid, 2007). Because for the majority of South Africans poverty and exposure to potentially traumatic events are daily realities, international research on rape has limitations in terms of applicability to our context, indicating a need for local research which takes into account the unique complexities of our context (Maw, Womersley & O'Sullivan, 2008).

2.5 THE PSYCHOLOGICAL IMPACT OF RAPE AND CHILDHOOD SEXUAL ASSAULT

It is widely recognised that responses to rape are diverse and unique to each survivor's experience (Yuan, Koss & Stone, 2006), however there is a large body of literature documenting the reported psychological impact of rape and childhood sexual assault on survivors. The vast majority of research is international and there is little published literature on the psychological impact of rape in South Africa. Not much is therefore known about whether the reported sequelae described elsewhere are applicable to our context.

2.5.1 Rape Trauma Syndrome

Burgess and Holmstrom (1974) conducted one of the first comprehensive studies of the impact of rape and attempted rape using a sample of 92 adult female rape survivors. From this research they documented common responses to rape, which they conceptualised as a set of "sensory, perceptual, cognitive, behavioural, and interpersonal symptoms" (Hartman & Burgess, 1993, p. 510) primarily based on anxiety and labelled Rape Trauma Syndrome (RTS) (Burgess & Holmstrom, 1974; 1979). These authors described an "acute phase" of disorganised reaction in the hours, days and weeks following the rape (Burgess & Holmstrom, 1974, p. 982). This includes several somatic responses, such as physical bruising

and pain, muscle tension, disrupted sleep, exaggerated startle response, stomach complaints, disrupted appetite and “gynaecological symptoms”, as well as emotional responses, comprised primarily of fear as well as “humiliation... embarrassment... anger, revenge and self-blame” (Burgess & Holmstrom, 1974, p. 982-983). The acute disorganisation phase is followed by a “long-term process [of] reorganisation” (Burgess & Holmstrom, 1974, p. 983) of the survivor’s lifestyle. This is manifested by increased motor activity such as moving house or seeking increased support from family members and friends, as well as nightmares and the development of “defensive... phobic reactions” such as a fear of being alone (Burgess & Holmstrom, 1974, p. 984). Although RTS is not a recognised psychiatric disorder, it is widely considered to be a particular form of post-traumatic stress and is used in making clinical decisions (Hansson, 1993; Herman, 1992a; van der Bijl, 2006).

2.5.2 Post Traumatic Stress Disorder

Post Traumatic Stress Disorder (PTSD) was first included in the Diagnostic and Statistical Manual for Mental Disorders-III (DSM-III) in 1980, based on increasing recognition of the psychological and physical impacts of trauma following the Vietnam War and the rise of the feminist movement (van der Kolk, 1996a). PTSD is considered a syndrome comprising three sets of symptoms following exposure to an extreme trauma. Re-experiencing symptoms include distressing recollections of the event, nightmares, flashbacks and psychological and physiological distress in response to internal or external reminders of the trauma; avoidance symptoms include behavioural avoidance of traumatic reminders, loss of memory for aspects of the trauma, anhedonia, feelings of detachment from others, restricted affect and a reduced sense of a future; and hyperarousal symptoms include disruptions in sleeping patterns, anger and irritability, concentration difficulties, hypervigilance and an exaggerated startle response (DSM-IV-TR; APA, 2000). Since many people experience some transient symptoms in the aftermath of a trauma, the diagnosis of PTSD requires that the symptoms endure for at least one month and cause significant impairment in functioning.

Since the inclusion of PTSD in the DSM-III, many authors have identified this as a common sequelae of rape and childhood sexual assault (Campbell & Wasco, 1993; Faravelli, Giugni, Salvatori & Ricca, 2004; Foa & Rothbaum, 1998; Hansson, 1993; Hartman & Burgess, 1993; Harvey & Herman, 1992; Resick, 1993; Steketee & Foa, 1987; White & Rollins, 1981; Wilson, 2010; Yuan et al., 2006), and it has succeeded RTS as the recognised syndrome following sexual trauma (Foa & Rothbaum, 1998; Maw et al., 2008). Yuan et al. (2006) in their review of the literature state that between 30% and 65% of rape survivors are reported to

develop PTSD. Rothbaum, Foa, Riggs, Murdock and Walsh (1992), in their prospective study of 95 female rape survivors found that 94% of the survivors met the criteria for the symptoms of PTSD approximately 12 days following the assault, and approximately 50% met the criteria at three to four months post-rape. Cloitre et al. (1997) reported similarly high levels of PTSD in their study: 70% of a group of women who had been sexually assaulted in adulthood and 75% of a group who were survivors of childhood and adulthood sexual assault met the criteria for PTSD. Thompson et al. (2003), in their investigation of psychopathology amongst a group of 97 women, found a six to seven times greater prevalence of PTSD in women with a history of rape and/or childhood sexual assault compared with a control group who had experienced no sexual trauma, and Koss and Figueredo (2004) reported significant rates of PTSD in rape survivors immediately following a rape, although this reduced to raised but non-significant levels after two years.

International studies report a variety of responses to rape, some of which overlap with the symptoms of RTS and PTSD (Rothbaum et al., 1992). Many authors document the experience of fear and anxiety in rape survivors (Ellis, 1983; Faravelli et al., 2004; Kilpatrick, Resick & Veronen, 1981; King & Webb, 1981; Meyer & Taylor, 1986; Morrison, 2007; Resick, 1993; Rothbaum et al., 1992; Smith & Kelly, 2001; Steketee & Foa, 1987; Yuan et al., 2006), particularly fear of situations related to the rape which is reportedly one of the most enduring symptoms over time (Foa & Rothbaum, 1998; Rothbaum et al., 1992). Memory disturbances have been noted, such as amnesia for parts of the trauma or the development of impairment in verbal memory when there is a history of multiple traumas (Harvey, 1996; Nixon, Nishith & Resick, 2004; Steketee & Foa, 1987). Numbing through “avoidance of thoughts and reminders of the trauma” (Rothbaum et al., 1992, p. 456) and dissociation (Harvey, 1996; Morrison, 2007; Resick, 1993) are also cited in the literature. Harvey (1996) describes how for some survivors of trauma, memory and feeling become dissociated, leading to psychological harm, and Foa and Rothbaum (1998) report that peri-traumatic dissociation is prognostic for the development of chronic PTSD. Ellis (1993) reports the experience of anhedonia by some survivors. Documented physiological symptoms include sleep disturbances such as nightmares and initial and terminal insomnia (Choquet, Darves-Bornoz, Ledoux, Manfredi & Hassler, 1997; Ellis, 1993; Foa & Rothbaum, 1998; Kilpatrick, Veronen & Best, 1985; King & Webb, 1981; Rothbaum et al., 1992; Smith & Kelly, 2001) and behavioural consequences have been noted such as social withdrawal (King & Webb, 1981; Smith & Kelly, 2001, Yuan et al., 2006). Intrusive sequelae such as flashbacks (King & Webb, 1981; Smith & Kelly, 2001), intrusive rape related thoughts (Foa

& Rothbaum, 1998; Rothbaum et al., 1992), concentration difficulties (Foa & Rothbaum, 1998; Kilpatrick et al., 1985; Rothbaum et al., 1992) and hypervigilance regarding safety (Ellis, 1983) also appear in the literature.

2.5.3 Other psychological responses to rape

Psychological responses to rape other than PTSD, RTS and their associated symptoms have also been described in the literature. These include worry (Kilpatrick et al., 1985), shame (Ellis, 1993; King & Webb, 1981), fatigue, confusion (Resick, 1993), anger (Ellis, 1993; Foa & Rothbaum, 1998; King & Webb, 1981, Resick, 1993), helplessness (Kilpatrick et al., 1985), self-blame (Janoff-Bulman, 1979; Meyer & Taylor, 1986), guilt (Ellis, 1983, King & Webb, 1981; Smith & Kelly, 2001), decreased self-esteem (Ellis, 1983; Maw et al., 2008; Resick, 1993), tearfulness and hopelessness (Choquet et al., 1997), depression (Choquet et al., 1997; Ellis, 1983; Faravelli et al., 2004; Foa & Rothbaum, 1998; Herman, 1992a; 1992b; King & Webb, 1981; Meyer & Taylor, 1986; Resick, 1993; Smith & Kelly, 2001; Steketee & Foa, 1987; Yuan et al., 2006), suicidal thoughts or attempts (Acierno, Resnick, Kilpatrick, Saunders & Best, 1999; Burgess & Holmstrom, 1979; Choquet et al., 1997; Foa & Rothbaum, 1998; King et al., 2004; Resick, 1993; Yuan et al., 2006), loss of trust (Resick, 1993; Smith & Kelly, 2001), difficulties with social adjustment, including disruption in intimate and close relationships (Ellis, 1983; Morrison, 2007; Resick, 1993) and reduced social interaction (Foa & Rothbaum, 1998), disrupted sexual functioning (Burgess & Holmstrom, 1979; Ellis, 1983; Faravelli et al., 2004; Foa & Rothbaum, 1998; King & Webb, 1981; Meyer & Taylor, 1986; Resick, 1993; Smith & Kelly, 2001; Yuan et al., 2006) changes in beliefs about the world (Frazier, Conlon & Glaser, 2001; Morrison, 2001), disruption of spiritual experience (Frazier et al., 2001; Morrison, 2007) and grief regarding emotional, interpersonal and financial loss (King, & Webb, 1981; Morrison, 2007).

Reported physical symptoms include exhaustion (Ellis, 1993), restlessness (Ellis, 1993), headaches (Ellis, 1993; Kimerling & Calhoun, 1994), nausea (Ellis, 1993; Kimerling & Calhoun, 1994), pain (Kilpatrick et al., 1985) and loss of appetite (Ellis, 1993, King & Webb, 1981). Behavioural changes have also been documented following rape and include the development of compulsive symptoms such as continual showering or bathing and checking doors and windows (Ellis, 1993; Foa & Rothbaum, 1998; King & Webb, 1981), increased use of cigarettes (Choquet et al., 1997), alcohol (Burgess & Holmstrom, 1979; Choquet et al., 1997; King et al., 2004; Resick, 1993; Yuan et al., 2006) and drugs (Burgess & Holmstrom, 1979; Resick, 1993; Thompson et al., 2003), disruptions in eating patterns and the

development of eating disorders (Ackarda & Neumark-Sztainerb, 2002; Faravelli et al., 2004, King & Webb, 1981; Yuan et al., 2006), and making life changes such as moving house or changing jobs (King & Webb, 1981). Choquet et al. (1997) reported increased running away, truancy, violence and stealing amongst male and female teenage rape survivors in France.

The link between rape or childhood sexual assault and psychopathology other than PTSD has also been well documented (Wilson, 2010; Yuan et al., 2006). Thompson et al. (2003) report higher rates of Major Depressive Disorder and Bipolar Mood Disorder for women who experienced rape in adulthood, or childhood sexual assault or both, as well as increased rates of anxiety disorders, particularly Panic Disorder, Social Phobia and Obsessive Compulsive Disorder, for the latter two groups. They further report double the rate of lifetime substance dependence for women with a history of both childhood sexual assault and rape compared with other groups (Thompson et al., 2003). Similarly, Burnham et al. (1988) found incidences of first episode psychiatric disturbance amongst sexual assault survivors to be twice as high compared with a control group, including “major depression, mania, drug abuse and dependence, phobia, panic disorder, and obsessive compulsive disorder” (p. 342, as cited in Watkins, 1990). Faravelli et al. (2004) similarly report higher rates of major depression, sexual disorders and eating disorders among survivors of rape. These findings indicate that the psychological impact of rape do not always neatly fit the RTS or PTSD symptom pictures, are complex, and affect all aspects of the survivor’s functioning.

2.5.4 South African studies

Currently, there is a lack of published studies on the impact of rape on South African women, despite the high prevalence of rape in the country. Most data are from unpublished Masters or Doctoral dissertations using very small sample sizes. For example, Booley (2007) describes the psychological symptoms reported by ten female South African rape survivors, and notes the similarity to international literature on post-rape responses. Symptoms include “depression, numbness, anxiety... suicidality... crying... difficulties with sleep and sexual intimacy... substance abuse... decreased self-esteem and feeling dirty” as well as feeling unsafe and fearful (Booley, 2007, pp. 57-58). Interpersonal relationships were reportedly negatively impacted upon as a result of anger, lack of trust and social withdrawal and there was a reported sense of loss and grief. A negative impact on work enjoyment and performance was described by some survivors (Booley, 2007). Also based on interviews with ten female South African survivors of rape, De Swardt (2006) describes how following rape, survivors experienced hypervigilance, fear, numbing, flashbacks, intrusive thoughts of the

rape, wanting to clean themselves, avoidance symptoms, and self-blame and loss, but describe the disruption of identity, interpersonal relationships and social roles as the most distressing impact of the assault. Included in the minimal number of published studies is Womersley & Maw's (2009) discourse analysis of nine South African women's narratives of surviving rape. They report survivors' "expressed feelings of shock, disbelief and a profound sense of violation which disrupts a sense of self" (p. 45), as well as survivors' sense of loss of trust, shame, humiliation, powerlessness, and a need to clean their bodies and surroundings. King et al. (2004) also reported increased anti-social behaviour such as theft, vandalism, bullying and physical fighting, in South African teenagers with a history of sexual assault. In a recently published epidemiological study of a nationally representative sample of South Africans, rape was also identified as presenting the highest risk for Post Traumatic Stress Disorder (PTSD) among women when compared with exposure to other forms of violence (Kaminer et al., 2008). Within the South African context, women are also at increased risk of contracting HIV/AIDS as a result of sexual assault and this is likely to intensify the distress experienced by the survivor (Armstrong, 1994; Kalichmun et al., 2005; King et al., 2004; Maw et al., 2008; Wood & Jewkes, 1997).

2.5.5 Psychological impact of childhood sexual assault

While survivors of childhood sexual assault (CSA) can experience any of the above mentioned outcomes, some authors argue that the reported sequelae of adulthood sexual assault, including PTSD, are insufficient to describe the range and extent of difficulties experienced by CSA survivors (Cloitre et al., 1997; Cloitre et al., 2009; Ford & Courtois, 2009; Herman, 1992*b*; Yuan, et al., 2006). Herman (1992*a*; 1992*b*) was one of the first researchers and clinicians to advocate for the recognition of Complex Post Traumatic Stress Disorder as a more accurate and appropriate diagnosis to describe the long term effects of chronic, repeated interpersonal traumatisation. This line of thinking has been developed by subsequent researchers. Some of the current diagnostic conceptualisations include "developmental trauma disorder" (DTD) in children (van der Kolk, 2005, p. 401). There is also consideration in the literature of the impact that developmental trauma or the ongoing experience of trauma throughout the lifespan has on adult functioning. These have been conceptualised and described in the diagnostic syndrome "Disorders of Extreme Stress Not Otherwise Specified" (DESNOS) (DSM-IV-TR; APA, 2000).

The fundamental long-term sequelae of complex trauma including CSA have been identified as extreme and chronic disruption in "affect and impulse regulation... biological self-

regulation... attention or consciousness... perception of perpetrators... self-perception... relationships... and... systems of meaning or sustaining beliefs” (Ford & Courtois, 2009, p. 23). The magnitude of difficulties suffered by CSA survivors in adulthood can be attributed not only to the chronic and extreme nature of the traumatic experiences but also to the fact that experience of trauma during childhood and adolescence leads to the disruption of key stages of emotional, psychological and physical development (Ford, 2009; Ford & Courtois, 2009; van der Kolk, 2005). According to developmental trauma theory, the experience of trauma during childhood can be considered harmful to development when it impedes the development of functions for “attention and learning... working... declarative... and narrative memory... emotion regulation... personality formation and integration; and... relationships” (Ford, 2009, p. 31).

For example, the ruptures in attachment caused by chronic childhood trauma such as CSA potentially disrupts the survivor’s ability to develop secure “internal working models” (van der Kolk, 2005, p. 402). This prevents the development of a cohesive ego or sense of self, and instead identity is fragmented (Herman, 1992*a*). Related to this is the disrupted development of emotional regulation capacities and deficits in the development of cognitive processing strategies, resulting in a limited ability to learn, develop understanding and act autonomously in the world (Herman, 1992*a*; van der Kolk, 2005). All this engenders chronic distress, impulsivity, self-harm, aggression and pervasive distrust of others (Herman, 1992*a*; van der Kolk, 2005). Ongoing somatic or physical problems may result from the disruption in physiological functioning experienced during the trauma (van der Kolk, 2005; Wilson, 2010). CSA survivors’ attempts to maintain attachment to abusive caregivers may lead to the development of dissociative capacities, which impact on attention and concentration, prevent integration of trauma related negative affect and significantly impair functioning (Ford & Courtois, 2009; Herman, 1992*a*). Attempts to maintain attachment may also result in self-loathing and feelings of guilt and shame (Ford & Courtois, 2009; Herman, 1992*a*). These pervasive difficulties generally result in disruption in interpersonal functioning such as the development of unstable and intense relationships, and may leave survivors susceptible to ongoing traumatisation by others, such as repeated sexual and physical assault (Cloitre et al., 1997; Cloitre et al., 2009; Ford & Courtois, 2009; Herman, 1992*a*; 1992*b*; Yuan et al., 2006).

Herman (1992*a*), Stefan (1994), van der Kolk (2005) and Yuan et al., (2006) criticize the ways in which psychopathological labels such as Dissociative, Somatoform and Personality Disorders, particularly Dissociative Identity Disorder and Borderline Personality Disorder,

are given to women as a result of their attempts to cope with and adapt to prolonged sexual abuse. They argue that these misdiagnoses lead to the experience of stigma and inappropriate or inadequate treatment which does not recognise the traumatic aetiology of the survivor's symptoms.

2.5.6 Mediators of adjustment to rape

The literature has also considered factors associated with the psychological adjustment of rape survivors. Although studies have yielded inconsistent results (Maw et al., 2008; Steketee & Foa, 1987; Yuan et al., 2006), particular factors have been identified across some studies as having a negative impact on recovery. Self-blame is one of the more commonly studied mediators of post-rape adjustment. Janoff-Bulman (1979) distinguished between characterological and behavioural self-blame and concluded that the latter is more common and may be an adaptive response to rape trauma. This assertion was however not supported by Meyer and Taylor (1986) who acknowledged the pervasiveness of self-blame as a response to trauma but concluded that all self-blame was associated with maladaptive adjustment. Other authors have reported similar findings to Meyer and Taylor (1986) regarding the negative impact of self blame (Frazier, 2000; Koss & Figueredo, 2004; Ullman, Filipas, Townsend & Starzynski, 2007a; Ullman, Townsend, Filipas & Starzynski, 2007b; Wyatt, Notgrass & Newcomb, 1990).

Additional factors identified in the literature which have been associated with post-rape maladjustment and/or psychopathology can be understood in terms of pre-trauma variables, aspects of the traumatic event and post-trauma variables. According to Kilpatrick et al. (1985), significant personal characteristics of the survivor which existed prior to the rape influence the development of, or disrupt already developed, coping strategies, which has an impact on post-rape functioning. Factors include a history of repeated traumatisation (Cloitre et al., 1997; Frazier, 2000; Maw et al., 2008; Steketee & Foa, 1987; Ullman et al., 2007a; Yuan, et al., 2006), a history of psychiatric difficulties such as obsessive-compulsive and anxiety symptoms (Resick, 1993), depression (Acierno et al., 1999) or previous suicide attempts or suicidal ideation (Resick, 1993), a history of substance abuse (Acierno et al., 1999; Resick, 1993; Smith & Kelly, 2001; Steketee & Foa, 1987) and low self-esteem (Burgess & Holmstrom, 1979; Kilpatrick, et al., 1985; Smith & Kelly, 2001). Aspects of survivors' social circumstances prior to the rape such as poverty (Maw et al., 2008; Steketee & Foa, 1987), the lack of a positive intimate relationship with a male partner (Kilpatrick, et al., 1985) and either no or very significant life changes prior to the rape have also been found

to influence post-rape adjustment through their effects on survivors' coping capacities (Kilpatrick et al., 1985).

Added to a survivor's ability to manage stress in the mediation of post-rape functioning are aspects of the rape itself (Kilpatrick et al., 1985). Those which have been identified as potentially disruptive to adjustment include the nature of the relationship between perpetrator and survivor, for example when perpetrators are known to the survivor, such as a caregiver or partner, post-rape adjustment is more significantly disrupted (Harvey & Herman, 1992). Greater severity of the assault, including injuries sustained, and greater perceived threat experienced during the assault, have also been found to contribute towards post-rape maladjustment (Acierno et al., 1999; Resick, 1993; Ullman et al., 2007a; Wyatt et al., 1990; Yuan et al., 2006).

Finally, particular post-rape reactions and experiences have been identified as increasing stress and/or compromising a survivor's ability to manage, thereby mediating post-rape adjustment (Kilpatrick et al., 1985). Cognitive and emotional responses include the experience of high levels of distress during the period initially following the rape, which has been associated with later development of PTSD (Kilpatrick, et al., 1985), the development of trauma related maladaptive beliefs about self and others (Koss & Figueredo, 2004; Resick, 1993), poor perceived control over the occurrence of future assaults (Frazier, 2000; Yuan et al., 2006) and ongoing rumination on why the rape occurred (Frazier, 2000). The latter may be an indication that a survivor has been unable to generate meaning out of the traumatic experience (Frazier, 2000). Behavioural responses associated with poorer post-rape adjustment include delayed disclosure (Ullman et al., 2007a; Yuan et al., 2006) and the use of avoidance coping mechanisms (Ullman et al., 2007a; 2007b). Exposure to "secondary victimisation" following engagement with the medical and legal systems (Maw et al., 2008, p. 129) and the experience of negative social reactions following rape, including blame and stigma (Resick, 1993; Steketee & Foa, 1987; Ullman et al., 2007a; 2007b; Wyatt et al., 1990) have also been found to have the strongest links to the development of PTSD in rape survivors (Ullman et al., 2007a).

2.5.7 Coping, resilience and post-traumatic growth

The literature also draws attention to some of the ways in which survivors have developed coping strategies and drawn on resilience in the aftermath of rape. This has partly been in an attempt to investigate the variance in survivors' post-rape adjustment and recovery (Maw, et

al., 2008). Positive changes in the aftermath of trauma have been described in some of the literature as “post traumatic growth” (Linley & Joseph, 2004, p. 11), and authors argue that positive and negative sequelae can co-exist in survivors' experiences (Borja, Callahan & Long, 2006).

Burgess & Holmstrom (1979) described survivors' conscious attempts at coping with the rape trauma including “conscious defence mechanisms” (p. 1279) such as explanation (finding a reason for why the rape occurred), minimisation (minimising the impact of the rape), suppression (attempting to control rape related thoughts) and dramatisation (talking about the rape frequently), as well as taking action such as moving house, seeking support or travelling, all of which were associated with positive post-rape adjustment and recovery. Behavioural coping mechanisms reported in the literature include speaking to others about the rape (Booley, 2007; Thompson, 2000), having control over timing of disclosure (Booley, 2007), developing goals, and aiding others (Booley, 2007). Booley (2007) also describes how time for self-reflection facilitated meaning-making among survivors, which has been associated with recovery (Frazier, 2000). With regard to further cognitive coping strategies, some authors have found an association between reducing stress through positive thinking (Booley, 2007; Meyer & Taylor, 1986) and specific techniques such as meditation (Meyer & Taylor, 1986). Thompson (2000) in her study of five rape survivors who received no psychological intervention describes the way in which survivors consciously “blocked” thoughts of the rape until they felt empowered enough to process them. Similar results were reported by Booley (2007). Additional cognitive adjustments reported include accepting that the rape had taken place as well as accepting the ways in which the survivor had changed following the assault (Booley, 2007), developing empowering narratives of the trauma (Thompson, 2000; Womersley & Maw, 2009), contextualising the rape within the wider social sphere thus integrating it into the survivor's personal narrative (Booley, 2007), working towards self-forgiveness (Booley, 2007) and favourably comparing the trauma and/or wider social circumstances to the experience of others (de Swardt, 2006; Thompson, 2000), echoing the minimisation defence described by Burgess and Holmstrom (1979).

Various indications of post-traumatic growth have been described in the literature. Frazier et al. (2001) report greater empathy, improved interpersonal relationships as well as increased “appreciation of life” (p. 1053) experienced by survivors as soon as two weeks following sexual assault. Thompson (2000) noted positive “emotional, cognitive and spiritual changes” (p. 1331) including enhanced creativity and increased self-esteem and perceived

psychological strength. Borja et al. (2006) found a positive correlation between supportive social responses from family members, friends and professionals and positive change or growth.

2.5.8 The course of adjustment and recovery

Ellis (1983), Resick (1993) and Steketee and Foa (1987) in their respective reviews of the literature on psychological responses to rape conclude that for many survivors, the majority of their symptoms abate by 3-4 months following a rape experience; however there are a significant number of women who continue to experience psychological distress for months and years. In a study by Burgess and Holmstrom (1979), 37% of survivors reported having felt recovered after a few months, 37% after a few years and 26% felt they had not yet recovered after 4-6 years. Kilpatrick et al. (1981) report that of the survivors in their study who reported experiencing difficulties, the majority of improvement in psychological functioning took place between one and three months following the rape. They noted no significant reduction in symptoms between 6 months and a year post assault. Rothbaum et al. (1992) and Kilpatrick et al. (1985) conclude that recovery from symptoms within the first month predicts later psychological functioning. Frazier et al. (2001) report that most post-rape recovery takes place between 2 weeks and two months following assault, however they noted many individual differences in post-rape recovery amongst their participants. Thus, it appears that while some survivors recover within months, others experience prolonged or lifelong negative sequelae requiring continued treatment (Resick, 1993). The most cited long term outcomes of rape in the literature include PTSD, anxiety, fear, depression and difficulties with sexual and social functioning (Foa, Rothbaum & Steketee, 1993).

2.6 PSYCHOLOGICAL THEORIES OF THE IMPACT OF RAPE AND CHILDHOOD SEXUAL ASSAULT

Various theories regarding the mechanisms of post-traumatic reactions have been posited, none of which is able to offer a full explanation of the complex picture of post-rape adjustment (Resick, 1993). Cognitive-behavioural, psychodynamic and feminist frameworks are the predominant theoretical approaches to understanding the psychological impact of rape and underpin the dominant approaches to intervention for survivors. These will be discussed in turn, preceded by a consideration of the neurobiological theories of responses to rape and CSA.

2.6.1 Neurobiological theories

Neurobiological theories of Post Traumatic Stress Disorder

The neurobiological correlates of PTSD reflect the body's attempt to maintain "homeostasis" following the experience of a traumatic event (van der Kolk, 1996b, p. 216). According to van der Kolk (1996b), a person perceives incoming stimuli through the sensory modalities, and these data (or signals) are sent to the thalamus before being redirected to the various structures in the brain responsible for thinking and motor activity (pre-frontal cortex) as well as those structures controlling memory and feeling (limbic system) (van der Kolk, 1996b). The limbic system plays an important role in "maintaining the balance between the internal world and external reality" (van der Kolk, 1996b, p. 214). Important structures of the limbic system include the amygdala, responsible for assessing the emotional valence of signals and directing emotionally based behaviour, and the hippocampus, responsible for the categorising and laying down of signals into memory, based on integration with past experiences (Kolassa & Elbert, 2007; van der Kolk, 1996b).

Studies have shown that during exposure to traumatic events or reminders of traumatic events, activity in the amygdala intensifies (Kolassa & Elbert, 2007; Lupien, McEwen, Gunnar & Heim, 2009; van der Kolk, 1996b). The intensity of signals subsequently passed from the amygdala to the hippocampus prevents the hippocampus from "proper evaluation and categorisation of experience" and instead memories are encoded as fragmentary "images, bodily sensations, smells and sounds", resulting in the re-experiencing and intrusive symptoms of PTSD (van der Kolk, 1996c, p. 295). It also interferes with communication to the pre-frontal cortex, preventing it from being able to adequately discriminate between salient (or dangerous) and irrelevant (or non-threatening) incoming signals and effectively plan and initiate responses (Kolassa & Elbert, 2007; van der Kolk, 1996c). "Decreased hippocampal volume" has been noted in people suffering from chronic PTSD (van der Kolk, 1996b, p. 295), resulting in impulsive behaviour, "hyper-responsiveness to environmental stimuli" (van der Kolk, 1996b, p. 231) and the experience of intense feelings which they are unable to name (van der Kolk, 1996c). However more recent research suggests that a smaller hippocampus causes predisposition to the development of PTSD in adulthood rather than resulting from this disorder (Kolassa & Elbert, 2007; Lupien et al., 2009). Research has also reported deactivation of the area "responsible for translating personal experiences into communicable language" (Broca's area), during exposure to stressors or traumatic memories (Kolassa & Elbert, 2007; van der Kolk, 1996b, p. 233). The consequences of these neurobiological changes are that a traumatised person experiences extreme distress, cannot

express their distress in words or adequately communicate it to others, and is unable to learn from or modify their maladaptive responses (van der Kolk, 1996c).

Exposure to stressors also activates the HPA (hypothalamus-pituitary-adrenal) axis, which produces stress hormones such as cortisol (Kolassa & Elbert, 2007; Lupien et al., 2009; van der Kolk, 1996b). Ordinarily, following reduction of exposure to the stressor, feedback loops between various brain structures lead to the reduction of HPA activity (in an effort to regain homeostasis) (Lupien et al., 2009; van der Kolk, 1996b). However, for a trauma survivor, their constant state of hyper-alertness and the increased activity in the amygdala interferes with this process, resulting in ongoing release of stress hormones, and leading to a reduction in the efficacy of the stress response (Lupien et al., 2009; van der Kolk, 1996b). This, along with the reduced ability to accurately assess environmental stimuli, leaves the body in a constant state of physiological arousal, prepared either to fight or to flee when faced with either traumatic reminders or powerful, but neutral stimuli (Kolassa & Elbert, 2007; van der Kolk, 1996b). Being in a state of physiological arousal can also trigger traumatic memories (such as flashbacks and nightmares) and thus the release of stress hormones. This interferes with the normal processes of laying down memories (see above) and adds salience to the fragmented memories, making them more easily activated than neutral memories in the face of stimuli interpreted as threatening (Lupien et al., 2009; van der Kolk, 1996b, 1996c). The result is a “positive feedback loop” which may underlie the development of PTSD (van der Kolk, 1996b, p. 229). Researchers argue that a person’s predisposition to develop PTSD as well as their capacity to recover from it depends largely upon early developmental processes (Ford, 2009; Lupien et al., 2009). The effects of maladaptive early experiences on the development of complex post-traumatic stress disorders are considered below.

Neurobiological theories of developmental trauma

The fundamental principal on which neurobiological theories of developmental trauma, including CSA, rests is that prolonged and early trauma wires the brain for surviving its environment rather than learning about and exploring its surroundings (Ford, 2009). This results in “a biological trade off between dealing with danger and facilitating growth, healing, rejuvenation, learning, and self-development” (Ford, 2009, p. 33).

The brain develops its structures and systems as a result of innate temperament combined with environmental experiences (Ford, 2009; Lupien et al., 2009). As a child develops, brain structures and systems or “developmental trajectories” become increasingly fixed, with

repeated experiences consolidating structures and decreasing the likelihood of the child seeking out and consolidating new, alternate experiences (Ford, 2009, p. 33). According to Ford (2009), this forms the basis of “the development of a consistent, integrated self” (p. 33), however the course of development is also subject to alteration during particular, sensitive developmental periods (Lupien et al., 2009). For example, a period of accelerated growth takes place at age two years where children develop language and begin the process of separation from caregivers, and a period of change takes place in early adolescence where symbolic, abstract thought and morality develops, and consolidation of the processes of separation and individuation takes place (Ford, 2009). The continued experience of psychological trauma, particularly if interpersonal in nature, during these sensitive developmental periods prevents the child’s brain from adapting from survival to learning mode, and the child or adolescent remains driven by strategies of “harm avoidance” rather than “openness to learning” (Ford, 2009, p. 35).

Lupien et al. (2009) also propose a “life cycle model of stress” (p. 440), which demonstrates how the stage of brain development at the time of exposure to chronic or acute stress determines the subsequent neurobiological effects on the individual (p. 440). For example, the hippocampus develops during the first two years of life, the amygdala from birth till pre-adolescence, and the frontal cortex up until almost the age of 30 years, making them sensitive to the impact of stressful experiences during those periods (Lupien et al., 2009). Studies indicate that the effect on neurobiological development of the experience of ongoing stress is mediated “through activation of the HPA axis” (Lupien et al., 2009, p. 440). For example, in adolescence, the brain (particularly the prefrontal cortex) may be more vulnerable to the impact of exposure to stress because of increased HPA reactivity during this developmental period (Lupien et al., 2009). Such effects may not be evident immediately but exposure to stress later in life “can lead to the manifestation of incubated effects of early adversity on the brain (manifestation effects) or to maintenance of chronic effects of stress (maintenance effects)” (Lupien et al. 2009, p. 440). The concomitant effects on emotion and cognition of the neurobiological changes following exposure to chronic or extreme stress during childhood are deficits in the functions of affective regulation and information processing, which, along with disrupted attachment leads to the complex emotional, behavioural, physical and interpersonal difficulties experienced by child and adult survivors of prolonged childhood trauma (Ford, 2009).

2.6.2 Cognitive behavioural theories

Cognitive behavioural theories traditionally drew on learning theory, including classical conditioning and operant avoidance, to elucidate the fear and anxiety related symptoms reported by many rape survivors (Foa & Rothbaum, 1998; Kilpatrick et al., 1981; Kilpatrick et al., 1985; Resick, 1993). According to learning theory, stimuli which were previously unthreatening but were present at the time of the trauma become associated with the distressing affect experienced at the time of the trauma. Contact with, or experience of, these stimuli or cues following the trauma therefore elicit similar feelings of anxiety and fear. These associations can also generalise to other words, thoughts and images related to the previously unthreatening stimuli (Foa & Rothbaum, 1998; Kilpatrick et al., 1981; Kilpatrick et al., 1985). This results in the development of a “pathological fear structure” through which the traumatic memory is encoded (Foa & Rothbaum, 1998, p. 74). Survivors then attempt to reduce their experience of anxiety and other distressing affect by avoiding thoughts, feelings, people and places associated with the distressing affect (behavioural avoidance). As a result, their experiences become increasingly restricted and they are never able to adjust and become desensitized to these feelings or discover that some associated cues no longer signal the trauma. Anxiety, fear and distress are therefore maintained (Foa & Rothbaum, 1998; Kilpatrick et al., 1981; Kilpatrick et al., 1985).

Cognitive theories regarding the psychological impact of rape trauma developed out of dissatisfaction with earlier learning theory models (Foa & Rothbaum, 1998). Cognitive theories call attention to the ways in which interpretations of events and fundamental beliefs about the self, others and the world influence the development of dysfunctional anxiety following trauma (Foa & Rothbaum, 1998). In particular, maladaptive interpretations and assumptions that develop as a result of a traumatic experience lead to chronic distress or pathological anxiety. For example, the experience of helplessness during a rape may be interpreted as a sign of personal incompetence, resulting in a tendency to avoid rape related thoughts and feelings as well as the experience of intrusive symptoms. It may also lead to the perception of the survivor's life as being enduringly damaged, resulting in symptoms of depression (Dunmore, Clark & Ehlers, 2001; Foa & Rothbaum, 1998).

Information processing theory more specifically elucidates the reported negative sequelae of rape as being a result of a survivor's inability to integrate the traumatic experience into existing cognitive schemas (Resick & Schnicke, 1993). When the rape contains elements inconsistent with a survivor's previous ideas or expectations about themselves, others and the

world, the memories of the traumatic event may not be integrated and the emotions incurred as a result of the trauma may not be adequately processed (Resick & Schnicke, 1993). The survivor must then try to reconcile her experience by either assimilating information about the rape into existing schemas or adapting their beliefs about self, others and the world. Inability to appropriately and adaptively do so results in intrusive symptoms, avoidance behaviour, loss of trust, self-blame or depression (Resick & Schnicke, 1993). Information processing theory has also been referred to in the literature on understanding the effects of CSA on adult survivors (Möller & Steel, 2002). Emotional processing theory combines learning theory with cognitive theory to explain post-rape PTSD (Foa & Rothbaum, 1998). This theory assumes that survivors' post-trauma schemas of the world as dangerous and the self as inept and powerless result from the development of a 'pathological fear structure', leading to behavioural avoidance and lack of opportunity to resolve the initial PTSD symptoms experienced in response to the rape (Foa et al., 1993; Foa & Rothbaum, 1998). Treatment necessarily requires activation of the 'pathological fear structure' so that it can be transformed through pairing with new, adaptive associations leading to a reduction in avoidance behaviour and symptomatology (Foa et al., 1993).

Some authors argue that cognitive behavioural theories pay inadequate attention to the intensity of some post-rape reactions compared with responses to other traumas (Resick, 1993). There is little dedicated literature discussing cognitive-behavioural understandings of CSA as opposed to rape in adult survivors, however more recent studies of the efficacy of CBT treatments include CSA survivors among their participants, suggesting that current CBT theories regarding the psychological impact of rape also apply to the experience of CSA. Some cognitive behavioural understandings of the impact of rape, such as emotional processing theory, have been linked to psychodynamic theories in trying to understand why some survivors recover and others experience chronic distress and psychopathology such as PTSD (Brett, 1993; Lindy, 1986).

2.6.3 Psychodynamic theories

The effects of trauma were first studied in the nineteenth century, conceptualised as hysteria (Herman, 1992a). Freud and Janet made the initial link between hysterical symptoms, including dissociation, and the experience of psychological trauma (Herman, 1992a). The earliest treatment involved helping patients to recall dissociated memories of traumatic events such as childhood sexual assault and rape, and the associated feelings, and integrate these into their life narratives, resulting in a reduction of symptoms (Herman, 1992a). Later theorists

proposed competing psychodynamic theories regarding the aetiology of the psychological responses to trauma (Brett, 1993). Some theories, similar to Freud's early theorising about the "stimulus barrier" (Brett, 1993, p. 62), proposed that the excessive nature of traumatic events overwhelms the psyche's ability to keep it out of conscious awareness, leading to the intrusive and avoidant symptoms of trauma (Brett, 1993; Lemma & Levy, 2004). Alternative theories advocated that the effects of trauma were due to early infant conflicts reawakened by the traumatic event (Brett, 1993; Garland, 2007a). More current theorists have taken an integrated approach, and a common tenet of psychodynamic understandings of trauma is that every survivor's response is unique, based on their experience of early object relationships along with their particular social context (Lemma & Levy, 2004).

According to psychodynamic theories, post-traumatic symptoms are thought to initially result from the failure to adapt to the immediate phase of psychic disorganisation following a traumatic event. At times, the nature of a traumatic event is so extreme and destructive, and the impact so shattering, that it incapacitates (or, in the case of childhood sexual assault, prevents the development of) the psychic structures needed to process the traumatic event, namely a cohesive ego or sense of self (Cloitre et al., 1997; Lindy, 1986, Rose, 1991). This leaves the survivor in a state of helplessness, stripped of the primitive belief of the self as an autonomous and powerful agent (Ulman & Brothers, 1988). In the case of rape, the loss of a cohesive sense of self occurs through attacks on attachment and the psychic destruction of the survivor's object relationships (Garland, 2007a; Lemma & Levy, 2004, p. 5). In other words, the internalised nurturing, containing maternal figure, which includes the sense of a safe and nurturing world and enables continuity of experience and sense of self, is lost (Garland, 2007a; Lemma & Levy, 2004; Rose, 1991). Alternatively, if the survivor has had neglectful or abusive early experiences, their sense of a malevolent, persecuting maternal introject, and of the world as hostile and dangerous, is confirmed (Lemma & Levy, 2004).

The loss of the containing maternal figure and the weakening of the ego have several consequences. The survivor is no longer able to "tolerate and manage anxiety" (Garland, 2007a, p. 110). They also lose the capacity for "mentalization" (Lemma & Levy, 2004, p. 10) and therefore the ability to maintain "inner dialogue" (Lemma & Levy, 2004, p. 16) between the self and the internalised object, which enables reflection on thoughts and feelings rather than impulsive action. As a result, they are no longer able to symbolise, which is the ability to reflect on and think about traumatic events rather than re-experiencing them (Garland, 2007a, p. 111), and they become unable to distinguish between reminders of the traumatic

event and the traumatic event itself (Garland, 2007a; 2007b). Garland (2007a) terms this “a state of equatedness” (p. 121). Loss of symbolisation may prevent the survivor from articulating her experiences to an empathic other, and traumatic reminders are also experienced as real, threatening and overwhelming, leading to pervasive anxiety and the use of regressive, maladaptive psychological defences such as splitting or denial (Garland, 2007a; Lemma & Levy, 2004; Lindy, 1986; Ulman & Brothers, 1988). Split off or dissociated memories are then experienced as intrusive symptoms such as nightmares and flashbacks, and denial may result in avoidance behaviour, feelings of numbness and social isolation (Lindy, 1986; Ulman & Brothers, 1988). A survivor may also move between these two defensive positions resulting in symptoms of “hyperarousal, startle reactions, cognitive dysfunction, and irritability” (Lindy, 1986, p. 199).

The longer term effects of the experience of trauma stem from the survivor's attempts at making meaning out of the traumatic event by linking it to any similar or identifiable experiences (Garland, 2007b). Often the only such experiences are “persecutory phantasies concerning primary object relationships” (Garland, 2007a, p. 120), which then become predominant in the survivor's psyche (Brett, 1993). The world, post-trauma, is therefore felt as persecutory, past experiences of abandonment, disappointment and empathic failure are regenerated, and the survivor becomes disconnected from those around her (Garland, 2007a). The heinous nature of the external traumatic event also serves to confirm these primitive fears (Garland, 2007a). Over time, the connection between traumatic cues and emotional and psychic responses also becomes disguised, which, along with the consolidation of “old fears about the unpredictability or untrustworthiness of one's internal objects, of the world itself” (Garland, 2007a, p. 113) leads to the survivor experiencing ongoing trauma and nameless distress, which is difficult to alleviate (Garland, 2007a; Lindy, 1986).

From a psychodynamic perspective, the intense symptoms, characterological changes and interpersonal difficulties experienced by childhood sexual assault survivors is a result of the lack of opportunity to internalise positive self-objects which would allow for the development of self-regulatory capacities (Cloitre et al., 1997; Herman, 1992a). The primary need for attachment and human connection forces the survivor to either develop schemas of the self as bad and damaged, or to repress and dissociate traumatic memories in order to enable attachment to an abusive caregiver (Brown, 2004; Herman, 1992a). These mechanisms result in the development of primitive defence mechanisms, such as splitting, dissociation and somatisation which, while adaptive at the time of abuse, become maladaptive later in life, for

example leading to the development of a “[fragmented]” self and intense, unstable relationships, chronic depression, suicidality, pervasive low-self esteem, self-harm and the many other reported sequelae of childhood sexual assault (Herman, 1992a, p. 107). These psychodynamic theories developed out of, and link to, feminist understandings of the impact of trauma (Brown, 2004; Herman, 1992a; 1992b).

2.6.4 Feminist theories

Feminist theories of rape are premised on the recognition that rape and sexual assault are more normative than an unusual or ‘extraordinary’ experience for women and girls, and that rape or the threat of rape occurs as a form of social control in societies with an ethos of patriarchy and male dominance (Driver, 1989; Harvey & Herman, 1992, Lebowitz & Roth, 1994). ‘Rape myths’, erroneous but widely propagated and endorsed beliefs regarding, for example, women’s complicity in and desire for rape, develop out of societies where rape and sexual assault is implicitly or explicitly condoned, and are propagated through gender socialisation (Driver, 1989; Harvey & Herman, 1992; Lebowitz & Roth, 1994).

Feminist theories therefore understand the impact of trauma as occurring within an ecological framework. They recognise the mutual impact of interpersonal, social, political and economic forces on an individual, and propose that change or transformation needs to occur on multiple levels in order to be possible and sustainable (Brown, 2004; Cohen, 2008; Lebowitz & Roth, 1994). Theorists argue that the distress following trauma extends beyond experience of the threat to one’s physical and psychological integrity to the experience of social responses, and is intensified by the social inequalities and prejudices represented by the traumatic event (Brown, 2004; Cohen, 2008). It is recognised in feminist theory that discrimination and social oppression are maintained by rendering certain groups of people vulnerable to trauma. For example, patriarchy is maintained through the rape of girls and women as well as the active failure to prevent childhood and adulthood sexual assault (Brown, 2004; Driver, 1989; Moffet, 2006). Therapy for survivors of rape and CSA within this framework would therefore move beyond symptom management to explicit exploration of the meaning of rape, for example as a destruction or contamination of socially accepted constructs of femininity, or as a vehicle for the disempowerment of women (Brown, 2004; Lebowitz & Roth, 1994; Moffet, 2006).

2.7 PSYCHOLOGICAL INTERVENTIONS IN THE TREATMENT OF RAPE AND CHILDHOOD SEXUAL ASSAULT

2.7.1 Treatment for adult survivors of rape and childhood sexual assault

Because the sequelae of rape and CSA are complex and are influenced by and impact on intrapersonal, interpersonal and social aspects of a survivor's life, therapeutic interventions need to address these multiple layers of experience (Hartman & Burgess, 1993; Lebowitz, Harvey & Herman, 1992). Hartman and Burgess (1993) advocate a "multidimensional model of intervention" (p. 512) for the treatment of rape survivors, which addresses the initial disorganised phase of response, including initial physiological, sensory and perceptual disturbances, as well as later affective, cognitive, behavioural (avoidance behaviour) and interpersonal difficulties, and finally disturbances in social roles and functioning. Authors argue that interventions should be designed to fit the individual needs of the survivor and should not be limited to particular theoretical modalities (Courtois, Ford & Cloitre, 2009; Hartman & Burgess, 1993).

Harvey (1996) similarly conceptualises an ecological approach to the treatment of trauma, which targets the personal, event related and environmental aspects of a survivor's experience and takes into account the impact of these interacting spheres on her post-rape (mal)adjustment and (non)recovery. This author emphasises that some survivors of rape will not receive clinical intervention and some survivors will not recover from the trauma (Harvey, 1996). She also argues that intervention should provide an "ecological fit" (Harvey, 1996, p. 13) for the unique needs of the survivor, should be informed by adequate assessment of person related, event related and environmental factors, and should consider both the survivor's difficulties and strengths (Harvey, 1996; Linley & Joseph, 2004). Harvey (1996) cites the collective conclusions of community psychology researchers in the field of trauma that in order for interventions to be effective and sustainable, they need to understand and respond to the social context of the survivor (including race, culture and ethnicity) and to be integrated into "the life and culture of more enduring social contexts" (p. 18). For example, Thompson (2000) found that survivor understandings of, and responses to, the rape were informed by social views on rape and gender, including rape myths which were identified as contributing towards survivors' self-blame.

2.7.2 A three stage model of recovery

The recovery from rape and childhood sexual assault has also been conceptualised by some authors as occurring in stages, with recovery at each stage being measured by various

indicators of psychological functioning including memory, the ability to identify, name and experience a range of emotions, reconnecting memory and feeling, mastering symptoms, increasing self-esteem, renewing relationships with others and the creation of meaning (Courtois et al., 2009; Harvey, 1996; Lebowitz et al., 1993). Courtois et al. (2009), Herman (1992a) and Lebowitz et al. (1993) advocate a three stage model of recovery for survivors of rape and CSA, which forms the basis of current best practice treatment guidelines for chronic and complex PTSD. According to Courtois et al. (2009), treatment should recognise and incorporate the individuality of each survivor, should be carefully planned, and should be based on a holistic assessment of the survivor's unique needs, strengths and context. The survivor should be empowered and their autonomy actively encouraged by the therapist throughout the treatment process. This is collaboratively achieved through exploration and validation of the unique meaning the survivor attaches to her traumatic and post-traumatic experience, by the working through of repressed or dissociated emotions, and through the acknowledgement of and attempt to redress the power differential within the therapeutic relationship (Courtois et al., 2009).

During the first and longest stage of treatment, the survivor's physical, psychological, interpersonal and environmental safety is ensured. For example, the survivor is helped with making sure any medical needs are attended to, that regular eating and sleeping patterns are restored, and that any self-harm or post-traumatic symptoms are brought under control (Courtois et al., 2009; Herman, 1992a; Lebowitz et al., 1993). Attention is also paid to ensuring that she has safe living conditions and access to basic resources. This phase forms the basis of the development of a safe and trusting relationship with the therapist and the survivor is encouraged to "plan and initiate action" (Herman, 1992a, p. 167) as the beginnings of re-establishing a sense of control and agency (Courtois et al., 2009; Herman, 1992a). For the treatment of complex stress disorders, treatment also focuses on developing self-regulatory capacities and fostering positive attachment experiences (Courtois et al., 2009). An essential part of this stage involves helping the survivor to manage and regulate emotional distress, improve their capacity "to approach and master rather than avoid internal bodily/affective states and external events that trigger intrusive re-experiencing, emotional numbing or dissociation, and hyper or hypoarousal", and to begin to develop a positive sense of self (Courtois et al., 2009, p. 92). The establishment of safety may require the use of medication, teaching anxiety-management techniques, skills training, and the involvement of the survivor's personal support network or community resources (Herman, 1992a; Lebowitz et al., 1993). This stage of recovery is made particularly difficult in the South African

context. The high levels of violent crime make ensuring physical safety almost impossible. High levels of poverty and limited community resources may prevent survivors from finding safe accommodation or gaining access to basic living requirements such as food, money or employment, and the overburdened health care system makes access to medical care difficult.

The establishment of safety is followed by the therapist acting as a witness and assisting the survivor to narrate the detail of the trauma within the context of recalling their life narrative, thus integrating it into their life story (Courtois et al., 2009; Herman, 1992a; Lebowitz et al., 1993). This enables the process of “remembrance” (Herman, 1992a, p. 175), particularly of previously dissociated aspects of the experience, and facilitates the inclusion of alternative narratives of resilience and growth into the survivor’s life narrative (Courtois et al., 2009; Herman, 1992a; Lebowitz et al., 1993). For survivors experiencing complex stress reactions, the emphasis is again placed on enhancing self-regulation and on developing the capacity to “examine reflectively the full range of past and recent memories, without focusing on traumatic experiences per se” (Courtois et al., 2009, p. 94). The process of “mourning” (Herman, 1992a, p. 175) what the survivor has lost through the trauma is also brought about during this stage of recovery, along with the expression and experience of feelings of shame and rage (Courtois et al., 2009; Lebowitz et al., 1993). The third stage of recovery involves the survivor reconnecting with others by developing or re-entering relationships from an empowered position and the creation of a new identity and future (Herman, 1992a; Lebowitz et al., 1993). For survivors of complex PTSD, this includes “work on unresolved developmental deficits and fixations” (Courtois et al., 2009, p. 95).

2.7.3 Treatment models

Various therapies and treatment modalities to assist rape survivors in the different stages of recovery have been identified in the literature from economically developed countries. These include crisis intervention, behavioural therapy, psychodynamic psychotherapy, group psychotherapy, pharmacology as well as various types of cognitive behavioural therapy (CBT). These will be reviewed below.

2.7.4 Crisis intervention

Crisis intervention is the model used by most rape crisis centres internationally, along with group psychotherapy (Foa et al., 1993). This model evolved from crisis theory and involves advocacy, psychoeducation, active listening and support (Foa et al., 1993; Hartman & Burgess, 1993). It aims to provide assistance in the acute aftermath of rape, including

acknowledgement of the survivor's trauma experience and assistance with anxiety management, problem solving and accessing social support (Hartman & Burgess, 1993). Foa, Hearst-Ikeda and Perry (1995, as cited in Foa & Rothbaum, 1998) assessed the efficacy of a treatment intervention comprising behavioural and cognitive techniques offered an average of fifteen days following the rape. They report significant improvement in symptoms for the survivors compared with a control group. However, there is generally little reported empirical investigation of the effectiveness of crisis intervention for the treatment of rape (Foa et al., 1993).

2.7.5 Psychodynamic psychotherapy

Individual and group psychodynamic psychotherapy have been advocated as an extension and augmentation of crisis intervention (Foa & Rothbaum, 1998). As with crisis intervention, limited empirical outcome studies are available, and the available studies report mixed results for the use of psychodynamic psychotherapy in the treatment of PTSD as well as having limited generalisability due to methodological flaws (Foa & Rothbaum, 1998; Steketee & Foa, 1987).

According to psychodynamic theorists, in order to facilitate meaning making and healing following a traumatic experience, the associated feelings need to be remembered and processed (Lindy, 1996). Treatment aims to transform "traumatic memory", which is stored as fragments of perception, split off and out of the survivor's control, to "narrative memory" (Lindy, 1996, p. 526), where the survivor is able to articulate and integrate their experience into their life narrative (Garland, 2007b; Lindy, 1996). The emphasis of treatment is also on understanding the particular meaning the traumatic experience has for the survivor based on an understanding of their early object-relationships and intra-psychic functioning, and seeks to develop understanding of what drove a survivor's particular traumatic responses (Garland, 2007a).

In the initial stages of therapy, the therapeutic relationship is formed before the therapist thoughtfully interprets the connections between affect, responses and the traumatic event (Lindy, 1986). This requires the therapist to provide a safe and containing space for the survivor and to provide validation of their experiences (Levy, 2004). The therapist also needs to perform a mentalizing function in order to help the survivor to experience memories of the trauma and the associated affect in a more manageable way, thereby rebuilding the capacity to symbolise and enabling them to put words to their experiences (Levy, 2004; Lindy, 1986).

This is facilitated through the process of validation and by the therapeutic alliance, which provides the necessary ego-strength for this task (Levy, 2004; Lindy, 1986). An example of this would be the therapist's capacity to bear witness to the survivor's story without falling apart (Lemma & Levy, 2004; Levy, 2004). It is hoped that as therapy progresses, the survivor will internalise the "cohesive self" of the therapeutic alliance and gain a sense of control, facilitating the final grieving process for what has been lost through the trauma (Lindy, 1986, p. 201). Therapy in the longer term necessarily involves working through the survivor's past and present experience of persecutory internal objects which have been regenerated by the trauma, thus enabling them to reconnect with those around them (Garland, 2007a). Traumatic experience may be relived in the transference, which provides useful evidence for the unique ways in which the trauma has impacted on the survivor's internal world, and enables the survivor to recall traumatic experiences without becoming overwhelmed (Garland, 2007a; 2007b; Lindy, 1986).

There are however limitations to applying psychodynamic treatment interventions in the South African context. Psychodynamic interventions are necessarily long-term and are implemented individually. This makes them expensive in a context where resources are scarce, making treatment inaccessible to the majority of South African survivors. The high prevalence of rape in South Africa also means that there are unlikely to be enough trained clinicians to provide such intensive therapy to the vast number of survivors in need of treatment. It is possible however that group application of psychodynamic principles would partly alleviate these barriers.

2.7.6 Cognitive-behavioural interventions

Cognitive behavioural techniques are by far the most widely researched treatments. They have received much empirical support for being successful in the treatment of PTSD following rape, even for survivors with previous histories of trauma (Foa et al., 1993; Foa & Rothbaum, 1998; Resick, Nishith, Weaver, Astin & Feuer, 2002; Steketee & Foa, 1987).

Foa and Rothbaum (1998) describe a group of empirically validated cognitive behavioural procedures called "exposure techniques", which were developed out of Learning Theory and are aimed at allowing survivors to overcome their fears through transformation of the dysfunctional aspects of trauma related memories (p. 51). This is achieved through a process of graduated and contained exposure to trauma related thoughts, feelings and external traumatic reminders, alongside relaxation and anxiety management strategies (Foa &

Rothbaum, 1998). A variety of exposure techniques have been developed which differ in their application but are based on these same principles. Systematic desensitization (SD) is an exposure technique aimed at alleviating dysfunctional anxiety. The survivor is asked to call to mind their trauma related fear while the therapist assists them to reduce anxiety and to relax (Foa et al., 1993). Treatment is scaffolded, starting with less anxiety provoking thoughts or memories, which increase in intensity as anxiety levels are mastered (Foa & Rothbaum, 1998). Several studies have found this technique to improve psychological functioning, including resolving specific trauma related phobias, however studies lack methodological rigour (Foa & Rothbaum, 1998; Steketee & Foa, 1987).

Exposure techniques which superseded SD include imaginal and *in vivo* exposure, otherwise referred to as flooding or prolonged exposure (PE) (Foa et al., 1993; Foa & Rothbaum, 1998). In addition to assisting the survivor to process the rape experience through systematic desensitization, imaginal exposure aims to activate the 'pathological fear structure' by means of a less gradual process. The survivor is encouraged to "vividly" talk through the traumatic event as if it is occurring in the present before being asked to rate her levels of distress and then being assisted to relax (Foa & Rothbaum, 1998, p. 159). The feelings associated with this experience are then discussed with the therapist and the process is repeated, with the survivor being encouraged to incorporate new, more anxiety provoking elements onto the trauma memory each time it is retold. According to Foa and Rothbaum (1998), this process aims to "habituat[e]" (p. 161) the survivor to the fear and anxiety associated with the traumatic memory, which reduces overall distress levels, demonstrates that "remembering the trauma is not dangerous" (p. 85) and shows that anxiety does dissipate even when the survivor engages with the traumatic memory. Survivors are also helped to distinguish between a traumatic reminder and the traumatic event itself and to develop a greater sense of autonomy, both of which challenge their distorted beliefs of the world as primarily dangerous and the self as incompetent (Foa & Rothbaum, 1998). If the survivor does not experience 'habituation', they learn to associate distress relief with avoidance of stimuli rather than repeated engagement with the traumatic memory, reinforcing behavioural avoidance (Foa & Rothbaum, 1998). *In vivo* exposure has the same rationale and encompasses the same goals as imaginal exposure. However, *in vivo* exposure requires gradually increasing actual (rather than imagined) exposure to traumatic reminders, such as situations or people reminiscent of the trauma, in order to gradually reduce painful affect triggered by trauma related cues and reduce avoidance behaviour (Foa & Rothbaum, 1998).

These techniques have attracted some criticism, particularly regarding the level of initial distress they engender in some clients (Foa et al., 1993; Steketee & Foa, 1987). However, Foa and Rothbaum (1998) report a study of imaginal and *in vivo* exposure for the treatment of rape survivors, where both techniques effected a 65-85% improvement in symptoms of PTSD (Richards, Lovell & Marks, 1994, as cited in Foa & Rothbaum, 1998). Hembree and Brinen (2009) also argue, based on a review of current literature, that prolonged exposure has not been evidenced to adversely affect treatment outcome or treatment completion rates even when used in the treatment of survivors of CSA.

Eye movement desensitization and reprocessing (EMDR) is another exposure technique which has generated much debate. The technique requires the survivor to imagine part of the trauma, focusing on thoughts and somatic responses, while the therapist “waves two fingers across the client’s visual field... [instructing] the client to track the fingers” and then assisting them to pair the memory with a more positive thought (Foa & Rothbaum, 1998, p. 59). There has been inconsistent empirical evidence for the efficacy of this technique reported in the literature (Foa & Rothbaum, 1998), however more recently the American Agency of Health Care Policy and Research has reported positive results in the treatment of trauma survivors (Sprang, Craig & Clark, 2008). Rothbaum, Astin and Marsteller (2005) also compared the efficacy of EMDR and PE with a waitlist control group in a sample of 74 female rape survivors suffering from PTSD. They found that compared with the control group, EMDR and PE both evidenced statistically significant reduction in PTSD symptoms so that a diagnosis of PTSD was no longer met.

Anxiety Management Training (AMT) programmes are another group of cognitive behavioural techniques reported by Foa and Rothbaum (1998). These techniques, including stress inoculation training (SIT), cognitive restructuring and relaxation, teach anxiety management skills, provide coping skills and are useful for the alleviation of more pervasive anxiety, fear and avoidance behaviour (Foa et al., 1993; Foa & Rothbaum, 1998). SIT is a two part intervention. It initially provides psychoeducation about the underlying principles of the treatment programme and the mechanisms of post-trauma fear and anxiety. This is followed by the provision of fear and anxiety management strategies, such as relaxation and breathing techniques, communication skills, thought stopping and “guided self-dialogue” to address cognitive distortions (Foa et al., 1993, p. 267). Veronen and Kilpatrick (1983) noted qualitative improvements in survivors undergoing SIT (as cited in Steketee & Foa, 1987) and various subsequent empirical studies have reported efficacy for this treatment for female rape

survivors (Foa & Rothbaum, 1998). Cognitive Therapy employs the technique of cognitive restructuring and is a treatment aimed at reducing symptoms of depression and anxiety (Foa et al., 1993). It is based on the premise that affect is generated according to interpretations of events and therefore assists survivors to recognise and transform maladaptive beliefs and cognitive distortions about self, other and the trauma into more rational, adaptive responses, beliefs and assumptions (Foa et al., 1993; Foa & Rothbaum, 1998).

Cognitive Processing Therapy (CPT) combines various cognitive behavioural techniques and predominantly aims to treat PTSD and depression in survivors of rape (Resick & Schnicke, 1993). CPT attempts to enable survivors to remember the trauma, experience the concomitant emotions and appropriately integrate the experience with previous beliefs about the self, other and world. This is achieved through exposing the survivor to memories of the trauma through activities such as writing and reading about the rape, as well as challenging post-traumatic maladaptive cognitions (Resick et al., 2002; Resick & Schnicke, 1993). CPT can be offered individually or in groups. Studies done by Resick and Schnicke (1993) indicated a significant reduction in symptoms of PTSD and depression immediately and six months following treatment for survivors partaking in both individual and group cognitive processing therapy. It should be noted however that survivors with a history of incest, psychopathology or substance abuse were excluded from the study (Resick & Schnicke, 1993).

Comparative studies of cognitive behavioural treatments

Frank et al. (1988) found equal and significant success for Cognitive Behaviour Therapy and Systematic Desensitisation in treating the impact of rape, particularly depression, fear and anxiety, on 67-75% of immediate and delayed treatment seeking survivors of rape. They hypothesise the mechanisms of healing to be the empowerment of the survivor through regenerating a sense of physical and emotional control, implementing active coping strategies and affording the survivor control over her own treatment and recovery process (Frank et al., 1988). Foa, Rothbaum, Riggs and Murdock (1991) compared the efficacy of stress inoculation training (SIT), prolonged exposure (PE), and supportive counselling (SC) with a waiting list control group in the treatment of rape survivors presenting with chronic PTSD and other psychological difficulties. These authors found that while SIT (55%) was most effective in alleviating symptoms of PTSD during the period initially following treatment, PE (50%) effected the most durable reduction in symptoms. Both techniques were found overall to be more successful than supportive counselling (45%) in treating PTSD, however survivors receiving supportive counselling as well as those on the waiting list for intervention

experienced a reduction in arousal symptoms (Foa et al., 1991; Foa & Rothbaum, 1998). No significant difference was found between treatment groups in the alleviation of psychopathology other than PTSD, and depression was alleviated in both treatment and non-treatment groups (Foa et al., 1991). Resick et al. (2002) also compared Cognitive Processing Therapy (CPT) with prolonged exposure (PE) and a control group in the treatment of female survivors of rape. They found that even for women with an additional history of childhood sexual assault, CPT and PE achieved significant reductions in acute and chronic PTSD and depressive symptoms compared with the control group. CPT was also found to be more successful than PE in reducing feelings of guilt (Resick et al., 2002). This study had less stringent exclusionary criteria, rendering the results more generalisable to survivors likely to present for treatment (Resick et al., 2002).

Foa et al. (1993) and Foa and Rothbaum (1998), in their reviews of treatment interventions for the sequelae of rape, conclude that cognitive behavioural treatments have shown success, with no one technique demonstrating greatest efficacy and with no evidence to date to support particular combinations of modalities. However they caution that methodological flaws such as lack of control groups and timing of interventions render results of some studies inconclusive. Foa and Rothbaum (1998), weighing the empirical evidence, advocate the use of exposure techniques in the treatment of rape survivors presenting with PTSD because of their accessibility to clients and clinicians. They argue that exposure techniques can be readily taught to clinicians not specifically trained in CBT and that the procedures are relatively easy for clients to understand (Foa & Rothbaum, 1998).

Cognitive behavioural treatments for survivors of childhood sexual assault

There have been few dedicated studies assessing the efficacy of CBT for women with a history of CSA and there has been debate as to whether CBT techniques should be moderated and adapted for this population. Of the few studies available, some refer to survivors of CSA with a diagnosis of chronic PTSD and exclude participants with acute co-morbid conditions (Courtois et al., 2009; McDonagh et al., 2005), however others have shown efficacy of single or combined CBT techniques in the treatment of the more pervasive symptoms comprising complex PTSD (Hembree & Brinen, 2009; Möller & Steel, 2002). McDonagh et al. (2005) conducted an empirical study comparing CBT (including PE, cognitive restructuring and *in vivo* exposure) with present centred therapy (PCT) and a wait list control group amongst a group of 72 women with a history of CSA and who met the DSM-IV criteria for PTSD. These researchers found that both CBT and PCT demonstrated significant improvement in

“PTSD symptom severity, state anxiety, and trauma-related cognitive schemas”, but not “symptoms of depression, dissociation, and anger or hostility, nor in improving quality of life” compared with the wait-list control group (McDonagh et al., 2005, p. 521). However, 41% of participants in the CBT group terminated treatment early and the authors conclude that “CBT may not be as well tolerated when the clinical picture is more complicated” (McDonagh et al., 2005, p. 523). In a South African study, Möller and Steel (2002) measured “clinically significant change” following rational-emotive behaviour therapy (involving cognitive restructuring) in a group of 26 adult female survivors of CSA. They reported highly significant recovery rates for symptoms of state anxiety and significant recovery rates for depression and state anger amongst participants. Less efficacy of treatment was demonstrated for guilt and low self-esteem (Möller & Steel, 2002).

Again, limitations exist in the applicability of CBT treatments in the South African context. There are limited numbers of therapists trained in CBT and the country's lack of resources makes it unlikely that this will be adequately addressed. South African survivors of rape and CSA also experience multiple and ongoing traumatisations which would make it difficult to identify which traumatic event should be targeted during treatment. The ongoing danger faced by South African survivors also means that aspects of ‘pathological fear structures’ may in fact be functional and habituation to objectively benign feared stimuli may compromise physical and psychological safety.

2.7.7 Feminist therapeutic interventions

While the aforementioned modalities generally address the personal and event related dimensions of the outcome of rape, there is scarce literature on interventions to address the social, economic and political (environmental) spheres highlighted by Harvey (1996). This is despite the evidence reported in the literature regarding the impact of social responses to rape on a survivor's psychological and physical adjustment (Borja et al., 2006; Kimerling & Calhoun, 1994; Ullman et al., 2007b). Stefan (1994), writing from a feminist perspective, also highlights how focus on treating intra- and interpersonal symptoms of rape pathologises the survivor and obscures the social, political and economic contributions to the rape pandemic. Various authors have made recommendations regarding intervention in the wider social sphere, such as the development of child-protection procedures in schools, training of educators and other professionals regarding the risks for and impact of sexual assault, and public and community based education and awareness initiatives (King et al., 2004; Peltzer & Pengpid, 2007; Resick, 1993; Ullman et al., 2007b). However, there remains a paucity of

structured or guided treatment interventions described in the literature. Feminist theory and treatment models seek to address this.

According to Brown (2004), it is the theoretical grounding and understanding of feminism which constitutes feminist therapy, rather than specifically prescribed methods of practice. Feminist therapy is “eclectic... theory driven” and aims to “develop feminist consciousness” (Brown, 2004, p. 464), which is the understanding that the aetiology of distress following trauma is social oppression within a patriarchal, unequal society rather than pathology located within the individual (Brown, 2004; Cohen, 2008; Wright, 2009). Various therapeutic modalities may be employed with the aim of remodelling relationships on individual, interpersonal and environmental levels (Wright, 2009). For example, Cohen (2008) argues that cognitive therapy encompasses feminist principles and can achieve feminist treatment goals such as enhancing autonomy and challenging beliefs about the self and the world based on patriarchal principles. There is also recognition in feminist therapy that the therapeutic relationship takes place within, and mutually influences, a wider social and political sphere (Brown, 2004; Cohen, 2008; Wright, 2009).

A fundamental tenet of feminist theory and intervention is the recognition that the client is the expert regarding her needs, and is the author of her own process of healing (Brown, 2004; Wright, 2009). Practice involves the empowerment of the client to access this knowledge and implement the steps towards recovery (Brown, 2004; Cohen, 2008). Strengths and resiliencies are recognised and the narrative of pathological symptomatology is rewritten as one of positive adjustment, survival and resistance (Brown, 2004). The emphasis on empowerment extends to assisting the survivor to recognise and react to ways in which the traumatic experience (or, in the case of interpersonal violence, the perpetrator and wider society) rendered her powerless and stripped her of autonomy (Brown, 2004). Another of the therapist's tasks is to empower the survivor to remember and talk about her experiences by always believing her and listening for alternative meanings in ‘unbelievable’ stories and to “meet the client where they are” (Brown, 2004, p. 468). Feminist therapy also involves examining and making explicit any attempts at meaning making which represent “internalised oppression” (Brown, 2004, p. 469), such as self-blame, as well as assisting the survivor to reconstruct meaning in a way which empowers rather than oppresses her (Brown, 2004; Lebowitz & Roth, 1994). Fundamentally, intervention extends beyond treating symptoms and facilitating empowerment and transformed relationships, into the political sphere through the therapist becoming involved in social action (Brown, 2004).

Feminist interventions in the treatment of adult CSA survivors involve similar principles compared with the treatment of rape in adulthood. For example, survivors are encouraged to locate the cause of the abuse within a patriarchal social context rather than within themselves (Cohen, 2008). Cohen (2008) also argues that survivors of CSA may benefit from participation in “activities for social change” (p. 242) such as consciousness raising and counselling. This propagates a “feminist consciousness” (Cohen, 2008, p. 242) by reinforcing the notion of CSA as a social problem, develops the survivor’s sense of autonomy, fosters relationships with like-minded peers, and may help the survivor to generate positive meaning from the trauma (Cohen, 2008). Current guidelines for the treatment of complex PTSD evolved out of Herman (1992*a*; 1992*b*) and Harvey’s (1996) treatment models and incorporate the ethos of feminist therapies (Cloitre et al., 2009).

2.7.8 Pharmacotherapy

Pharmacological treatments, particularly anti-depressants, have been used to treat symptoms of PTSD with varying degrees of efficacy (Foa & Rothbaum, 1998; Sprang et al., 2008). There are two mutually exclusive theories regarding the mechanisms of efficacy. One theory espouses the “abreactive” effects of medication, namely that with the aid of medication, repressed and split off psychological distress is uncovered, addressed and thus dissipates (Foa & Rothbaum, 1998, p. 44). The conflicting theory advocates medication as a means of containing disruptive symptoms to re-enable previous positive coping strategies (Foa & Rothbaum, 1998). Cloitre et al. (2009) and Foa and Rothbaum (1998) caution that pharmacological treatments should be administered in a considered manner, and advocate for continued research on the combined use of pharmacotherapy and psychosocial interventions. Rose (1991) also cautions about the unconscious meaning for rape survivors of being referred for medication. She argues that the use of medication reduces the survivor’s sense of control over her body and thus her sense of autonomy, which may be experienced as re-victimisation (Rose, 1991). Survivors may also interpret the need for medication as a sign that their symptoms are uncontrollable, exacerbating feelings of helplessness (Rose, 1991). In addition, Rose (1991) argues that symptoms may be intensified in response to the medication’s “anxiolytic effect[s]” (p. 88), and that the physical side effects of medication could exacerbate somatisation as a response to rape (Rose, 1991).

2.7.9 Group psychotherapy

Empirical evidence for group psychotherapy has shown mixed results, ranging from minor to significant improvement, although methodological issues render the results ambiguous (Foa

et al., 1993). For example, one study by Roth, Dye and Lebowitz (1988) assessed the efficacy of one year of group psychotherapy for treatment of the chronic impact of sexual assault on a group of seven female survivors. They report that after twenty weeks of group psychotherapy, survivors showed improvement regarding various aspects of psychological functioning, rape related fears and the intrusive symptoms of PTSD compared with the control group, with effects being maintained at six months post-treatment (Roth et al., 1988). However survivors were undergoing concurrent individual therapy which, along with other methodological difficulties, is likely to have confounded results of the study (Foa et al., 1993). Scarvalone, Goitre and Difede (1995) report that incidence of PTSD amongst a group of sexually retraumatised women was halved following participation in "short-term interpersonal process group psychotherapy" (p. 450, as cited in Cloitre et al., 1997) which concentrated on naming and interpreting affect. Taylor and Harvey (2009) found that across therapeutic modalities, individual interventions demonstrated significantly better results than group interventions.

Group psychotherapy has been identified as useful for survivors of CSA because of the development of relationships within the group. This may help to validate survivors' experiences, decrease feelings of isolation and disconnection from others and facilitate risk taking and the development of trust (Cohen, 2008). Mutual peer support within the group may also help to increase self-confidence amongst members (Cohen, 2008). However, therapists caution that group members need to be engaged in similar stages of recovery in order to avoid re-traumatisation (Cohen, 2008; Herman, 1992a). Foa and Rothbaum (1998) report on one study by Scarvalone, Cloitre and Diefde (1995) which found a significant decrease in PTSD symptoms in a group of female survivors of childhood sexual assault following interpersonal group therapy treatment compared with a control group. However, no significant difference was noted between groups on measures of depression and dissociation (Scarvalone et al., 1995, as cited in Foa & Rothbaum, 1998).

2.7.10 Family or support network interventions

The impact of family and broader support networks on survivors' post-traumatic adjustment has been highlighted (Figley, 1986), yet there are few reported treatment models in the literature. Figley (1986) asserts that for survivors of various traumas, including rape, intervention should include assisting the survivor's family or immediate support network with psychoeducation regarding the effects of trauma on the survivor and family members as well as techniques for managing this impact. Cohen (1988) describes one psychotherapeutic

group intervention for partners of survivors of rape or childhood sexual assault. Treatment aimed to assist partners to engage and cope with their own psychological responses to the rape or sexual assault and to provide skills to promote beneficial support for the survivor, as well as including psycho-education and the facilitation of mutual support (Cohen, 1988). Qualitative assessment of the efficacy of the group by participants and their partners (the survivors of rape and childhood sexual assault) indicated that the group was beneficial for the couples' relationships, with most effective impacts on communication, anger management and empathy (Cohen, 1988).

2.7.11 The South African Context

There is currently little available data on which types of treatment are being used by South African practitioners treating rape and CSA survivors, in a context where resources are far scarcer than in economically developed countries (Suffla, 2004). Harvey, Mitchell and Goredema (2008), in response to this lack of information, published a practical guide for South African trauma survivors and counsellors on dealing with the aftermath of trauma, based on their collective experiences working in the field of sexual assault and trauma treatment. This body of knowledge includes coping strategies to deal with the physical and emotional sequelae of rape, childhood sexual assault and other trauma. These include psychoeducation, access guides to local resources, symptom checklists to help survivors to identify and name feelings they may be experiencing, as well as practical exercises for symptom alleviation (Harvey et al., 2008). It specifically addresses coping strategies for the experience of fear, guilt, anger, grief, loss of self-esteem and loss of trust, and serves as a precursor or adjunct to professional support where this is indicated (Harvey et al., 2008). However, there is currently no research in the literature outlining and evaluating South African treatment interventions for survivors of rape and childhood sexual assault, and while internationally based empirical studies on treatment and intervention are useful, it has been noted throughout this review that their applicability to the local context is limited.

2.8 SOUTH AFRICAN NATIONAL POLICIES OF RESPONSE TO RAPE

In 1999, due to dissatisfaction by advocates for women's health regarding the quality of service provision following rape, a change in policy meant that South African rape survivors could be treated by any doctor instead of by state employed district surgeons (Christofides et al., 2005a). Although this brought some improvement to services, research has shown that the treatment of many rape survivors following assault remains inadequate (Christofides et al., 2005a). Since 1993, South Africa has also provided victim-oriented courts specially

dedicated to prosecuting sexual offences, which have improved, but to an inadequate degree, the legal service offered to rape survivors (Moore, 2005; Walker & Louw, 2003).

The introduction of the new sexual offences bill in 2007 brought necessary changes in legislation, including widening the definition of rape, replacing the common law offences of rape and sexual assault with statutory laws, affording greater protection to children and people with intellectual disabilities, providing preventative treatment for HIV ("Post-Exposure Prophylaxis" or PEP), and making provision for improved guidelines for the management of sexual offences by all professional and government agencies involved (Combrinck, 2006; Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, p. 23). Currently, survivors can report to their nearest health care facility, where they will be referred to a specialist clinic for free medical, psychological and forensic treatment (Cape Gateway, 2004). This includes a private interview and counselling with a trained health care worker, a medical examination with consent, the provision of treatment for sexually transmitted infections, the provision of emergency contraception within a specified time period, the provision of HIV counselling and PEP, and the opportunity for referral for further counselling (Cape Gateway, 2004).

According to Christofides, Muirhead, Jewkes, Penn-Kekana and Conco (2005*b*), many South African rape survivors choose not to utilise health services following rape. Possible reasons include limited choices regarding methods of treatment available within existing services and the negative experiences (secondary victimisation) reported by many rape survivors following contact with police and health care professionals (Christofides et al., 2005*b*; Suffla, 2004; Walker & Louw, 2003). For example, Christofides et al. (2005*a*) found that 32.6% of health care workers in their study did not classify rape as a "serious medical condition" (p. 495), and this was associated with decreased standards of care. Christofides et al. (2005*b*) report that access to HIV prophylaxis and HIV testing, access to counselling, and the provision of a thorough physical examination were identified as priorities for a sample of rural and urban South African women following rape. This research validates the need for timely provision of accessible and sensitive psychological support to survivors of rape.

CHAPTER 3

METHODOLOGY

3.1 AIMS

This study aims to document the clinical knowledge that has been gained by Rape Crisis counsellors in Cape Town. South Africa has been identified as having the highest prevalence of rape amongst comparative countries worldwide, and also has other significant challenges emerging from a history of racial oppression and rapid social transformation, high levels of poverty and unemployment, ongoing violence and traumatisation, and inadequate health care resources. South Africa's under-resourced and overburdened mental health care system means that NGO's such as Rape Crisis fulfil a critical role in the care and treatment of rape survivors. However, the clinical knowledge developed within these organisations has seldom been formally documented.

The vast majority of literature regarding treatment interventions for rape survivors has been conducted internationally. While international literature provides a useful starting platform, interventions demonstrating efficacy in economically developed countries cannot be uncritically adopted for use in our context. Local research exploring effective and feasible treatments for rape survivors is therefore imperative. The information gained in this study aims to contribute towards the development of a shared knowledge base of skills for managing the particular struggles faced by South African practitioners working with rape survivors.

3.2 EPISTEMOLOGICAL FRAMEWORK

3.2.1 Qualitative Research

White and Farmer (1992) argue that both qualitative and quantitative studies are important when studying sexual violence. This study focuses on counsellors' experiences, which are unique, personal, nuanced and subjective. This complexity of human experience is unlikely to be adequately explored using quantitative methods (Strauss & Corbin, 1990). Qualitative research was chosen as the appropriate methodological framework because of its ability to generate rich description of complex phenomena (Denzin & Lincoln, 1998; Marshall, 1996). The broad aim of the study is also to document clinical knowledge within the South African context in response to the paucity of local literature. This would not be adequately addressed through a quantitative approach because not enough is currently known for the generation

and testing of specific hypotheses. What is called for is an exploration and description of rape within the South African context in order to initiate the development of a knowledge base.

3.2.2 Phenomenological hermeneutics

The study was conducted from within a phenomenological hermeneutic epistemology. Phenomenology can be understood as a systematic approach to understanding human experience (including behaviour and “states of being”) and the ways in which that experience is constructed (Spinelli, 2005, p. 131). Rennie (2007) defines hermeneutics as “the interpretation of written and oral texts about matters that include human experience and social conduct” (p. 3). Consideration of the way that participants and researchers interpret experience is central to the phenomenological hermeneutic approach (Spinelli, 2005). This epistemological framework attempts to examine the way that experience is created through interactions between the self and others and to identify common threads underlying the ways in which many people make meaning (Schmidt, 2006; Spinelli, 2005). It adopts an “open [minded]” approach which seeks “increasingly adequate” explanations or meanings rather than absolute truths (Spinelli, 2005, p. 133-135). There is an attempt to look beyond the surface expression to try to discover multiple meanings while trying to ensure that interpretations continue to fit the data closely (Schmidt, 2006; Whitehead, 2004).

Phenomenological hermeneutics has been identified as the most appropriate epistemological framework for a descriptive and exploratory study (Whitehead, 2004). It was chosen for the current study as it allows the researcher to explore, describe, understand and interpret counsellors' experiences, while acknowledging the complexity and subjectivity of human interaction. This epistemological approach is particularly useful for considering the treatment of rape and childhood sexual assault because it acknowledges the ways that experience, including treatment and healing, is created inter-subjectively and is therefore influenced and constructed by both survivor and counsellor. It also enables recognition of and engagement with the uniqueness and depth of each counsellor's experience and each therapeutic relationship, yet allows for the discovery of commonalities across experiences in an attempt to inform future treatment practices.

3.2.3 Researcher reflexivity

One of the tenets of qualitative research is the importance of researcher reflexivity. Namely, that the researcher should incorporate an awareness of their own particular gender, class, race, culture and chosen “interpretive framework” (Denzin & Lincoln, 1998, p. 26), and

should be cognisant of their impact on the research process (Denzin & Lincoln, 1998; Whitehead, 2004). The aim is for the researcher to identify and suspend these pre-conceived socio-cultural ideas while simultaneously acknowledging and reflecting on how they influence understanding of the phenomena being researched (Spinelli, 2005). Whitehead (2004) acknowledges that for a researcher to completely suspend their bias is a near impossible task. In response to this dilemma she advocates for explicit researcher reflexivity (Whitehead, 2004). The phenomenological hermeneutic approach thus encouraged the researcher to consider and describe the ways in which her own position, experiences and preconceptions influenced the research process. In a later chapter, consideration is given to the ways in which these factors may have influenced the data generated and the various interpretations and conclusions drawn in the current study. Authors also recommend methodological transparency as part of, or along with, reflexivity (Pidgeon & Henwood, 1997; Rubin & Rubin, 1995; Whitehead, 2004). This allows the reader access to decision-making processes and enables them to assess the “trustworthiness” of knowledge generated from the data (Pidgeon & Henwood, 1997; Whitehead, 2004, p. 513). The present chapter therefore seeks to describe and explain the methodological decisions and steps taken in designing and carrying out the research, as well as during the process of data analysis.

3.3 STUDY DESIGN

The study is based on collective case studies. Yin (2003) defines a case study as “an empirical enquiry that investigates a contemporary phenomenon within its real-life context” (p. 13), particularly when there is a special interest in the impact of context on the phenomenon under study. He advocates the appropriateness of case studies when undertaking exploratory and descriptive research (Yin, 2003). Case studies are described as being richly descriptive and inductive (Sarroub, 2001), and although unable to provide information which is highly generalisable (Stake, 1995), are able to provide the type of data appropriate to the study of such personal and complex experiences. The use of collective case studies also preserves the depth of the data while increasing representation (Stake, 1995; Yin, 2003). The aim of the research to develop a data set which will be of use to other rape counsellors in South Africa, indicates the need for some degree of “transferability” of the findings, for example to inform the practice of counsellors in other organisations and in different geographical locations (Pidgeon & Henwood, 1997, p. 271).

3.4 SAMPLE

3.4.1 Selection of participants

The sample consisted of 11 participants from across the three Rape Crisis centres in Cape Town. Three counsellors and one counselling co-ordinator were interviewed from each of the Khayelitsha and Observatory Rape Crisis centres, and two counsellors and one counselling co-ordinator from the Gatesville centre. According to Stake (2006), multiple case studies often include between 4 and 15 cases in order to ensure that there is enough interactivity between cases, but within reasonable limits given the restraints of the researcher's resources. The sample size was therefore limited to 11.

Purposeful sampling was used to identify and select a rape counselling organisation to participate in this research. Rape Crisis was identified as an appropriate agency because of the organisation's important role in responding to the needs of rape survivors in South Africa. While purposeful sampling does not afford the same level of generalisability as random sampling, Stake (2000) argues that even in bigger collective case studies, the small sample size prevents random selection techniques, and at times "opportunity to learn" should be prioritised above representative sampling (p. 447). This is appropriate to a research area about which little is currently known.

Counsellors were chosen as participants because gaining access to rape survivors can be difficult and involves complex ethical considerations. Jewkes, Watts, Abrahams, Penn-Kekana and Garcia-Moreno (2000) identify research on gender based violence in Southern Africa as posing particular risks, including traumatisation for both respondents and researchers. Accessing counsellors rather than rape survivors is one way to circumvent such risks while still gaining valuable knowledge about the impact and treatment of rape.

A combination of purposeful and volunteer sampling was used to identify individual counsellors within the larger sample. Approximately the same number of counsellors from each Cape Town Rape Crisis office was included in the study in an attempt to represent the experiences of counsellors and rape survivors over a wider geographical area. The Counselling Co-ordinator from each centre was approached for inclusion because their lengthy experience of working in the organisation was thought likely to increase the richness of the data. According to Coyne (1997), purposeful sampling involves identifying particular respondents in line with the aims of the research, and can include criteria such as a person's role in an organisation. Counsellors who volunteered to participate in the research were then

approached. Counsellors' positions as volunteers within the Rape Crisis organisation led the researcher to only approach those who expressed willingness to participate following initial presentation of the research proposal to counsellors at each of the three centres. This was due to awareness of the level of commitment and amount of time already dedicated by volunteers to the organisation, as well as respect for the personal nature of elements of counselling work. The first three counsellors from each centre who volunteered were selected for participation.

3.4.2 Counsellor demographic information

Counsellors ranged in age from 29 to 58 years with an average age of 41 years. Their length of service with Rape Crisis varied from 1-11 years, with the average length of experience within the organisation being 4 ½ years. Counsellors' first languages and the languages in which they counsel differed slightly between the different centres. Of the counsellors from the Observatory and Gatesville centres, five were first language English speakers and two first language Afrikaans speakers. All but one counselled in both languages, and one counselled only in English. The Khayelitsha centre counsellors all spoke and counselled in isiXhosa primarily, however three of the four reported that they also counselled in English and all were competent English language speakers. No counsellors reported counselling in a third language; however several recalled having used an interpreter when working with non English, Afrikaans or isiXhosa speaking survivors. Generally counsellors reported being members of the communities serviced by the Rape Crisis Centre where they work or volunteer.

The majority of counsellors had experience of counselling for other organisations and had received training other than that offered by Rape Crisis. Additional training included degrees in Social Work, Sociology and Psychology, as well as counselling courses run by other NGO's, for example The Simelela Centre, Lifeline, FAMSA, NICRO, The Salvation Army, the Parents Centre and the Trauma Centre, amongst others. Four participants specifically reported having HIV/AIDS counselling training either through Rape Crisis or through external organisations. Two participants had experience counselling for a Christian organisation or a church. Two of the volunteers reported working full time for other NGO's and two reported having had experience facilitating groups outside of Rape Crisis. One participant had only experienced training through Rape Crisis.

3.5 INSTRUMENT

3.5.1 Semi-structured interview

Data were collected through the use of semi-structured interviews. Fontana and Frey (1998) describe interviewing as “one of the most common and most powerful ways we use to try to understand our fellow human beings” (p. 47) and Gillham (2000) notes the “richness and vividness of the material” that interviews are able to generate (p. 10). Interviews were chosen for this study in order to capture the richness of the lived experience of counsellors in their work with rape survivors. Qualitative interviewing allowed the researcher to capture both the idiosyncratic experiences, meanings and understandings of individual counsellors, as well as the commonalities across counsellors' narratives, in line with the epistemological framework and aims of the research (Rubin & Rubin, 1995). The personal nature of counsellors' work and experiences also called for the development of rapport and trust between researcher and counsellor during the research process. According to Gillham (2000), face to face interviews provide greater opportunity to build rapport and facilitate the development of trust compared with other methods, thus enabling the elicitation of good quality data. Although interviews have been identified as having certain methodological weaknesses, such as potential participant “response bias” or “poorly constructed questions” due to bias on the part of the researcher (Yin, 2003, p. 86), the advantages to interviewing were considered predominant.

Kvale (1996) describes the semi-structured interview as including a set of proposed questions, but with flexibility in terms of the order and the form in which they are presented. The researcher fluctuates between active guiding of the interview process and taking a more passive role in order to allow for less structured, participant-guided data collection (Rubin & Rubin, 1995). Semi-structured interviewing can thus be located on a continuum between structured and unstructured interviewing, facilitating the collection of certain demographic data while allowing the flexibility of pursuing and exploring themes in greater breadth as they arise (Fontana & Frey, 1998; Kvale, 1996). It further enables the researcher to clarify and explore alternative meanings and explanations offered, as well as to learn more about the context in which phenomena occur (Rubin & Rubin, 1995). Semi-structured interviews were deemed appropriate for the current study because the lack of available local knowledge necessitated open, unstructured exploration of counsellors' clinical experiences, while the aim to inform future clinical practice required a more structured exploration of trends and themes, all of which could be accommodated in a semi-structured interview. The use of a semi-structured interview is also congruent with the epistemological framework of the study.

3.5.2 Interview schedule

The way in which the semi-structured interview schedule was constructed and the interviews conducted reflects the phenomenological hermeneutic approach. Overall, questions were guided by the current literature; however the interview schedule was scaffolded in such a way that initial questions were very broad and non-specific. This was to elicit counsellors' own interpretations of the questions as well as allowing them to choose which experiences to prioritise. Only following further exploration of counsellors' chosen responses were more specific questions asked (Rubin & Rubin, 1995). These were based on the researcher's psychological knowledge of the effects of trauma as well as on the responses of participants who had been interviewed earlier in the research process, and sought to substantiate, broaden or challenge existing knowledge as a way of exploring multiple- or alternative meanings.

The interview began with questions about the counsellors' backgrounds and the demographic and socio-economic circumstances of their clients. Clients' ongoing stressors, such as additional trauma experiences, secondary traumatisation experiences or daily stressors were also explored. Questions regarding the types of rape experiences reported by clients were followed by an exploration of counsellors' observations of the psychological impact of rape on their clients. This exploration started with broad questions, which were then narrowed to enable a more structured consideration of the psychological impact of rape, including the kinds of psychiatric diagnoses that may have been given to clients by other professionals. Questions then explored the types of interventions offered by the counsellors, including the timeframes within which counsellors are expected to offer counselling. Counsellors were first asked to openly describe the counselling intervention model used as well as the specific types of support offered during counselling sessions. More structured questions then enquired about working with safety, symptom management, history taking as well as what aspects of treatment counsellors and clients have found most useful. Finally, the interview schedule included exploration of the particular struggles or difficulties experienced by counsellors in their work with rape survivors and the resources they draw on to assist their work. Issues of culture and language differences between counsellors and survivors were also considered.

3.5.3 Pilot interviews

Two pilot interviews were carried out in order to assess the suitability of the interview schedule. The schedule was then reworked and refined to incorporate new questions generated as a result of unanticipated participant responses, or to alter questions which were

experienced by the respondents as ambiguous or unsuitable. The use of pilot interviews for this purpose is recommended by Stake (1995) and Yin (2003).

3.6 PROCEDURE

Following the signing of a research agreement with Rape Crisis, the researcher presented the planned study at a group meeting at each of the three centres, in order to invite counsellors to participate in the research. This allowed counsellors to ask questions regarding the research and interview process. Counsellors were not immediately asked to indicate agreement to participate but were invited to contact their Counselling Co-ordinator should they be willing to be interviewed. Each Counselling Co-ordinator then forwarded the contact details of interested participants to the researcher, who contacted counsellors individually to initiate the interview process. In two of the centres all participants who volunteered were interviewed and at the third centre the first three participants who volunteered were recruited. Face to face interviews were carried out by the researcher at a pre-arranged time and at a location chosen by the participants. The majority of the interviews took place at the three Rape Crisis centres, one took place at a participant's place of work and another at a participant's home. Written consent was obtained from participants prior to each interview. Recording equipment was used to capture the data and the recorded material was then transcribed and checked for accuracy before the process of analysis began.

3.7 DATA ANALYSIS

Grounded theory was identified as providing the most appropriate method of analysis for use in this study. Grounded theory involves inducing themes from the data collected in research in order to generate theory (Coyne, 1997), through "continuous interplay between analysis and data collection" (Strauss & Corbin, 1998). This method of analysis was chosen because the inductive nature of grounded theory means that it generates meaning categories out of the data rather than comparing data to a set of predetermined categories, which is particularly useful when seeking to explore and describe phenomena about which little is known. It is also able to "capture the complexity of problems and the richness of everyday life" (Corbin, 1986, p. 91). Strauss and Corbin (1998) also advocate for grounded theories to be used to provide positive practical implications for a wider group of people, and the information generated in this study is intended to be of practical use to rape counsellors in South Africa. Grounded theory methodology is also congruent with the epistemological framework of the study. For example, it is an appropriate methodology for identifying and exploring alternative meanings in participants' responses while remaining close to the data, it recognises the inter-subjective

construction of reality, it understands that interpretations are relative, it espouses researcher reflexivity and it encourages methodological transparency through explicit descriptions of decision-making in order to promote “trustworthiness” (Charmaz, 2000; Pidgeon & Henwood, 1997, p. 272).

The Grounded Theory Method (GTM) first emerged in North America in the mid 1960's (Bryant & Charmaz, 2007a; Strauss & Corbin, 1998). It was developed within the context of the emergence of a constructivist epistemology in response to scientific positivism (Charmaz, 2000; Pidgeon & Henwood, 1997), and was generated as an attempt to address the observed disparity between theory and the predominantly quantitative research of the time (Charmaz, 2000; Strauss & Corbin, 1998). A qualitative approach which accommodated the ways in which subjective perspectives influence knowledge, but with sufficient structure to satisfy concerns regarding validity and reliability was deemed necessary to fill this gap (Bryant & Charmaz, 2007b; Charmaz, 2000).

GTM provides specific techniques and procedures for managing large amounts of qualitative data (Pidgeon & Henwood, 1997). Grounded theory analysis techniques were used to code and categorise the data in order to identify trends, themes and differences amongst counsellors' experiences. Strauss and Corbin (1990) define concepts as “conceptual labels placed on discrete happenings, events, and other instances of phenomena” and categorisation as the “classification of concepts... under a higher order, more abstract concept” based on similarities and differences (p. 61). Following grounded theory data analysis techniques, each transcript was closely read several times in order to identify codes, or labels identifying key and secondary themes or concepts (Pidgeon & Henwood, 1997). Strauss and Corbin (1990) advocate for the use of “line-by-line analysis” in order to maximise the identification of concepts (p. 72). The concepts were then grouped into categories based on related and divergent elements (Corbin, 1986; Strauss & Corbin, 1990; Swanson, 1986). Each category was considered in terms of its “properties... attributes or characteristics” as well as its “dimensional profile” (Strauss & Corbin, 1990, p. 69-70) or the way that it changes under different circumstances (Swanson, 1986). The identified codes and categories were developed and refined as more data was analysed (Charmaz, 2000; Pidgeon & Henwood, 1997; Ryan & Bernard, 2000), with careful attention being paid to maintaining a balance between “maximum flexibility in generating new categories” and ensuring congruity between categories and data (Pidgeon & Henwood, 1997, p. 256). The category names were either taken directly from the data or from the relevant literature, or were developed from an

interrogation of the relationships between identified concepts (Charmaz, 2000; Corbin, 1986; Strauss & Corbin, 1990).

The constant comparison method was used throughout the process of analysis to compare coding categories identified within and across the case studies, as well as in relating the categories to each other (Charmaz, 2000; Ryan & Bernard, 2000). This involved identifying similarities and differences between themes or concepts and identifying how they related to the categories being explored (Corbin, 1986; Pidgeon & Henwood, 1997; Strauss & Corbin, 1990). For example, sub-categories were identified in order to better understand particular conditions or processes which might give rise to a specific category or phenomenon (Corbin, 1986; Strauss & Corbin, 1990). The ways in which categories or phenomena were related or divergent and the possible reasons for this were also considered (Strauss & Corbin, 1990), however in the present study associations between categories were noted but could not necessarily be explained, because of the limitations of the data collected.

3.8 ETHICAL CONSIDERATIONS

The research proposal was presented to the Rape Crisis Centre in Cape Town for ethical approval and a research agreement was signed with the organisation. Written informed consent was sought from each participant prior to the interview. Because counsellors, rather than rape survivors, were interviewed, the risks to participants were minimised. Participants' accounts have been kept anonymous in order to enhance confidentiality, including any distinctive information about clients. Where there was a need, transport costs were reimbursed. The interview data were stored on the researcher's personal computer and transcripts were kept at the researcher's home in order to secure confidentiality. The research findings will be made available to Rape Crisis and the hope is that counsellors will benefit from having access to detailed information about clinical observations of the impact of rape, and the treatments being offered and the resources being utilised by other counsellors. Given the small sample size and the fact that the only three counselling co-ordinators working in Cape Town were all interviewed, complete confidentiality could not be assured. Participants were informed of this as part of the process of obtaining written consent.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 INTRODUCTION

This chapter first presents demographic information about the clients seen by Rape Crisis counsellors and the type of rape experiences they report. It then considers the observed psychological impact of rape and CSA before providing a description of the treatment offered by counsellors. Finally, additional factors impacting on counselling and the reported outcomes of treatment are considered. Because of limited space, only the themes appearing in at least three or more of the interviews are discussed. Examples of excerpts from the interviews are included in order to illustrate and verify the findings presented.

4.2 CLIENT DEMOGRAPHIC INFORMATION

This section aims to contextualise the work being done by the counsellors, rather than to provide a comprehensive profile of Rape Crisis clients. The reported age range of clients seen by counsellors varied widely from 14 up until the age of approximately 80 years. Although there were differences between counsellors within each centre, on the whole counsellors at the Khayelitsha and Gatesville centres reported seeing mostly adolescent survivors, while counsellors in Observatory reported seeing mostly adults. The vast majority of clients were women; however several counsellors had counselled between one and six male rape survivors or male family members. Counsellors at Observatory and Gatesville reported having primarily English and Afrikaans speaking clients and the vast majority of clients presenting at the Khayelitsha centre were first language isiXhosa speakers. Counsellors from Observatory also reported having seen an increase in refugees at their centre following the xenophobic attacks over the last few years, necessitating the use of interpreters.

Clients presenting at the Observatory centre were from the widest geographical area, ranging from very affluent neighbourhoods to informal settlements. The clients seen at the Gatesville centre were usually from the Cape Flats area, otherwise Nyanga or Gugulethu, and the large majority of those presenting to the Khayelitsha centre were from Khayelitsha itself, with some clients also travelling from areas of the Cape Flats. On the whole, very few clients had a tertiary education. Some had achieved a Grade 12 level of education or were still attending school. Many adult clients were unemployed. For those working, occupations were usually semi-skilled or unskilled, such as domestic work or factory work, however counsellors did

report having seen some professional or self-employed clients, for example nurses, teachers or psychologists.

4.3 TYPES OF RAPE EXPERIENCES REPORTED

In addition to penetrative rape and CSA, counsellors also referred to survivors having experienced attempted rape as well as forced oral sex. Although information on the types of rape experiences reported to counsellors was not collected quantitatively, the following trends were identified from the data. All eleven of the counsellors reported having seen clients with a history of CSA. Survivors of rape in adulthood more commonly reported multiple rapes by different perpetrators (re-traumatisation) than single incidences of rape. Eight counsellors had seen at least one survivor of gang rape, although rape by single perpetrators was more commonly described. The majority of perpetrators were reportedly known to the survivors, which has been identified by Harvey and Herman (1992) as negatively impacting on survivors' post-rape adjustment. Of the known perpetrators, most were family members (including fathers, stepfathers, grandfathers, uncles and brothers) followed by family friends, (ex)boyfriends, acquaintances, neighbours, community figures (such as church elders or policemen) and friends.

With regard to the contexts in which rapes occurred, all eleven counsellors reported that many of the rapes and incidences of CSA took place in survivors' own homes. Ellis (1983) has previously highlighted in the literature how survivors assaulted in their homes tend to feel unsafe in almost all environments. All eleven counsellors described public transport related rapes, ten reported drug assisted rapes, eight referred to rapes taking place at clubs or social gatherings and five described the assaults taking place outside, for example in fields or between shacks. Seven counsellors described the use of weapons or objects (such as bottles, knives and guns) during the rape, leading to sometimes severe physical injuries for their clients such as cuts, burns and bruises, or resulting in physical complications, for example having the womb removed. Five counsellors reported that perpetrators used verbal threats during the sexual assault, including threatening to kill the survivor or members of her family. Some researchers have demonstrated an association between greater perceived threat during an assault or greater physical injuries sustained and post-rape maladjustment (Acierno et al., 1999; Resick, 1993; Ullman et al., 2007a; Wyatt et al., 1990; Yuan et al., 2006). According to counsellors, most clients sought help months to years following the rape or CSA. Some exceptions included adolescent survivors who were sent for treatment by caregivers immediately following the rape.

4.4 THE PSYCHOLOGICAL IMPACT OF RAPE AND CHILDHOOD SEXUAL ASSAULT

This section describes the psychological impact of rape and childhood sexual assault (CSA) on survivors as observed by the counsellors. It begins by outlining the contextual factors impacting on survivors' post-rape adjustment before considering the emotional, interpersonal and cognitive impact of sexual assault, the negative effect on survivors' functioning, the physiological and somatic sequelae of rape and CSA, the PTSD symptomatology and other indicators of psychopathology displayed by survivors, as well as changes in survivors' behaviour. Included is a description of survivors' attempts at coping, their observed resilience, the extent and longevity of post-rape symptoms and some of the complicating sequelae of sexual assault.

4.4.1 Contextual factors impacting on survivors' post-rape adjustment

Prior to consideration of the psychological impact of rape and CSA, it is important to outline the socio-economic and interpersonal context in which many survivors in Cape Town are grappling with post-rape adjustment.

Multiple traumatisation

All eleven counsellors referred to having had clients who either presented with or later disclosed the experience of CSA. Eight counsellors reported having worked with clients with ongoing (or a history of) domestic violence by a partner, and eight described having had clients who experience (or have a history of) physical or emotional abuse and/or neglect. As a result, all eleven counsellors had worked with clients who had been multiply traumatised (had experienced rape or CSA as well as one or more other forms of interpersonal violence).

The experience of ongoing stressors

Ten counsellors described working with survivors living in conditions of poverty, including inadequate or over-crowded housing. Ten counsellors identified HIV/AIDS as an ongoing stressor faced by their clients, including survivors or their family members being sero-positive, or survivors having lost a parent to HIV/AIDS. Seven counsellors referred to clients experiencing ongoing relational difficulties in the home, which resulted in poor family support, five referred to survivors with a previous history of psychopathology, and four described survivors living in single parent families. All eleven counsellors had therefore worked with clients who had experienced ongoing stressors in addition to dealing with the impact of rape or CSA.

These contextual factors reflect Williams et al.'s (2007) findings that just over half of the participants in their national South African survey had experienced multiple traumatic events during their lifetime. While it is not clear exactly what impact these experiences had on survivors' post-rape adjustment in the present study, research has associated the presence of a trauma history, including CSA, and/or the experience of ongoing stressors with increased psychological distress following rape in adulthood (Ellis, 1983; Ullman et al., 2007; Williams et al., 2007). Cloitre et al. (2009) particularly found a significant association between cumulative experiences of trauma during childhood and adulthood and symptom complexity in adulthood. Feminist theorists have similarly identified the ways in which traumatic stress results not only from the experience of threat to personal safety, but also from interpersonal and social responses as well as political and economic forces (Brown, 2004; Cohen, 2008; Lebowitz & Roth, 1994). King et al. (2004) have also reported an association between adolescents living in single parent families or families with one step parent as being at increased risk for sexual abuse.

4.4.2 The emotional impact of rape and childhood sexual assault

Emotional presentation

Fear was identified by all eleven counsellors as a common emotional response to rape and CSA. Fear included survivors generally feeling unsafe, experiencing generalised fear when faced with reminders of the rape and fear of re-victimisation. Four counsellors also described survivors feeling that others could see they have been raped, which was at times connected to feelings of vulnerability.

Counsellor 11 – “Yes, well the fear is always there the anger and the fear is very prevalent, I mean always there most of the time... I can't remember not seeing an angry person and a fearful person for counselling... Every aspect, going back to school, finding a job it affects every aspect of their life”.

Counsellor 1 – “Fear has been a massive threat to a lot of survivors... you know fear of will it happen again, what can I do, what can I not do... It spills over into a confidence issue as well, and spills into a kind of daily anxiety about life and about working situations and relationships and whatever else”.

Counsellor 6 – “And the other one was saying to me, it is like someone saw you when you are walking, it is like there is something that attracts people to her, that say this person was raped and then he will again – it will attract this other person to come and rape you”.

Additional emotional responses to rape and CSA included anger, identified by eleven counsellors, tearfulness, identified by seven counsellors, anxiety (including panic attacks) identified by six counsellors, and frustration and nameless or unidentifiable affect all identified across four of the eleven interviews.

Counsellor 3 – “ Very angry, bitterness... But anger and bitter, it is one of the main – especially anger, a lot of them are very, very angry”.

Counsellor 4 – “...there’s a lot of crying more often than usual”.

Counsellor 10 – “Some of them have like the anxiety, I know”.

Counsellor 2 – “Ag, frustration, but I think you know that shame and guilt and humiliation, and the anger. Sometimes it is – the anger is not right after it, sometimes it is just bubbling. And often the frustration is aimed at themselves or aimed at not feeling like they can get the support that they want or need at the time”.

Counsellor 1 – “...and you know, people who talk about these massive overwhelming feelings that are so huge and so murky that they can’t even pull out you know, this is anger, and this is shame and this is depression and this is fear, it is just this kind of murk of nameless feelings”.

Fear, anger, tearfulness and anxiety have all been identified in international research as common emotional responses to rape (Choquet et al., 1997; Ellis, 1983; Foa & Rothbaum, 1998; Resick, 1993; Rothbaum et al., 1992). Fear of rape related situations has been particularly identified as one of the most enduring post-rape symptoms (Foa & Rothbaum, 1998; Rothbaum et al., 1992). However, eight of the eleven counsellors reported survivors having ongoing contact with the perpetrator, for example, four counsellors referred to survivors who continued to live with the perpetrators because of financial dependence. This is likely to have an impact on survivors' emotional presentation, and particularly their experiences of fear, following the assault.

Feelings towards the self

Ten of the eleven counsellors reported that survivors they worked with blamed themselves following rape and CSA. Survivors' self-blame generally resembled the behavioural self-blame described by Janoff-Bulman (1979), and at times reflected attempts at finding meaning or reason for the trauma as reported by Burgess and Holmstrom (1979). However, contrary to helping survivors find meaning, their self-blame was noted by some counsellors to negatively

impact on their self-concept. For example, nine counsellors described survivors' feelings of shame and seven identified feelings of guilt, both of which were at times related to survivors' self-blame. Calhoun, Cann and Selby (1981, as cited in King & Webb, 1981) similarly describe guilt and shame as often being related to survivors' self-blame. Five of the eleven counsellors also reported survivors being self-critical as well as loss of self-esteem, which was either connected to self-blame or was associated with how survivors perceived that they were managing their healing process.

Counsellor 10 – “But it is more self-blame and guilt, because they have got to deal with the reality of what has happened and if only, you know, that is always, if only I did not go into that, if only I was more informed, if only I had known. So there is a lot of self rejection that they present after the rape”.

Counsellor 11 – “Well obviously there is complete loss of self-esteem and there is or you know to some degree, so the fact that um... they take the blame... You know it's all that 'why's', all those questions that they have, so it all boils down to them totally taking the blame”.

Counsellor 1 – “...anger, shame, and a lot about the shame is you know, how could I have let this happen conversation ...but also highly critical like you know there will always be the concentration on what I didn't do and what I haven't done and what I haven't managed, rather than what I have accomplished and what I have made and what I have done and what I have survived”.

Ten of the eleven counsellors referred to having worked with some survivors who received support from those in their family and community. However, counsellors reported that not all support offered to survivors was experienced by them as helpful. Social support has been identified in the literature as having a complicated relationship with post-trauma recovery. For example, Borja et al. (2006) describe how some kinds of social support can be interpreted by survivors as positive and others as negative. Negative social support includes reactions by others which are based on good intentions but don't meet the survivor's needs, or reactions which are over-controlling of the survivor (Borja et al., 2006). Linley and Joseph (2004) also reported that support satisfaction rather than social support per se was associated with post-traumatic growth. Some survivors' emotional presentation, self-blame and negative self-concept should therefore be understood as occurring within a context of poor support and negative responses to disclosure of rape or CSA, occurring on family, community and societal levels. For example, all eleven counsellors described having worked with survivors who were blamed or held responsible for the rape.

Counsellor 11 – “... what I find, because I was at the court as well is that children then don't know whether they, they blame themselves because they went willingly and they, people are telling them 'it is your fault because you went with them, you went with the guy we saw you with him' and maybe they had gifts or whatever so everyone would convince this child that you know you have some blame”.

Counsellor 8 – “Because you still find communities that does not believe even that takes place, there will be questions what kind of a woman you are, where you were, what you were wearing, what you had done to provoke the rapist... And then of course in families as well, you still find families that totally would not really want to support a little girl who went out on her own, and it is like something that you have invited to yourself”.

Similarly, six counsellors described survivors not being believed following disclosure.

Counsellor 7 – “When she mentioned that 'I was raped by this guy, he always raped me when you go to work', she will beat her and said 'you are telling lies'”.

Counsellor 8 – “...when she came out, the whole community was against her, was against her because they never wanted to believe that she really was raped. In [their] mind she was involved with him... So in her anger now, what really took her back to the trauma, it is because she never could believe that actually older people in that community could actually turn the whole rape scenario against her”.

Seven counsellors also spoke about different social understandings of rape, including rape myths and lack of understanding about what constitutes rape or CSA, or about post-rape adjustment. These factors may inform others' responses to survivors and/ or impact on survivors' post-rape adjustment.

Counsellor 8 – “Of course I have been through a trauma, but then people will always measure rape as the lesser trauma to somebody. So maybe that is why it is hard for people to understand what really rape does to one person, whilst you change in life, people won't understand why”.

Counsellor 9 – “...they got raped by a taxi driver, friends would say 'but you knew what he was like' so her day at school, having to be around 'taxi queen' and 'you knew what he was about' and whatever and 'how can you say that he raped you' and whatever so they are having to deal with that at school”.

The degree of reported disbelief, blame and lack of understanding is likely to impact on survivors' tendencies to blame themselves. Harvey (1996) similarly described how the

attitudes, behaviours and responses of those in a survivors' social environment, including family members, friends, community members and wider society, impacts on their post-rape adjustment, and Thompson (2000) reported that survivors' self-blame was influenced by social views on rape, including rape myths.

4.4.3 Interpersonal impact of rape and childhood sexual assault

Social isolation

The most frequently described impact of rape and CSA on survivors' interpersonal relationships was that of social isolation. Social isolation was referred to by all eleven counsellors and included social withdrawal by the survivor as well as enforced isolation by others. Social withdrawal was often associated with loss of trust in others, which was described by ten of the eleven counsellors. Survivors' loss of trust also led to difficulty with sustaining relationships, as well as manifesting in, and negatively impacting on, her ability to form new relationships. In particular, survivors were described by six counsellors as withdrawing from contact with men following rape or CSA, and disrupted sexual functioning was reported across four of the interviews.

Counsellor 10 – “And like I said, they go into isolation, they do not really come out and share openly, they have lost that freedom of just being free, so you'll find them very lonely, they don't really – not even with the parent or anyone close immediately. The only way that they can find trust with anyone is that they just have to take that step you know, and have in mind the knowledge that it could be broken again, you know”.

Counsellor 1 – “...she has isolated herself from a bunch of her friends because she doesn't trust them... She doesn't trust what they will do with the information she gives, she doesn't trust you know that they will be sensitive to what is going on with her and going through the process of now trying to get her to make new friends is really, really difficult. She doesn't know how to do it, she doesn't know where to start”.

Counsellor 3 – “Yes, they are not very trustworthy you know, especially if it was a known person, known to the family, known to her, they are not very trustworthy, they don't socialise anymore as they used to... they find it very, very difficult. Most of them actually turn – they begin hating men”.

The impact of rape and CSA on survivors' interpersonal functioning, particularly social withdrawal and loss of trust, was again reported within the context of other's responses to their disclosure of the assault. In addition to the blame and lack of belief of survivors (as

reported above), seven counsellors described how following disclosure survivors were rejected by those around them, at times in favour of offering support to the perpetrator. Wyatt and Notgrass (1990) discuss how blame and lack of support from those to whom the rape is disclosed is likely to negatively impact on the survivor's ability to trust others.

Counsellor 3 – “They do not believe, just deny it you know. Mothers do not want – she actually asked to do a phone call to the parents, they just said ‘I’m sorry I am sorry, I can’t come, I don’t believe her, she is a little trouble maker, I don’t want her in my house’ and things like that”.

Counsellor 4 – “...particularly in cases of incest and things like that they um... the entire family will drop the client and support the perpetrator so they become completely isolated from the family”.

Although the eleven counsellors all reported that survivors they worked with had disclosed the rape or CSA to a trusted other, nine indicated that they often choose not to disclose to family members, including, in the case of adolescents, their parents. Six counsellors also described survivors' fear of others' responses to disclosure. It is therefore possible that survivors not only withdraw from social contact as a psychological consequence of the sexual assault, but may also be forced into isolation through fear of disclosure and/or others' rejecting responses. The above excerpts also suggest the possibility that factors such as poverty or financial dependence on perpetrators might have an influence on others' responses to disclosure.

Negative impact on caregiver role

Four counsellors also described rape as having a negative impact on the survivor's care-giving capacity, for example her ability to care for her family and children in an empathic manner. This was at times attributed to symptoms such as depression or to survivors' attempts at managing their symptoms interfering with their care-giving capacities.

Counsellor 10 – “...there is a lot of irritation, they are limited in the way that they care for their loved ones because like I said, they have got so much internal emotions that they have got to work through, so they are not really at a place that they could give of themselves more in a caring way, so it does bring a strain on the partners”.

4.4.4 Cognitive impact

Disruption in beliefs about self and the world

Counsellors also reported alterations in survivors' views and beliefs about themselves and the world. For example, six counsellors described some survivors' feelings of helplessness and powerlessness, both in terms of being able to protect themselves and being able to manage their symptoms.

Counsellor 2 – “And just like feeling stuck, you know feeling really stuck, not being able to... feeling absolutely helpless and stuck. Feeling as though there is no sense of control in my life, yes”.

Counsellor 3 – “...then it is like I am hopeless. I can't do – I couldn't even protect myself you know, that hopelessness comes up a lot”.

Five out of the eleven counsellors described survivors' beliefs that the world had been irrevocably altered, for example their sense that the world is no longer a safe or benevolent place.

Counsellor 1 – “I think it is you know, one of the things about rape and you – most of us have a world view, like the world is a fundamentally beneficial place, like whatever your belief system is. But fundamentally people are out there to do good. I think most of us have that, no matter what our circumstances. And I think what trauma and repeated trauma does is take away your trust in the world as a beneficial place or a place where people are out to do good”.

Counsellor 4 – “Quite often when they come here they feel that they aren't the same person anymore, 'who are they', 'what is the world' ...and they feel like the world has changed and they're no longer a part of it... a part of the normal world”.

The above cognitive alterations were also associated with a sense of apathy, possibly also related to symptoms of either depression or PTSD. For example, seven counsellors described survivors believing their lives had come to an end or were no longer worth living following the rape. Seven counsellors also described survivors' post-rape beliefs that they no longer had a positive future.

Counsellor 11 – “Ja, basically because they have stopped living you know, they have given up on being a person again...”

Counsellor 10 - "...in her own words she said, she does not have – she does not look out to the future, she does not look ahead because if this could have happened, you know what more, like life was not worth it anymore, there is no positive outlook on the future".

The reported disrupted beliefs about self and the world resemble the accommodation process described by Resick & Schnicke (1993) in information processing theory, where a survivor tries to reconcile her traumatic experience, which is incongruous with existing schemas, by adapting her beliefs about self, others and the world. Frazier (2003, as cited in Yuan et al., 2006) linked survivors' perceived lack of control over their recovery or over future victimisation with poor post-rape recovery.

While counsellors at times linked survivors' sense of powerlessness directly to the rape experience, six counsellors also described the ways in which people in the survivor's support network removed their autonomy following disclosure of the rape by, for example, making decisions on their behalf or becoming overprotective. This happened particularly with adolescent rape survivors. Six counsellors also referred to those around the survivor imposing their own ideas about appropriate traumatic responses.

Counsellor 3 – "She wants to do everything for her daughter. Now she crowds her daughter, she takes her to school, she go fetch her, when she wants to go to the mall, she is there, she walks around you know, so that is a bit – you know, she feels that, 'I can't' you know".

Counsellor 9 – "...they want their girls to now sit in the corner now because she's been raped they don't understand the behaviour if the survivor is still normal they are thinking the survivor must be sitting in the corner or whatever, or of the child is too outspoken they think there is something wrong and all of a sudden the child must be in by 7 o'clock and the child can't go to the gate anymore the child mustn't befriend, the child can't go to the shop anymore...".

While these responses were often described as well intentioned, they are likely to have had an additional impact on survivors' sense of powerlessness. Foa and Rothbaum (1998) acknowledge that post-trauma experiences can influence the development of faulty schemas following rape.

4.4.5 Impaired ability to function

All eleven counsellors identified a reduction in survivors' abilities to function at work, at school or doing other tasks of daily living, at times leading to school or work avoidance. This was often linked to difficulties with concentration, which was reported by nine counsellors as one of the sequelae of rape and CSA.

Counsellor 11 – "... they can't concentrate then they come to that when they can't concentrate in class and they know they've got a problem and then they rather not go to school".

Counsellor 2 – "...sometimes it does have a profound affect on their ability to function while at work, because they can't concentrate, they really are having difficulty with concentrating".

Booley (2007) similarly reported the negative impact of rape on work performance for a group of South African survivors. Seven counsellors also linked survivors' reduced functioning to a restriction in their lifestyle resulting from fear, and three linked it to survivors' attempts at avoiding rape reminders.

Counsellor 11 – "Every aspect, going back to school, finding a job it affects every aspect of their life. Some girls will say, like an adult will come in, maybe a girl of 24 I've never worked again. You know that kind of thing. Just the thought of getting back on the train or getting back or going back to work or something just scares them so much".

Counsellor 4 – "...they don't feel able to do the things they used to do like go out to the movies because they get afraid of the dark or who's going to be there or walking... taking public transport is usually a big issues because it's so dangerous so that either means they have to go through the daily terror of taking the taxi or the train or they stop using it and lose their jobs".

Initially, these fears resemble the pathological fear structures, behavioural avoidance and related lifestyle restriction noted in the literature on cognitive behavioural theories of the impact of rape (Foa & Rothbaum, 1998; Kilpatrick et al., 1981; Kilpatrick et al., 1985). However, as De Swardt (2006) has noted, the high levels of violent crime in South Africa may necessitate reconceptualising avoidance behaviour as strategic decisions of safety as opposed to avoidance symptoms. Each survivor's individual circumstance would therefore need careful exploration and assessment to ascertain whether avoidance behaviours are adaptive or maladaptive.

4.4.6 Physiological and somatic symptoms

All eleven counsellors identified sleep disturbances as one of the common physical sequelae of rape and CSA reported by survivors, which could also be part of PTSD symptomatology. Disturbances in eating patterns, including overeating and loss of appetite were also reported by eight counsellors, two of which described survivors having developed diagnosed eating disorders. Two counsellors described how for some survivors, eating disturbances were a direct result of traumatic associations between the act of ingesting food and the rape trauma.

Counsellor 6 – "...they say so, I sleep at 6pm, at 6pm – the whole night I was not sleeping, I was thinking about this. That is what they say".

Counsellor 3 – "I have one client currently that has actually developed an eating disorder... she weighs 31 kilo's. So she can't eat, she can't keep anything down you know, that is what she say".

Counsellor 10- "...those that presented not being – you know, not eating well, were the ones that was orally forced to have sex with the perpetrator. So they have problems swallowing and digesting, because it keeps on bringing out little memory, you know flashes of what happened. So they are repulsed by the food that they eat because of the force of the swallow of the act".

Eight counsellors described headaches as well as other physical pain, including stomach and back pain as additional physiological sequelae of rape and CSA. Sometimes pain was described as directly resulting from the assault and at other times it was described as ongoing.

Counsellor 3 – "Yes. Yes, especially headaches, lots and lots of headaches and abdominal pain or stomach pains, or just feel that there is pain there all the time, but when they go to the doctor there is actually no pain. Back pain is also one of the high rates that they also have..."

Counsellor 6 – "Headaches and panic attacks and shoulders, they will always cry about that. Even their stomach... She will say, I have got a pain in my stomach, I don't know what is happening, my stomach is upset always, ever since this thing happened".

Eating and sleeping disturbances, headaches and physical pain have all been reported internationally as common symptoms following rape (Ellis, 1993; Kimerling & Calhoun, 1994; King & Webb, 1981).

4.4.7 Symptoms of Post Traumatic Stress Disorder

Only one counsellor referred to a survivor who had been given a diagnosis of Post Traumatic Stress Disorder (PTSD). However, in addition to general feelings of anxiety and fear described elsewhere, almost all of the characteristic symptoms of PTSD were referred to throughout the interviews, indicating that survivors may experience a range of PTSD symptomatology at varying sub-clinical levels. It is also possible however, that counsellors are not trained in psychiatric diagnoses and would therefore not recognise particular constellations of symptoms as PTSD, or, that because of their particular training, counsellors conceptualise symptoms as constellating Rape Trauma Syndrome (RTS) rather than PTSD. Alternatively, the feminist epistemological framework of Rape Crisis counsellors may mean that they choose not to identify particular symptoms as constellating PTSD because of the potential pathologising implications of this diagnosis (Stefan, 2004). It is therefore possible that some survivors evidencing these symptoms might qualify for a diagnosis of PTSD. These findings are in line with Kaminer et al.'s (2008) findings that the experience of sexual violence is associated with a higher risk of developing of PTSD in South African women than exposure to other traumas, as well as with reports in international literature that PTSD is a common sequelae of sexual assault (Campbell & Wasco, 1993; Faravelli et al., 2004; Foa & Rothbaum, 1998; Hansson, 1993; Hartman & Burgess, 1993; Harvey & Herman, 1992; Resick, 1993; Steketee & Foa, 1987; White & Rollins, 1981; Wilson, 2010; Yuan et al., 2006).

In relation to re-experiencing symptoms, nine counsellors described survivors experiencing intrusive thoughts or memories of the rape, including sensory memories.

Counsellor 10 - "They clearly can remember, it is like just flashes of memory that is triggered with a song, if it took place in a club or in a social gathering, a kind of drink and you know perfumes, things like that. So it does bring back the memory of the rape, so they do try and avoid".

Counsellor 2 - "I think the most problematic thing - you know it could be either that they are struggling to get to sleep because now I am in bed and all my defences are down and my brain is just working things out all the time. So there is this constant thought about the rape or about other circumstances, or about the effects".

Ten counsellors described survivors experiencing flashbacks, and eight reported nightmares.

Counsellor 4 – “Well Rape Trauma Syndrome, I think because they often experience a lot of those, particularly the nightmares, the flashbacks”.

Counsellor 8 – “So there will be some flashbacks that you saw, doesn't really know how to put the pieces together because of the shock that a person was in”.

Counsellor 7 – “They have got night fears also, it is what they used to mention. Sometimes if the rape has just happened recently, and the client is saying, ‘I do not sleep for maybe two weeks, I cannot sleep, it is difficult for me to sleep, when I start sleeping this nightmare comes, it is like this man is here now in the house, raping me again’ ”.

Counsellor 5 – “Some of them, they are not coping that now, it is taking a long time, they are thinking about that thing, if they were dreaming they are dreaming about this thing, maybe if they were sleeping and they just sleep, but their minds are always working at night”.

As previously mentioned, five counsellors described survivors' experiences of fear or distress when faced with traumatic reminders.

Counsellor 3 – “...and she saw this man, and this man looked... not exactly, but he looked similar to the rapist, she freaked, she was screaming...”

With regard to avoidance symptoms, all eleven counsellors referred to survivors avoiding thoughts, memories or external rape reminders.

Counsellor 2 – “...definitely ja if you think someone who has been raped on a taxi she never wants to take a taxi again or going past the bushes where you were taken to and maybe that's part of your route some anyway so you have to go past there or um, ja no definitely they try and avoid it”.

Counsellor 7 – “Because sometimes the discussion, the topic is about rape, you know, and then she said, ‘I just decided to pull off, you know, I am not interested in their talking’. Or at home, if she is watching TV and there is a film that is similar maybe to the rape, ‘I just leave people sitting there in the dining room and I go sleep’, things like that”.

Ten also referred to survivors' fear or avoidance of talking about the rape trauma or any associated feelings; however it should be noted that, in contrast, six counsellors also referred to some survivors who were able to and chose to narrate their traumatic experiences.

Counsellor 3 – “Definitely avoid talking about it. I have seen a client for 16 sessions, she hasn't mentioned rape once. She talked about everything else but the rape, you know”.

Counsellor 7 – “They avoid sometimes to talk, they avoid... I think one or two clients, they mentioned themselves that I am just here, but even now I don't want to talk about this rape, you know”.

Nine of the eleven counsellors reported clients being unable to remember certain aspects of the traumatic experience, and three indicated that amnesia for aspects of the sexual trauma was more pronounced in survivors of CSA compared with survivors of adult rape. This reflects the increased dissociation of trauma memories described by Courtois et al. (2009) in survivors of complex trauma.

Counsellor 11 – “They'll often tell you that they, they'll often say ‘I don't know what happened’... like they'll say ‘it happened and I sort of just I was lying there and I looked and I was back home and I don't know how I got home’”.

Counsellor 1 – “...with her childhood sexual assault experience, you know she says she gets little flashes of it but she doesn't have the whole thing in her mind. So you know, her being somebody who had that experience who really dissociates... So the bits of it that she remember, it is like she remembers the smell and she can remember particular sensations...”

Eight counsellors also referred to survivors' experiencing emotional numbing. As described above, counsellors also reported that some of their clients had ceased to live their lives, and this sense of apathy, along with some of the depressive symptoms described by counsellors (see section on 'Other psychopathology and related symptoms' below), might be considered to represent anhedonia in survivors. Survivors' previously mentioned lack of a sense of future could also be considered one of the avoidance symptoms of PTSD. In addition, four counsellors described how survivors felt disconnected from others and at times no longer human.

Counsellor 4 – “...they'll say that, they'll use the word numb sometimes or ‘I don't feel like I can feel anything’...”

Counsellor 6 – “Mm, that is what they always say, ‘I feel like I am not alive, I am not a person and I don't think I can help anyone, I feel numb’, it is like that”.

The increased arousal symptoms of PTSD were also referred to by counsellors. As mentioned elsewhere, eleven counsellors described survivors having sleep disturbances and nine counsellors referred to concentration difficulties. Five counsellors also reported hypervigilance in their clients and four described both an exaggerated startle response and outbursts of anger or irritability.

Counsellor 1 – "...a hyper aware, sort of constant looking, constant checking... the awareness of what is going on around you is cast much wider and your kind of tendrils for potential danger and stuff is very much on the alert all of the time".

Counsellor 4- "Yeah, they battle to, when they're at work they battle to stay in their jobs, stay focused on their tasks, they have outbursts at work um... they don't get enough sleep because they can't fall asleep or have nightmares, um... they don't feel able to do the things they used to do like go out to the movies because they get afraid of the dark or who's going to be there or walking..."

4.4.8 Other psychopathology and related symptoms

Five counsellors referred to survivors developing some form of (sometimes unspecified) mental illness (other than PTSD) following experience of rape or CSA, including two counsellors who reported that their clients had been diagnosed with eating disorders. Psychopathology following rape or CSA has been similarly reported in the international literature (Faravelli et al., 2004; Thompson et al., 2003).

Counsellor 4 – "...and then uh a lot of the clients that I see develop diagnoses, psychological disorders as a result of the rape and then only come here much... much later... schizophrenia, depression, anxiety, uh... quite a few will have like a number of diagnoses from you know there'll be the borderline personalities that's always one of the favourites... major depressive disorders or like one was Bipolar".

Counsellor 6 – "There was a client who was here this year, I think March, she is mentally ill because she say she was raped while she was 11, by her step dad and he still does the same thing even now, and her mom still doesn't believe her".

Nine counsellors reported that survivors they worked with became suicidal or attempted suicide following a rape experience or CSA, and six reported having counselled survivors who they described as depressed. Two of the counsellors associated lack of support from others with suicidality in survivors. Counsellors also described additional symptoms displayed by survivors, which may be related to depression, for example, four counsellors described survivors' lack of self-care post-rape.

Counsellor 10 – "...and she was actually suicidal. She was suicidal and she had a child of two years old..."

Counsellor 9 – "...because clients are not going to say that 'I tried to commit suicide' but they will tell you things that they tried to do like 'I tried to swallow pills' or 'I tried to cut myself' or whatever not with the intent, not acknowledging that they wanted to commit suicide or anything".

Counsellor 1 – "And I have had depression although it has been more of a kind of a not directly spoken about... Low moods, tiredness, I think people, when people are really exhausted, for me it is kind of one of the indicators, not wanting to get out of bed".

Counsellor 7 – "Some of them they do not even want to get dressed. They used to tell me that – especially when the rape is new, I do not even want to – I can just – I am just feeling for sleeping the whole day, I am not even feeling for standing up and going to get food in the kitchen for myself, I am just feeling for sleeping the whole day, doing nothing".

4.4.9 Behavioural changes

Substance misuse

Six counsellors reported that survivors they worked with either started using or abusing alcohol following rape or CSA, and six identified clients who started to use illegal substances. Three counsellors also described their clients' abuse of over the counter or prescription medication as a means of escaping from, or coping with, difficult feelings or other symptoms.

Counsellor 8 – "...they are using dagga. And in their minds they are so relaxed and they think as soon as we are high on dagga, then we are fine... When we are studying, when we could not cope we are using dagga. Now that we are still working and I find I am not coping, I am smoking dagga".

Counsellor 3 – "Yes, they use their anti depressants, quite a lot, but they over medicate themselves man. You know, some said to me, I want to be in that stage where I don't have to think about it".

Substance misuse has been identified in the literature as a maladaptive coping strategy in post-rape recovery (Burgess & Holmstrom, 1979; Choquet et al., 1997; King et al., 2004; Resick, 1993; Thompson et al., 2003; Yuan et al., 2006). However, six counsellors in the sample reported that survivors they worked with sometimes used prescribed medication (such

as sleeping tablets or anti-depressants) correctly, as an adaptive form of coping with their symptoms.

Increased sexual activity

Four counsellors reported that survivors increased their sexual activity, including engaging in risky sexual behaviours and prostitution. They reported that sometimes survivors identified this as a self-protection strategy, or had been socialised into frequent sexual behaviour as a result of CSA.

Counsellor 3 – “Some overindulge, goes promiscuous and they you know– another lady I asked her why and she said to me I don’t want to get hurt anymore so I give myself”.

Counsellor 11 – “...a woman that presented that she was molested sexually by her own father and through the years... And then from there she has always been used in life as a sex object, she even turned to prostitution because that was the only lifestyle that she knew”.

Herman (1992a) similarly identifies how survivors of childhood sexual abuse engage in substance use, compulsive sexual behaviour and other risk-taking behaviours as attempts at emotional regulation.

4.4.10 Psychological attempts at coping

Five counsellors described how survivors attempted to cope with negative symptoms through the use of psychological defences such as intellectualisation, suppression, denial or minimisation. Burgess and Holmstrom (1979) also identified the use of conscious psychological defence mechanisms such as minimisation and suppression as adaptive responses to the experience of rape.

Counsellor 1- “For the people that I’ve seen, it has usually been denial and suppression, so there is not a lot of people who managed to find where to channel their emotions, it is more like ‘I will clamp them down’... Effort of will I think more than anything else... like an iron will of ‘I am just not going to let myself feel this right now’”.

Four counsellors also reported that clients attempted to cope by masking their feelings from others; however this was often identified as a maladaptive coping strategy, for example leading to disconnection from others or a disrupted sense of self.

Counsellor 6 – “They say ‘I pretend I am fine while I know I am not fine’. The other one said to me... she said, ‘I think I am a faker’. I asked her why, she said, ‘when I am in front of people, people will see me laugh and they will say that no, she is okay’... And when I asked her, how do you feel about that, she said ‘I am not feeling okay about that, because it is not me, it is not who I am’”.

4.4.11 Coping and resilience

Conscious attempts at coping

Six counsellors reported that survivors they worked with made significant life changes, including moving home or changing schools or jobs, following the experience of rape.

Counsellor 1 – “I had one person... she got raped in a rural area... and came to Cape Town afterwards because she just needed to get the hell away from this place and was in the process of rearranging her entire life and asking for a transfer to work somewhere else... So there are people who literally uprooted their lives”.

Four counsellors described survivors talking to parents or others in their support network about their traumatic experience, and four referred to survivors becoming more involved in churches or religious organisations as a way of distracting themselves, keeping themselves safe or seeking comfort.

Counsellor 9 – “...and some of them do talk to their parents although the majority of them have relationship problems there are those 2 out of 10 really strong relationships between mother and child where the child is able to talk to the mother which is wonderful because she can wake up in the middle of the night and the mother will be there and the mother will be listening to her”.

Counsellor 6 – “They become more religious because some of them they will say, ‘this is where I feel safe, going to church, it is where I feel relieved and take all my stress, and when I go home it will come back again’”.

Taking action such as moving house or talking to those in one's support network have been identified in the literature as adaptive responses to rape (Booley, 2007; Burgess & Holmstrom, 1979; Thompson, 2000).

Survivor resilience

Four counsellors also referred to survivors' resilient responses. They described the ways in which survivors had demonstrated determination and courage, had been pro-active and had

continued to function and care for themselves despite experiencing many psychological difficulties as a result of the sexual trauma.

Counsellor 1 - "...and I think it is very kind of important for me to say, the other thing that always blows me away about my clients is their resilience and determination and sheer like courage and strength. You know like at the same time as all of this stuff that is going on and it is what you deal with... just kind of taking stuff on, doing things that you know they feel like they can't do it but they go out and they do it anyway... And often quite an amazing emotional literacy from people that I wouldn't necessarily expect it from".

Counsellor 2 - "But these women have something else, they have this kind of resilience where they see a future in which the rape becomes a part of their motivation for life really... Screw the perpetrator, he put me down but I will no longer allow people to do that to me, and I will lead a productive life".

4.4.12 The extent and longevity of psychological impact

In addition to highlighting the various effects of sexual assault on survivors' lives, seven counsellors also drew attention to the profoundness of the impact of rape and CSA, for example, the way in which all aspects of survivors' lives, functioning and relationships were affected as a result of sexual assault.

Counsellor 2 - "It pervades everything that she does... It pervades her sleeping her waking hours..."

Counsellor 11 - "...basically they are not stable anywhere because it affects their whole life especially when they are younger so obviously it affects everything they do, their relationships with people and that kind of thing so um a lot of the time they don't have stable jobs".

Eight counsellors also described the protracted length of recovery from trauma that survivors face, including the way in which many have to face a resurgence of symptoms some time after the traumatic event.

Counsellor 4 - "...then there's uh injuries during the rape, some of those can cause problems for years and years after that and then uh, a lot of the clients that I see develop diagnoses, psychological disorders as a result of the rape and then only come here much... much later".

Counsellor 2 – “...especially – you know I cannot say at the beginning because when is the beginning ever, because sometimes clients will have been raped, and then there will be that adjustment period, and they will now try and deny it and outwardly adjust. And then maybe seven years later things start coming up for them, and that is the beginning in a sense... You know but by then all those entrenched personality traits, you know the way of living that you have had, because it is still there, the trauma is still there, you have learnt other ways of coping in a world with those feelings of unsafeness”.

In line with current conceptualisations of complex post-traumatic responses described by Ford and Courtois (2009) and Herman (1992a), six counsellors identified survivors of CSA as experiencing longer lasting and more entrenched psychological difficulties. For example, CSA survivors were described by four counsellors as particularly struggling to access their feelings. This was sometimes attributed to the ongoing nature of CSA and survivors having been socialised into thinking that it is 'normal'. Five counsellors spoke about the ways in which rape and particularly CSA made many survivors vulnerable to re-victimisation and re-traumatisation in the future. This echoes Cloitre et al.'s (2009) assertion that those with a history of trauma, for example CSA, are more susceptible to re-traumatisation.

Counsellor 2 – “...they find it really hard to get in touch with those feelings or to talk about the feelings, the feelings feelings really well. It is a struggle. And a lot of those clients turn out to be the adult survivors of childhood sexual abuse as well”.

Counsellor 9 – “...when it comes to rape for me if it is in families I think, I think that is I don't know, what is the word that is the most difficult to deal with if it is somebody that you actually know I think those are the ones that have lived with it for 7, 8 years and then so much damage has been done. Those are the ones that don't know how to protect themselves. Those are the ones that will get drunk in a club and that will actually become survivors”.

4.4.13 Post-rape complicating factors

In addition to the psychological impact on survivors, counsellors identified particular complicating sequelae following rape or CSA. Seven counsellors reported that survivors became involved in court cases following the sexual assault. This at times led to increased anxiety, a resurgence of previously resolved symptoms or was experienced as re-traumatising.

Counsellor 4 – “...and they know the courts aren't on their side and it's really frightening to talk about that in front of people or even to say the rape took place”.

Counsellors' experiences

Counsellor 5 – “It is difficult, especially – it is not difficult to go to open the case, but when she is going to the court with the perpetrator. Some of them didn't succeed because they were so afraid”.

Six of the counsellors described pregnancy and children as further complications experienced by survivors they worked with, resulting in survivors having a termination, putting the child up for adoption, or raising the child themselves. Three counsellors described how the latter decision, while considered positive by the survivors, also resulted in survivors facing ongoing reminders of the rape and led to complications later in the child's life.

Counsellor 1 – “But certainly that kind of complication in terms of dealing with trauma on an ongoing basis of seeing her boy child on a daily basis and constantly seeing the face and the kind of personality, and the real physical embodiment of her rapist - that is somebody that she loves intentionally, but also was very ambivalent about at the same time, took out a lot of her frustration and anger on as well”.

Five counsellors also identified HIV/AIDS as complicating sequelae following rape. They reported that survivors either worried about their HIV status post-rape, or became aware of their sero-positive status for the first time as a result of the post-rape medical treatment. This reflects finding by other researchers that risk of contracting HIV/AIDS as a result of sexual assault increases survivor distress (Armstrong, 1994; Kalichmun et al., 2005; King et al., 2004; Maw et al., 2008; Wood & Jewkes, 1997).

Counsellor 2 - “...or clients sometimes find out for the first time that they have HIV when they go for their forensic examination and they have their baseline test. It does happen. And I think the most worrying thing is if someone is not positive, there is that three month window period, that is a huge thing for people to have to wait”.

The following section outlines the treatments offered by counsellors in their work with survivors.

4.5 TREATMENT

This chapter considers the principles of treatment informing counsellors' work, the aims and methods of counselling, the impact of the work on counsellors and traumatic counter-transference, factors impacting on treatment, and reported treatment outcomes.

4.5.1 Principles of treatment

Empowerment

Counsellors spoke about the principle of empowerment as guiding their treatment of rape survivors. The concept of empowerment was conceptualised and expressed by counsellors in several ways. The principle that clients are experts in their own healing was articulated by all of the eleven counsellors. For example, counsellors described their role as facilitators of survivors' healing, while the survivor is responsible for undertaking the work. Counsellors also described the way in which treatment is client led, as the client determines the focus of treatment, as well as the pace at which treatment progresses. This was achieved by listening to and respecting the client's views.

Counsellor 2 – “And just providing her with whatever support it is that she needs, not what support I think she needs, but what support she feels that she needs. And maybe make the suggestions, but if they are not taken up, that is perfectly okay, that is her process. I think the most important thing is to not feed into that helplessness, but to rather work from an empowerment, self-determination perspective, because it is her process, it is not ours as counsellors' process, we don't know best, she knows best, she knows what her context is”.

Counsellor 7 – “What do you want us to talk about today, which part you want just to talk about today’, because it is up to her. You mustn't always be telling the client, or guiding the client, the client must also guide you because she has got a problem, you understand, give the client a space to talk the way she wants to talk”.

Four counsellors particularly highlighted the importance of clients choosing to engage in treatment, and exploring with a client their readiness to engage in the treatment process was identified as forming part of the treatment process. Four counsellors also referred to empowering survivors by encouraging them to make their own choices and decisions. The aim of empowering clients was expressed as being in direct contrast to the disempowering experience of the rape and this therapeutic stance can be recognised throughout the counsellors' treatment process.

Counsellor 8 – “In a way of starting to empower a person to take the lead in her own life, rather than being told, because we believe when she was raped, her power was taken away from her, everything was forced, she was forced to do everything by somebody else. This is the time now she needs to get back her power by making her own decisions”.

Although only two of the eleven counsellors referred to the Rape Crisis counselling model as a Feminist model, empowerment, and particularly the notion that a survivor is the expert regarding her own healing process, has been identified as a fundamental tenet of feminist therapeutic interventions (Brown, 2004; Cohen, 2008). Courtois et al. (2009) similarly emphasise the importance of personal empowerment in the treatment of survivors of complex trauma.

5.5.2 Childhood sexual assault, ongoing stressors and multiple traumatisation

There was recognition amongst counsellors that survivors of CSA require longer and more in depth treatment compared with survivors of rape in adulthood. For example, two counsellors highlighted the need for CSA survivors to receive treatment at different developmental periods throughout their life. While it was stated that Rape Crisis does not have sufficient resources to counsel survivors of CSA, there was acknowledgement amongst counsellors of the high level of need to provide these clients with treatment. It was reported that several counsellors within Rape Crisis therefore work with CSA survivors or alternatively provide them with containment until alternative referrals are in place. These counsellors reportedly receive monthly supervision from a clinical psychologist. Eight out of the eleven counsellors interviewed reported having counselled CSA survivors.

Nine counsellors also highlighted the impact on the treatment process of survivors' experience of ongoing stressors in addition to the rape or CSA, for example making it difficult to determine a particular treatment focus. Counsellors reported that poverty, HIV/AIDS or relational difficulties are at times considered by survivors as treatment priorities, necessitating flexibility in the counselling process or that referrals to other agencies be put in place alongside counselling before the rape trauma could be addressed. Two counsellors described how survivors who are in relationships where there is domestic violence are immediately referred for specialised counselling, and that counselling for the rape would not start until they are no longer at risk for ongoing traumatisation.

Counsellor 2 – “Yes, because the previous trauma always filters in, always. And it is very difficult when you focussed, when you are Rape Crisis trained and you focus on rape trauma, then to – you have got that intrusion always, you know it is there, you know that the previous trauma is always being invoked as well, and you know you are not just working with the rape trauma, you are working with the other previous traumas too”.

Counsellor 9 – “...besides the rape now you are sitting with that problem of the client and what we don't realise is that all these other factors affect how they heal with regards to the rape all the other factors”.

Counsellor 8 - “I think if you look at rape in itself, that is where sometimes you will look at counselling, where there is a lot of things that need to be unpacked, as you mentioned poverty and unemployment amongst them, HIV amongst them. Also the social issues... in some cases you would see where a person doesn't even really see rape as a priority, ‘I have been raped, but my priority is my social issues, my priority is my health’”.

Counsellor 9 – “...with HIV and the rape your mind is not going to be with the rape because your mind's thinking ‘I'm going to die soon so what is the point of having to deal with the rape’. So you would refer a client, if there is HIV involved to actually seek counselling specifically for her to deal with the fact that she is HIV positive and how she can live with that and deal with that”.

Although these ongoing stressors made it difficult for counsellors to help their clients to establish safety, counsellors drew on a wide professional support network. For example, nine of the eleven counsellors reported having referred clients to one or more of eighteen non-government or other individuals, institutions or organisations as part of the counselling and two described helping survivors to access social grants. Some of the organisations used include those working with domestic violence or family difficulties such as FAMSA and NICRO, those offering counselling for HIV/AIDS such as Wolanani or Attic, those working with children such as RAPCAN or Childline, those tackling poverty such as Mosaic or Olive Leaf, and organisations working with people who have a mental illness such as Nonqeba Mental Health, Empilweni or Fountain House, among others.

4.5.3 The counselling process

While all eleven counsellors reported that Rape Crisis offers a twelve session treatment model, nine of the eleven counsellors described the need for counsellors to be flexible depending on the client's needs, not only with regard to the length of counselling but also the content. For example, the reported number of sessions attended by survivors ranged from a

single session to weekly sessions for up to nine months. Seven counsellors highlighted how each individual client has a unique presentation following sexual assault. As a result, the importance of assessing and tracking the psychological and physical impact of the rape or CSA on the client was described by eight counsellors, and seven counsellors reported collaborating with the client to prioritise treatment needs. As part of this assessment, counsellors used the Rape Trauma checklist (a list outlining the symptoms of Rape Trauma Syndrome). Along with the psychological impact of rape, counsellors reported assessing contextual factors in the client's life, for example seven described taking the client's personal history at the start of counselling and five referred to exploring the extent and nature of their support network. Courtois et al. (2009) similarly emphasise the importance of recognising the uniqueness of individual responses to trauma, as well as collaborative planning and holistic assessment when providing psychotherapy for survivors of complex trauma. Following the assessment stage of counselling, four counsellors described discussing and clarifying with the survivor their expectations of the counselling and recovery process.

Counsellor 1 – "...a lot of people come with the expectation of 'I want to make it better and I want to make it go away' and it is often very difficult with that, because there is no way of making it go away, there is only a process of dealing with it. So some clients have got a long conversation because it's kind of – 'but it must be done now'".

Nine counsellors also reported socialising clients into counselling. This involved explaining the prospective benefits of counselling as well as the potential for it to be painful and making explicit the treatment process. This also formed part of setting the therapeutic frame, as described by five of the eleven counsellors, for example ensuring that the client knows how many sessions she will be offered as a way of providing containment. Courtois et al. (2009) and Lebowitz et al. (1993) similarly emphasise the importance of being explicit about the counselling process.

Counsellor 8 – "Of course, what you do as a counsellor, just explaining the introduction about Rape Crisis, what we do in Rape Crisis in order for her to be able to go back to healing".

Counsellor 9 – “And for me personally I need them to know that it is going to be difficult... I don't want to make it a sorry thing a pity sorry thing I want them to know that it is difficult. Finding ways of having to sleep at night and me telling you to put that what you see on paper it is going to be difficult but as you start to get rid of the stuff up here and out here and you put it somewhere else it becomes lighter it won't be so heavy on your mind so much”.

Four counsellors also referred to their role in monitoring and guiding the progression of counselling while still respecting the principle of client-led treatment. This process of meta-thinking was described as important in order to prevent counsellors from colluding with clients in avoiding dealing with the trauma.

Counsellor 2 – “...like I have a client later today and I know the thoughts I have for my next session I have actually written down in my last report... but that client might come today with something that she really needs urgently to talk about. But I still keep this other thing in my mind because I know that that was what was important and maybe there is a link somehow, maybe this somehow links throughout, when I am reflecting on all the sessions that we have had so far”.

Finally, seven counsellors referred to the importance of encouraging clients to seek additional counselling in the future and ensuring that they provide an experience which would facilitate future treatment seeking.

4.5.4 Aims and methods of counselling

Ensuring safety

The aims and methods of treatment described by many of the counsellors could be conceptualised in terms of a process of ensuring survivor safety, including initial containment of the survivor in a crisis period, management of distressing symptoms, physical and community safety, and safety within the therapeutic space. This process of ensuring safety reflects the first of the three stage model of recovery advocated in the literature on post-traumatic recovery (Courtois et al., 2009; Herman, 1992a; Lebowitz et al., 1993).

Physical and community safety

Ten of the eleven counsellors described the importance of establishing a survivor's physical safety in the community as well as facilitating access for the survivor to emergency and longer term medical and/ or mental health care. Establishing community safety included referrals to shelters or places of safety, discussing ways a client can ensure her own safety both in the community and within interpersonal relationships, as well as problem solving for

situations where she feels unsafe. Facilitating access to immediate and/ or longer term medical and mental health care involved providing survivors with information, or writing referrals to other NGO's, social agencies, hospitals, clinics or psychologists (particularly in the case of CSA). For example, suicidal clients would be immediately referred to a Psychiatric Hospital as well as some counsellors continuing to support them through the counselling. Counsellors reported that, where possible, survivors were encouraged to make practical arrangements themselves as a way of empowering them through facilitating their autonomy, which reflects Herman's (1992a) assertion that a survivor should be encouraged to "plan and initiate action" (p. 167) as part of regaining control and autonomy.

Counsellor 4 – "I'll give them numbers or options or things and then they can do it for themselves, cause that's our kind of, I think it's more empowering to get them to sort something out for themselves, for shelters we have to call the shelters but most of the time it's writing letters to give to them as referrals to get anti-depressants to get help from the hospital or to get yeah to get whatever..."

Counsellor 9 – "...so if a survivor comes up and tells you I wasn't supposed to allow him to put his arm around my shoulder you as a counsellor get an opportunity to talk about boundaries, 'was it comfortable for you when he put his arm around your shoulder, so when did it start getting uncomfortable' and then you start making them aware that they need to start creating boundaries for themselves".

Crisis containment and symptom management

Four counsellors described treatment as providing containment for their clients in an immediate period of crisis. This was connected to assisting survivors with symptom management and reduction, as described in eight of the interviews. Eight counsellors described how crisis containment and symptom management was achieved through psycho-education to contextualise survivors' symptoms as normal responses to rape or CSA and six reported making use of a Rape Trauma Symptom checklist during this process.

Counsellor 2 – "When a client is really uncontained, she just comes here and she is really, really uncontained, we have got that RTS check list and we can use that with the client to try and contextualise or try and normalise those experiences that she is coming with, those feelings, those thoughts, those physical symptoms that she might be coming with. And that can be a really containing thing".

Counsellor 1 – “But before we could even start talking about anything else, the fear needs to be the thing that gets managed first. And I say managed specifically because it doesn't go away. But actually for a lot of people getting to the point where it is debilitating... but those things are kind of the immediate presenting emotional symptom and you can't even get anywhere until you have gotten past that or are dealing with that”.

Six counsellors also described helping clients to reduce the impact of their symptoms by teaching coping skills and techniques.

Counsellor 4 – “...and psych-education is quite important to us so basically if she's unsure or whatever then I can say I've used this in the past with clients and they've found this helpful and I've used this which they've also found helpful and there's this so do any of those sound useful to you and so on”.

Lebowitz et al. (1993) and Courtois et al. (2009) similarly describe how psycho-education and normalisation of symptoms provide containment for survivors of trauma and are essential elements of treatment. The therapeutic aims of crisis containment and symptom management also resemble two of the recovery criteria for trauma reported in the literature, that survivors are able to link memory of the trauma to current affect, and that they learn to manage and master their symptoms (Cloitre et al., 2009; Harvey, 1996; Lebowitz et al., 1993).

Safety in the counselling space

Developing survivors' trust in the counsellor and creating a safe therapeutic space were priorities described by counsellors. Ten counsellors described the importance of developing trust between the counsellor and the survivor. As part of establishing trust in the therapeutic relationship, nine counsellors described spending time getting to know a client and building rapport.

Counsellor 3 – “Very first session is to get to know each other you know. I normally tell them who I am ... how long I am at Rape Crisis, what our core business is, what we do, you know ask them a bit about themselves and their family you know. That is how I normally gain their trust, I ask them how did you get here you know, that type of thing. Was it difficult, tell them how bold they are to just come to Rape Crisis”.

Eight counsellors also reported ways in which they aimed to be available and accessible to survivors in order to be experienced as reliable sources of support. Being available included being emotionally present during sessions, the importance of the twenty-four hour crisis line and being flexible with appointments.

Counsellor 7 – “...if the client comes to you and you are not here, you must have that chain with the client, that if the clients wants you, the client must get you”.

Counsellor 3 – “...just all about support. Be there and say ‘I will really be there’, you know, these are the times and if you – extraordinary they ask you for something else and you know you can do that, why not...”

Related to this, six counsellors spoke about ways of relating to clients that provided an alternative, more positive experience of relationship than they may have experienced elsewhere in their lives, which reflects Courtois et al.'s (2009) recommendations that therapists “create relational conditions in which the client is emotionally validated and is ‘seen’ and is appreciated” (p. 86). Four counsellors also referred to the importance of being empathic.

Counsellor 2 – “...safety first, safety, respect, ongoing support and yes – yes safety. Absolutely safety. I think this house provides – many clients talk about feeling safe here, it feels homely, it feels okay. You know it feels friendly, there is no sign outside I feel – it is on the transport line, convenient. All those things feed into my feeling of safety. So you’ve thought about me in your mind when you chose this spot”.

Counsellor 9 – “...especially with the youth they have to know that they are important we don’t know them and we can’t make statements or whatever but they need to know that they are actually important especially when they come in here because nobody has ever told them how good they look and that is what they need, they need to know that they are an important part of the family they need to know that they are important in the school they need to know that in order to keep them going”.

Ten of the eleven counsellors highlighted how survivors were better able to engage with treatment once trust had been developed in the counselling relationship and six of the eleven counsellors described the importance of counsellor reflexivity, including acknowledging and working through their own difficult feelings, as part of developing a safe relationship. In support of this, four counsellors identified survivors’ experience of the counsellor as genuine and trustworthy as one of the most helpful aspects of the counselling experience. This evaluation was based on their own experience as well as client feedback. Smith and Kelly (2001) similarly emphasise the importance of counsellor reflexivity when treating rape survivors and Lebowitz et al. (1993) describe how the “therapist’s interpersonal stance” (p. 382) aids the development of a trusting therapeutic relationship.

Counsellors' experiences

Counsellor 4 – "...you've just got to notice and work through it or sometimes just be angry or frustrated or discuss it when you're really mistrusting your client, or things like that... I analyse what I am feeling and I figure out what's mine and what's the client's, what's it connecting to in my history what do I need to work through here".

Counsellor 8 – "I said you as the counsellor, be honest... That will help you when she doesn't feel comfortable enough to be honest to you, you start being honest to your own feelings and acknowledge those feelings and be honest about them".

Eight counsellors spoke about creating a safe space for their clients to talk or to be able to show their true feelings. Nine counsellors referred to their role as being there to listen to their clients, as part of creating the safe space. Seven counsellors also emphasised that they needed to listen in an open and non-judgemental manner, as emphasised by Thompson (2000). The counsellor's role of listening to the survivor and adopting a non-judgemental stance were identified as most helpful to the client by five and four counsellors respectively.

Counsellor 6 – "If she is crying, I will let her cry and tell her let it come out, I don't say no, I won't say no, you mustn't cry, stop it and – no, I give her a space to do what she wants to do, because by coming here, this is where she feels safe... So this is where she is safe, she can cry loud, she can do whatever she wants to do, as long as she is taking the pain away".

Counsellor 2 – "Listening. Listening, that is what they come here for. Listening and non judgementalism, that is what they want. Those are the very basic things that they need. I mean obviously linking with other things if needs be, but I think the most critical things are the listening, really listen, and hear the story, when the story comes".

Seven counsellors referred to the confidential nature of the treatment, which is likely to be an integral part of creating safety in the therapeutic space, particularly as five counsellors highlighted survivors' desire to keep the rape or CSA confidential but that this was not always respected by those in their support networks. The creation of a safe space for clients to express themselves was identified by six of the eleven counsellors as one of the most important aspects of treatment. Levy (2004) similarly describes the need for a safe, containing space to be created prior to engaging with the trauma memory.

Counsellor 3 – “I am very secretive about it, nobody must know, you know. And they actually want you to swear that you are not telling anybody... If mother and father and just the immediate family know, yes, but not uncles and aunts and things like that, no, they don't want to, cousins and nieces and nephews no, the majority don't want to. But the parents always force them to let everybody know, and that is where the problem comes in”.

Counsellor 8 – “...as the counsellor you are a stranger to that person now, there is a lot of bonding that needs to take place, there is a lot of trust that needs to take place, there is a lot of assurity of confidentiality between me and her”.

Increasing autonomy

Counsellors described assisting survivors to increase their autonomy, not only by helping them to function more independently and increase control over their emotional and behavioural functioning, but also by equipping them to manage and sustain their own healing process.

Self-awareness

Six of the eleven counsellors referred to facilitating survivors' ability to become conscious of and reflect on their behaviour and functioning. This would enable them to create choices for themselves rather than enacting unconscious behavioural patterns. Particularly in the case of CSA, four counsellors described the need to explore childhood experiences and make links to current functioning as part of assisting clients to understand and direct their own behaviour. Courtois et al. (2009) similarly describe the need to develop awareness of as well as augment “personal control and self efficacy” (p. 92) when treating survivors of complex trauma as part of the development of survivor safety.

Counsellor 3 – “And the journal really works for them. I said to them, every day look at your behaviour, what ticks you, what made you – what happened before you just gone off the rocket, you get so upset and you know, why didn't you eat you know for the whole day, how are you feeling”.

Counsellor 1 – “So for example, I met somebody who has been through a childhood assault sexual experience, it is probably one of the first times that they have that, ‘oh there is something wrong here’, and it is quite a profound there is something wrong here, along with ‘I can't trust anybody’. And they go into like, ‘I am going to be independent’, and independent wins in a lot of different situations, but it also cuts you off in a lot of other stuff. So if you can start recognising where it helps you win and where it limits you, you can actually start shifting that as well... But you can only do that choice once you have actually seen what it is that you are doing”.

Counsellor 8 – “Because now if you are talking to a 30 year old girl who was raped when she was four, you had to take the little 30 year old somebody to a 4 year old girl which is very hard to do”.

Decision making skills

Seven counsellors described giving their clients as much choice as possible in order to foster autonomy and empowerment. This included asking survivors questions rather than making suggestions in order to encourage self-determination and greater ownership of their own healing, as well as monitoring and discouraging survivor dependence on the counsellor. Seven counsellors referred to teaching survivors problem-solving skills, for example, thinking through the steps required to make changes or highlighting or exploring the consequences of particular choices or decisions. This was in order to ensure that when presented with choices, survivors would be equipped to make healthy, informed decisions.

Counsellor 8 – “As the good counsellor and you use your counselling skills, it is just to show the consequences of taking step one, it will lead to step two, it will step to the different way. Let her then see, you just put all the cards on the table, whatever she wants to do, these are the consequences, these are the later stages that might happen on the road that she wants to take, and then let her decide”.

Counsellor 9 – “...so [I] would start... ‘so if you run away and then what’ and you need to make them think also they need to think by themselves”.

Developing a survivor's self-awareness and their ability to problem-solve and engage in healthy decision-making echoes what Ford (2009) describes as the scaffolding process towards “therapeutic stabilization” (p. 50) in the treatment of complex trauma, where a client is helped to be able to think through situations in a manner less driven by automatic emotional responses, and therefore make healthier choices.

Fostering sustainable healing

Counsellors often recognised the time and resource limited nature of the counselling model and expressed the importance of providing clients with sustainable tools to help them cope with symptoms and manage their own healing process. Eight counsellors described providing clients with techniques which they could implement themselves in order to manage their symptoms and cope with future challenges. Identifying and building on survivors' already existing talents as part of this process was identified by seven counsellors as a means of both validating survivors' strengths and making improvements sustainable.

Counsellor 2 – “You are only there as a witness for a short period of time, you don't know how long it's going to be and the client could come for all 12 sessions but she might not, so the journal is there for a lifetime”.

Counsellor 4 – “...well normally what our approach is to look at what the client's using already anyway so you know she may come with ‘I'm really worried about this aspect of myself’ and I'll go ‘well what have you done in the past that's helped you with this or what are you doing, what helps you feel the opposite?’ and they'll come up with a list of things and then we'll work from those and maybe built on them some more, add exercises to them”.

Counsellors described a variety of the techniques which they taught and encouraged survivors to use in order to help manage their symptoms and promote sustainable healing. Nine counsellors described using various forms of writing such as keeping a journal or writing poetry, which would then be explored with the counsellor during a session. The use of written exercises was identified by four of the eleven counsellors as one of the most effective techniques to use with clients.

Counsellor 9 – “I think what is happening most amongst the counsellors is a lot of things if it is practical things it is drawings and it is writing and keeping journals and a lot of them write poems like to write poems so we do give them homework... and we do ask them to do stuff like practical stuff so they come back and we sit with it. That happens mostly with clients that has difficulty talking”.

Five counsellors described using one of various cognitive behavioural techniques including reframing and re-evaluating the meanings of events, thought stopping, reality testing and positive affirmations. These techniques appear to be aimed at challenging maladaptive beliefs about the self and the world as described in cognitive processing therapy (Resick et al., 2002).

Counsellor 4 – “...to write the bad thoughts down the one side and then to turn that into a positive statement on the other side of the paper and then they tear off the bad side and burn it or bury it or something like that and then they read through the positive affirmations daily”.

Four counsellors also used breathing and relaxation exercises and five provided clients with information and psycho-education in a written form. The use of drawing techniques, collages,

distraction and physical techniques to reduce the intensity of feelings, such as Capacitar techniques and tai chi exercises, were each described by three counsellors.

Counsellor 10 – "...encourage them to do relaxation like the deep breathing, the rolling of the shoulders, you know stretching, things like that, some exercises before they go to bed, or when they feel all tensed up".

Counsellor 2 – "...say for example a client is experiencing a particular emotion, and she is wanting to feel some sort of release from that emotion, the tapping, what you do is, there are certain points on the body that you tap.... And this feels quite – it does feel quite a calming thing, it feels like a calming process. Some clients giggle and laugh and you know it is not going to work for them".

Counsellors emphasised the importance of collaborating with clients to find techniques which work for them. The use of techniques to reduce stress was identified by Meyer and Taylor (1986) as being associated with positive post-rape adjustment.

Returning to previous levels of functioning

Counsellors referred to trying to help their clients to return to their level of functioning before the sexual assault. Four of the eleven counsellors described helping survivors to face situations, people or places they had been avoiding following the rape and which had been restricting their ability to function in the world. This was done through, for example, challenging faulty beliefs, talking a survivor through what would happen and how they imagine it will feel or discussing ways the survivors could be practically supported by others to face avoided situations. The latter two techniques respectively resemble aspects of systematic desensitisation and *in vivo* exposure as described by Foa and Rothbaum (1998).

Counsellor 1 – "But it would really be also you know, what is the things that I could do in that situation when I am right there, kind of the pre-imagining of it, if that makes sense? Like actually going through the process and kind of going, well what do you want to do, what do you see happening. Actually talking them through it".

Four counsellors also reported assisting survivors with linking affect, cognitions or behaviours to the rape experience. Contextualising these responses as related to the sexual assault appears similar to Foa and Rothbaum's (1998) description of increasing survivor autonomy by dismantling their fear network.

Counsellor 2 – “I think it starts linking to the thoughts and the feelings again, if we can try and somehow kind of know that those thoughts and feelings belong there, in that particular time for that particular event, then you know if those symptoms does somehow manifest in her everyday life now, then maybe there is something to that, maybe those two are there somehow... to really put it away, put it to where it belongs”.

Remembering the trauma

Ten of the eleven counsellors expressed the view that a survivor talking about the sexual trauma they experienced facilitated the healing process, through generating a sense of release or relief, through being able to share one's experience with an 'other' or through integration of the trauma memory into narrative memory.

Counsellor 8 – “...and also explaining the importance of sharing what happens to her. Actually counselling is about re-saying exactly what he did for you, that is actually the start of you starting the road to healing, but if you are ready now”.

Counsellor 10- “...by submission of the other ladies, they find that once they have disclosed the detail to the counsellor, it is out there, it is not a tormenting thought anymore, someone else has heard what I felt and what I have experienced, and that also gives them a sense of freedom to the extent where it is not as tensed up... and [they] come back and say they have slept better because they are not holding onto that bad memory”.

Connected to this belief, nine counsellors expressed feeling that it is important for a survivor to talk about their rape experience during the counselling. This positions the counsellors as witnesses to their clients' stories. Herman (1992a) similarly describes the therapist's role as “witness and ally” (p. 175) to the trauma narrative and being able to bear witness to the trauma is also referred to by Levy (2004) as part of providing clients with the necessary ego strength to facilitate remembrance of the trauma without falling apart. There was also a clear sense of conflict expressed by some counsellors between encouraging remembrance of the trauma and prematurely forcing a client to talk. For example, five counsellors emphasised that this should be done at the client's own pace and that survivors should not be forced to speak if they are not comfortable. Four counsellors also indicated that if the effects of the rape were identified by survivors as more distressing than the memory of the assault, that this should be the focus of counselling.

Counsellors' experiences

Counsellor 6 – “I always encourage them to do that, to talk about rape. You know something, if there is something that you come across, it is not – and it is eating you, you are not feeling well about it, it is good to talk about it, because this is where it leaves your system. In my experience it is good to talk about that”.

Counsellor 2 – “I feel that at least if I am really the witness and I am really listening intently, then hopefully most of my work is done”.

Counsellor 1 – “So there is a level to which I do think talking about it is important, but it is tampered by not wanting to force somebody to do something that they are not ready or willing to do... I think some people get stuck and some people get really afraid when they see what it might take to actually go through... she keeps on coming but her great fear is actually even taking... She just feels so scared of the levels of emotions that she thinks are sitting there”.

Encouraging survivors to remember the trauma and bearing witness to their account is part of the second phase of recovery described in the literature on post-traumatic healing, which aims to integrate the traumatic experience into the survivor's life narrative thereby facilitating mastery over the experience (Courtois et al., 2009; Herman, 1992a; Lebowitz et al., 1993). The counsellors' reported conflict between encouraging remembrance of the trauma and following the survivor's pace reflects the notion that the survivor's safety, including the capacity for emotional regulation, should be ensured before the trauma narrative is uncovered (Courtois et al., 2009; Herman, 1992a; Lebowitz et al., 1993).

Facilitating access to and expression of feelings

Counsellors discussed the importance of helping survivors to gain access to and express the difficult feelings they experience following sexual assault. This can be understood in relation to the reported avoidance symptoms of PTSD and the nameless affect displayed by some survivors. Nine counsellors reported encouraging their clients to talk about and express their feelings during counselling sessions as a way of facilitating healing. In order to achieve this, ten counsellors reported needing to help their clients to identify and give name to their feelings.

Counsellor 4 – “...so if she says “all I want to do is talk about um... my feelings of guilt and what happens and then she keeps avoiding that then I'll mention okay you wanted to talk about this but you're avoiding it are you maybe not ready to talk about it and that will be the way in and we'll look at another technique maybe writing it down. And then we'll go through that”.

Counsellor 1 – “Like I will sit in a room and I will say like I am feeling dizzy, are you feeling dizzy, you know. Or I am feeling like I want to burst into tears, what is going on with you... And she can't name it so I will name it. And she will have the space to actually then say something about it”.

Five counsellors also described how using techniques, including activities such as drawing or writing, to create some distance from the emotions facilitated clients' ability to engage with negative affect. Herman (1992a) describes identifying trauma related feelings as part of the remembering process and similarly recognises the need to use alternative means of expression such as drawing when survivors struggle to put words to their experiences.

Counsellor 10 – “Well I sometimes have a scrap paper and like drew the happy faces and I ask them – we will use maybe the weather, you know, how are you feeling today, it is raining outside, do you feel sunny, do you feel misty, do you feel windy, so these different things I will ask them to describe their emotions. And then from there, as you put words to that”.

Again, these aims appear to reflect one of the reported outcomes of recovery from trauma as described by Cloitre et al. (2009), Harvey (1996) and Lebowitz et al. (1993). These authors describe the importance of survivors being able to identify, name and tolerate varying degrees of affect, which would impact on their ability to tolerate future stressors.

Improving self-concept and reconnecting to inner strength

Counsellors described the ways in which they aim to bolster survivors by improving their self-concept and re-connecting them to the strong, healthy parts of themselves. In order to achieve this, eight counsellors described helping to reduce survivors' self blame by, for example, reassuring them they were not responsible for the assault, and five referred to helping clients to re-build their self-esteem. In many cases loss of self-esteem and self-blame appeared to be connected.

Counsellor 1 – “...we were getting her to write a letter to her 14 year old self, knowing what she knows now... it was all about compassion and giving space and telling her that it is okay and telling her that she did all the right things and you know that you can't expect – yes, she could have done anything differently”.

Counsellor 10 – “If it is somebody that presents a low self-esteem because of rejection in the family... you tap into where that person is and you journey with them and bring out that inner strength, that inner beauty”.

Eight of the eleven counsellors described attempting to reconnect survivors to their pre-assault identity and sense of self, including helping them to see that the sexual assault does not define them, and reconnecting them to previous personality characteristics and ambitions. Nine counsellors also sought to reinforce a survivor's strengths by identifying and validating her survival of the trauma and her resilient post-trauma responses, at times also encouraging her to generalise these strengths to address other areas of difficulty in her life.

Counsellor 11 – “I think I want to see clients live again and to be able to pick up their lives and I like to ask, ‘what did you want to become, what was your dream?’ and if the child wanted to be a nurse ‘and now?’ and well ‘I don’t know’, so you almost want them to go back to what they wanted to become before the rape and so on”.

Counsellor 1 – “I keep on being like, but look at what at you’ve done you know, look at what you have actually managed to do in the face of these – of what seem like overwhelming circumstances to you. Okay, if you can do that there, then you can do that anywhere”.

Meyer and Taylor (1986) report the connection between self-blame and poor post-rape adjustment and recommend that interventions should attempt to decrease self-blame in sexual assault survivors. Courtois et al. (2009), Harvey (1996) and Lebowitz et al. (1993) similarly describe replacing feelings of self-blame and guilt with new or regained self-esteem and sense of identity as integral to healing from the psychological effects of trauma. The focus on recognising and validating survivor strengths also reflects the feminist treatment approach of rewriting a victim narrative as one of survival and resistance (Brown, 2004).

Reconnection with others

All eleven of the counsellors described different ways in which they helped survivors to reconnect with those around them. Ten counsellors described fostering relationships between survivors and their relatives or friends through, for example, educating family members about how to support survivors, exploring family relationships and helping survivors and their families to improve communication.

Counsellor 5 – “...like the mother of the client... we were dealing about her child, so I tried to convince about her child, how to support her child, how to communicate with her child”.

Counsellor 6 – “I have asked her questions, ‘how do you feel about your parents?’ She never know how does she feel about her parents. And then I said to her, ‘you know, you must take a pen and a paper and write what you feel about your parents’... and then she wrote down that letter, and then she drew a picture, she make it nicely and then I said to her, ‘can you give this letter to your parents?’ She gave them. And then that is where their relationship started to build”.

Six counsellors reported ways in which they helped survivors to extend their support network by, for example, exploring who they could call on for support, encouraging participation in activities, discussing ways of developing new relationships, working with clients on distinguishing who it is safe to trust, or referring them to a support group. Four counsellors also described helping survivors to disclose the sexual assault to those in their support network.

Counsellor 1 – “... like who do you know, who could you be in contact with, who do you want to be in contact with, you know make yourself a list, take on phoning one person a week or whatever it is that you feel that you can manage. Find kind of post-work, outside of work social activities, sports clubs, sports that you do... You know, try and think it through of how do you actually make friends, and you make friends by coming into contact with people.”

Counsellor 4 – “...helps with how far to trust people and how to figure out what trust means all of that helps to establish relationships with people through a bit of role playing, letter writing...”

Reconnection with others, including extending the survivor's support network, fostering healthier relationships with others and aiding with disclosure, is the third stage of recovery from trauma described by Courtois et al. (2009), Herman (1992a) and Lebowitz et al. (1993). Given the reported influence of responses of those in the survivor's environment on her post-rape adjustment and the difficult family dynamics reported by many of the counsellors as an ongoing stressor in survivors' lives, intervention on the family level seems particularly important.

Providing hope and facilitating post-traumatic growth

Seven of the eleven counsellors described helping to give their clients hope, often by showing them that they have a future. Six counsellors also described encouraging or facilitating post-traumatic growth in their clients by, for example, thinking with clients about how they can improve their lives, set goals for their future, develop their talents or help others. Linley and Joseph (2004) similarly advocate for recognition of the positive change and post-traumatic

growth demonstrated by survivors of trauma, and report that this therapeutic aim is associated with alleviation of survivor distress.

Counsellor 10 – “...for me personally it is to make them aware that there is hope for them, there is a way forward for them, despite what has happened to them and to give them back the power of choice, the power of turning a negative into a positive and to see them you know just rising above their circumstances”.

Counsellor 6 – “Because I will make sure that she must know what she needs, what she wants to do, what does she want to achieve in future other than this thing. And this thing doesn't stop, this rape, it doesn't stop her to achieve her dreams... So it doesn't stop anything, let it be a transport. That is what I always tell them, let this thing be a transport to success so that in future you will say you know this is what happened to me, but look where I am now”.

4.5.5 The impact on the counsellor and counter-transference feelings

Counsellors described the emotional impact of the work, which at times was related to taking on the feelings of their clients as part of the counter-transference, but was also elicited in response to the overwhelming need of clients within a context of limited resources. Ten of the eleven counsellors referred to experiencing vicarious traumatisation and taking on many of their clients' emotions.

Counsellor 3 – “You know, I would prefer not listening to their stories you know, will prefer not because some of them are very violent, it is violent, it is gruesome, it is just very violent and some of them speak, you know I take it home, I try not, but some of them I do take home and that is one of the stuff that really gets to [you]”.

Counsellor 8 – “And also of course in counselling we need to be aware of vicarious trauma, where you as a counsellor, you will be carrying these things over and then you need to talk about it, as you are a human being”.

Nine counsellors described having become more fearful or hypervigilant since starting counselling. Eight counsellors described having felt anger towards others as a result of hearing about survivors' experiences, seven identified having felt helpless on some occasions, five reported having felt numb and four described having experienced exhaustion or burnout.

Counsellor 1 – “...occasionally quite helpless... Fear, it has definitely come up for me. I mean there are some things that I will do and not do now because of the stories that I've heard. So very much the same kind of symptomatic symptoms that other people experience but on maybe different levels and different things”.

Counsellor 6 – “I felt the way she feels when she was telling me, I had the same feelings she told me. I couldn't understand what is happening, I was – shoe, I was dizzy, didn't understand anything, I feel like I can stay alone and think about this, why the world is like this. It is where you don't feel anything”.

Six counsellors reported having experienced difficult feelings towards their clients during counselling, such as anger or frustration, often in response to clients having failed to protect themselves or using maladaptive coping mechanisms. All these experiences reflect the traumatic counter-transferences described by Herman (1992a).

Counsellor 3 – “You know sometimes they transfer that over to you, that is why you need to be on guard at all times, it do irritate – sometimes, like I find you know, then I know I need to step down a bit, don't take on such a lot of clients because I feel very irritated”.

Connected to these feelings four counsellors described questioning whether they had made enough of a difference in a survivor's life and six described having on occasions lacked confidence in their abilities as a counsellor.

Counsellor 9 – “Feeling like you haven't sometimes tried... you are so aware of what your boundaries are and then you sometimes know or you feel you needed to do more that you are limited in some way. I think the biggest reason for a lot of counsellors is to know that we cannot save these people we are only meant to be there for them for one hour... they need to get something for them that they can hold onto so it is sometimes difficult to see them walk out of here and not feeling sure, did I give her something now?”

Herman (1992a) identifies feelings of helplessness and self-doubt in the therapist as an empathic sharing of the helplessness and powerlessness experienced by the trauma survivor. However in the South African context, counsellors feeling de-skilled may also be linked to their clients' poverty, multiple stressors and ongoing lack of safety. Five counsellors also reported worrying about their clients' safety and well-being outside of counselling sessions and this was at times related to a strong desire to fix or solve all of the social and/or interpersonal difficulties in their clients' lives. This wish for omnipotence reflects Herman's (1992a) description of therapists' attempts to defend against the difficult feelings in the traumatic transference.

Counsellors' experiences

Counsellor 3 – “I do think about it, I do you know, think about it when I walk away, when I go home you know. Sometimes you worry about a client, you actually have a sleepless night over a client you know, you do”.

Counsellor 11 – “...sometimes helpless I wish I could you know especially with everything a child has gone through I wish I could help you more I wish I could just take some of your pain away immediately because there is just so much that children go through”.

Counsellors reported drawing on several internal and external resources to enable them to do the work and manage their counter-transference reactions and experiences of vicarious traumatisation. Eight counsellors reported debriefing with either the counselling co-ordinator or the administrative worker immediately following a challenging session and nine reported taking their own difficult feelings to discuss during either peer supervision or group supervision (supervision with a counselling co-ordinator present).

Counsellor 11 – “...and then she will say how do you feel about this little girl or something so that helps a lot because like I say a lot of times you don't know how it has affected us we don't know how a session has affected us because we just go on you know we just carry on and she'll come up and she'll talk about it again and it kind of allows you to feel it”.

Counsellor 3 – “...supervision is extremely important, you need to download, you need to – what is so nice at Rape Crisis, is that once you had done with your session, the co-ordinator is there and you just talk about the session and that is good, I find that very helpful”.

Receiving practical help from counselling co-ordinators was described by four counsellors and another four indicated that they privately receive supervision or guidance from a health care professional. Nine of the counsellors described drawing on the support of those in their personal lives for support and six described receiving emotional support from colleagues at Rape Crisis. Nine counsellors also reported engaging in activities to help manage their difficult feelings, for example exercising, being creative or engaging with nature. Counsellors also described how they drew on their own personal experiences and resources in the counselling. For example, five reported having increased empathy for clients drawn from their own personal experiences.

In addition to the negative or traumatic impact of the work on counsellors, eight counsellors highlighted the rewards they received, for example, a sense of satisfaction or personal gain.

Six counsellors also reported having experienced personal growth and development as a result of the counselling work and three highlighted the mutually beneficial nature of counselling.

Counsellor 1 – “But I’m doing this because it fulfils my sense of who I am and because of what it provides for me as well, so I think that is also a part of it and sort of the satisfaction in that”.

Counsellor 6 – “I do see a change and that makes me feel better to help someone, to see someone have a smile on their face again”.

4.5.6 Factors impacting on treatment

Issues of difference

When asked about the impact of difference between the client and counsellor on the treatment process, six counsellors referred to language difference and age difference as causing some level of difficulty in the counselling. For example, they discussed ways in which language difference can hinder communication even when interpreters are used and how differences in age or using interpreters can negatively impact on the development of trust in the therapeutic relationship. Five of the counsellors described actively raising and discussing issues of difference with their client and five described discussing the difficulties caused with colleagues as ways of managing issues of difference. Four counsellors reported the usefulness of matching clients and counsellors in terms of age and language.

Counsellor 4 – “...but it is complicated and I think it makes it more difficult because most of my thinking is around language and what’s going on, where she’s stumbling over words and that kind of thing so I try and figure that out with the interpreter so that she can say you know she’s stumbling over this word but it’s not really possible and then the sessions are a lot longer, so everyone’s very exhausted by the end”.

Counsellor 7 – “It is so important because you know a young girl, I am bigger than her, the thing is, maybe she is going to be shy because sometimes I am the mother to her, I am the age of her mother. It will be difficult for her to speak out everything, you know. That is why you must ask if it is easy for her to talk to me or I must look for the younger counsellor for her, you know”.

Barriers to treatment

Barriers to treatment both internal and external to the client were described by counsellors. Nine counsellors identified poverty as a barrier to clients attending counselling. Although

counsellors reported that Rape Crisis subsidises client travel where there is a need, this was not always sufficient to ensure that clients were able to attend sessions.

Counsellor 2 – "...and that [poverty] is something that often stops people from coming as well – We do have something called client relief, but it doesn't cover the full extent of the transport".

Counsellor 6 – "'Even when I was coming here I didn't even have the money to come here, my neighbour borrowed me the money'. Some of them they will say".

Nine counsellors also identified the limited number of sessions they are able to offer survivors as curtailing what could reasonably be achieved during treatment. The avoidance symptoms of PTSD, as a barrier to clients engaging in counselling, was identified across six of the eleven interviews. For example some survivors reportedly experience counselling as a reminder of the rape and are fearful of, and avoid talking about, the traumatic experience, leading to difficulty engaging with or talking during the counselling sessions.

Counsellor 2 – "The actual process of counselling can be quite traumatising I think one of the reasons why, some of the reasons could be that people feel it is too traumatising to come for counselling".

Counsellor 3 – "...it is also because of I don't want to remind – remember this – don't remind me of the rape".

Six counsellors discussed how the stigma attached to rape and to being a rape survivor at times prevented survivors from reporting rape or seeking or completing treatment. Some related this to issues of confidentiality and disclosure. Smith and Kelly (2001) similarly identified the social stigma of rape as preventing survivors from attending counselling. Six counsellors identified survivors being sent for treatment or being forced to engage in counselling as counter-therapeutic.

Counsellor 4 – "It is stigma and also to try and contain, uh... contain information have control over the information because if you tell one person then the whole community knows, um it's overwhelming, particularly because of the shame associated with it you know despite my personal belief that it's the rapist who should be ashamed not anybody else, but many people do feel shame after a rape so the way to try and control that".

4.5.7 Treatment outcomes

What came across clearly in all eleven interviews were counsellors' views that the work they do has a positive impact on clients despite the overwhelming challenges faced by survivors.

The link between counselling and healing

Nine of the eleven counsellors identified a link between incomplete or lack of treatment following rape or CSA and later treatment seeking as a result of re-experiencing of symptoms and/or deterioration in functioning. This was at times, but not always, related to the use of maladaptive coping mechanisms. The link between counselling and healing also appeared to be connected to counsellors' beliefs in the importance of survivors talking about their traumatic experiences.

Counsellor 4 – "...in the initial stage there's shock and you tend to get a lot of the symptoms of shock like rape trauma symptoms in that initial period and then it goes into the denial phase... in the denial phase they tend to not think about the rape very much and just rely on their, they just kind of give their coping strategies a work up and see how long they can cope, and then after that then there's normally a big onset of symptoms again and that's often when clients come here because they think oh damn I thought I was over all of this and now I'm going crazy".

Counsellor 11 – "...if it is not dealt with at some point, at another point it will make you deal with it".

Observed outcomes

Counsellors also articulated some of the positive changes they observed in their clients. With regard to physical appearance, seven counsellors described seeing survivors smile again during the course of treatment and three described improved body posturing and better self-care.

Counsellor 10 – "And you know, you can see it after the third or fourth counselling, you see them, they present themselves much better. You can even see it on the posture, you can see it on the way they present themselves with their clothing you know".

Counsellors described having observed improvements in survivors' daily functioning, for example, seven of the eleven counsellors described having worked with survivors who returned to, or improved in, education or employment during or after treatment. Four described survivors who had stopped abusing substances.

Counsellor 6 – “At school she was doing Grade 11 for the fourth year. But last year I received a call from her, she was telling me that I did pass my grade, I thank you”.

Survivors' improved ability to remember aspects of the rape or CSA as a result of counselling was reported over seven of the eleven interviews, which then allowed better engagement with the sexual assault. This correlates with one of Courtois et al. (2009), Harvey (1996) and Lebowitz et al.'s (1993) outcome criteria for post-trauma recovery, “authority over the remembering process” (Harvey, 1996, p. 11). Four counsellors also observed a reconnection between their clients and those in their social environment, and three specifically described improved relationships between adolescent survivors and their parents, thereby augmenting their support networks and reflecting the recovery criteria of attachment (Harvey, 1996; Lebowitz et al., 1993).

Counsellor 6 – “And then when she came back, she said ‘you know what, every day when I wake up I always told – I told my parents now that I love you, but that is something that I have never done before and I am proud to say that to my parents, that I love you’... So that makes me feel happy, because bringing a family together is a good thing”.

Six counsellors highlighted the way in which counselling reconnected survivors to a sense of motivation and hope for a positive future, for example reconnecting them to previous goals or ambitions, and four described how survivors had managed to create meaning from the trauma through pro-social action. A survivor's involvement in pro-social action is one of the treatment goals in feminist therapeutic interventions and has been identified as one of the ways that survivors generate meaning out of traumatic experiences (Brown, 2004; Cohen, 2008). This in turn has been associated with post-rape recovery (Frazier, 2000).

Counsellor 3 – “You know, one client, brilliant girl... has decided that she wants to open a rape centre herself you know, to empower other women and she said ‘it took me three years you know, to get to the point where I am now you know, and that is why I want to open a centre and talk to young people and women about being raped and how you can survive and letting your story out there you know’”.

Six of the eleven counsellors reported observing little or no positive change, or deterioration in functioning in some of their clients, stating at times the belief that counselling ended before change could be observed.

4.6 CONCLUSION

The data indicated that many of the survivors presenting for treatment at Rape Crisis have a history of CSA, have experienced multiple traumas and/or face ongoing stressors in their lives. Counsellors' descriptions of the psychological impact of sexual assault and the treatments offered were organised into several themes which are summarised and related to the literature in the following chapter.

University Of Cape Town

CHAPTER FIVE

CONCLUSION

This chapter will summarise the findings of the current research and their relation to the literature surveyed. It then provides consideration of the study's limitations before offering recommendations for future research and practice.

5.1 SUMMARY OF RESEARCH FINDINGS

Demographic information described by counsellors indicated that the vast majority of survivors of rape or CSA presenting for treatment at Rape Crisis are women. Two out of the three Rape Crisis centres reported working with mostly adolescent clients. This is particularly significant given that adolescence is a key stage of emotional, psychological and physical development and the experience of trauma during this time is likely to have more enduring consequences than at other life stages (Ford, 2009). Although rape was shown to occur across all socio-economic strata, counsellors reported working mostly with clients who do not have a tertiary education and who are either unemployed or in semi- or unskilled employment. Lower levels of education or insecure employment were attributed by some counsellors to the survivor's experience of sexual assault, and are also likely to reflect the extent of the socio-economic difficulties and the particular political history of the country.

The research indicated that for the survivors of rape seen at Rape Crisis, the experience of childhood sexual assault (CSA) was common. Counsellors recognised the ways in which a history of CSA led to survivors requiring longer-term and more in-depth treatment, as has been well documented in the literature (Cloitre et al., 1997; Cloitre et al., 2009; Ford & Courtois, 2009; Herman, 1992b; Yuan, et al., 2006). Consistent with these findings were counsellors' reports that the majority of perpetrators were known to the survivors and that many of the assaults took place in survivors' homes. Counsellors also reported that some survivors had continued contact with the perpetrators following the rape or CSA, indicating that threat and danger were very real and ongoing. Apart from CSA, multiple rapes in adulthood were more commonly reported by survivors than single incidents of rape, and a significant number of counsellors reported having worked with survivors of gang rape. Wood (2005) identifies gang or group rape as part of "a continuum of sexual coercion in South Africa" (p. 303).

Counsellors' experiences

Many survivors were reported to experience chronic stressors such as poverty or living with HIV/AIDS in addition to the sexual assault. Harvey (1996) in her ecological theory of recovery from trauma elucidates how social stressors such as poverty can hinder not only the survivor's ability to adjust, but also the capacity of those around her to offer support. Survivors' past or ongoing experiences of domestic violence and physical and emotional abuse and neglect, in addition to the sexual assault, were also commonly described by counsellors. Researchers such as Williams et al. (2007) have similarly identified how many South Africans experience multiple traumas throughout their lifetime. Counsellors also reported that many survivors experience relational difficulties in the home. While counsellors indicated that some survivors do receive social support from those around them, they also commonly described the negative, or well-intentioned but unhelpful, responses of others, including blame, rejection, lack of understanding about rape or post-rape adjustment, or removing the survivor's autonomy. The experience of negative social reactions following rape has been associated in the literature with poorer post-rape adjustment (Resick, 1993; Steketee & Foa, 1987; Ullman et al., 2007a, 2007b; Wyatt et al., 1990). Borja et al., (2006) also found an association between negative support (well intended support but which doesn't meet the survivor's needs) from those in the survivor's support network and increased symptoms of post-traumatic stress.

The research findings suggest a complex relationship between the various forms of trauma and ongoing stressors experienced by survivors, social understandings of and attitudes towards sexual assault, survivors' post-rape adjustment and recovery, and their engagement with treatment. Counsellors identified how survivors' experiences of multiple trauma and/or ongoing stressors impact on counselling, for example delaying treatment until safety can be ensured, preventing the development of a clear treatment focus, or social issues being prioritised for treatment above the sexual assault. Tummala-Narra (2007) similarly describes how interpersonal, social and political factors can influence the "relevance and the efficacy of professional interventions" in the treatment of trauma (p. 206).

Counsellors reported that survivors experience similar patterns of post-rape symptomatology to those described in international literature, however there were also some differences noted. Many of survivors' post-rape symptoms reported by counsellors resemble those described as part of Rape Trauma Syndrome (RTS) (Burgess & Holmstrom, 1974). However, many of the same symptoms could also be conceptualised as indicators of PTSD (DSM-IV-TR; American Psychiatric Association, 2000). Counsellors described having worked with survivors who

experienced one or more symptoms in each of the three symptom sets, namely re-experiencing, avoidance and intrusive symptoms. The most commonly reported symptoms of PTSD (those reported by eight or more counsellors) included intrusive thoughts or memories of the sexual assault, flashbacks, nightmares, the avoidance of rape related thoughts, feelings or reminders, avoidance of talking about the rape, amnesia for parts of the rape, sleep disturbances and concentration difficulties (often leading to impaired ability to function). Sexual assault has been associated with the development of PTSD both in international and local research (Faravelli et al., 2004; Hartman & Burgess, 1993; Harvey & Herman, 1992; Kaminer et al., 2008; Resick, 1993; Wilson, 2010; Yuan et al., 2006). It is unclear how many survivors demonstrated sub-clinical levels of PTSD and how many would have met the full diagnostic criteria, possibly due to counsellors' particular training and/or the feminist epistemological framework of the Rape Crisis organisation.

Fear and anxiety, which are associated with PTSD presentation, were also commonly described by counsellors as post-rape emotional responses, particularly fear when faced with rape reminders, fear of re-victimisation, and restriction in lifestyle due to fear, with an associated decrease in functioning. However, these responses need to be interpreted within the context of South Africa's high levels of crime (Altbekker, 2007) and some survivors having ongoing contact with the perpetrator. They may therefore be realistic or adaptive responses to rape (De Swardt, 2006) rather than due to the development of pathological fear structures as described in the literature by Foa and Rothbaum (1998). This emphasises the importance of the individual assessment process for each client presenting for treatment.

Symptoms other than those associated with PTSD reported both in international literature as well as the present study include tearfulness, helplessness or powerlessness, disrupted interpersonal relationships (including disrupted sexual functioning) and disruptions in beliefs about the self and the world (Choquet et al., 1997; Ellis, 1983; Frazier et al., 2001; Kilpatrick et al., 1985; Morrison, 2007; Resick, 1993). The experience of loss, grief or mourning was less commonly referred to by counsellors, which deviates slightly from other South African research (Booley, 2007; De Swardt, 2006). The behaviour changes reported by counsellors such as increased substance use and increased sexual activity also resemble behavioural post-rape responses cited elsewhere (Burgess & Holmstrom, 1979; Choquet et al., 1997; Herman, 1992a; Resick, 1993). However, these behaviours are also more normative to the adolescent stage of development and therefore, when displayed by adolescents, may have a complicated relationship with the sexual assault.

Survivors blaming themselves for the rape and experiencing associated feelings of shame and guilt was frequently described by counsellors, as was survivors' experience of social isolation and associated loss of trust in others. However, these were at times reported within a context of negative responses to disclosure or negative social support (Borja et al., 2006). Wyatt and Notgrass (1990) similarly discuss how blame and lack of support from those to whom the rape is disclosed is likely to negatively impact on the survivor's ability to trust others. Self-blame was not described by counsellors as helping survivors to find meaning from the trauma as reported in some of the literature (Burgess & Holmstrom, 1979; Janoff-Bulman, 1979), but was rather associated with a negative self-concept and reduced self esteem. The negative impact on caregiver role reported by counsellors in this study was not specifically referred to in the literature surveyed but may form part of a more general picture of difficulties in social adjustment reported by Ellis (1983), Morrison (2007) and Resick (1993) as a common response to rape. The symptoms of psychopathology reported in this study, such as depression and suicidality, coincide with international descriptions of post rape responses, as do the descriptions of eating disorders and the presence of other (sometimes unspecified) mental illnesses (Faravelli et al., 2004; Resick, 1993; Thompson et al., 2003).

Adaptive coping strategies such as the use of psychological defences, making life changes and speaking to others about the rape have been referred to both in this and other research (Booley, 2007; Burgess & Holmstrom, 1979; Thompson). Counsellors also identified post-rape complicating sequelae experienced by survivors. Involvement in court cases was often associated with increased anxiety or a resurgence of previously resolved symptoms. Secondary traumatisation has also been identified by Maw et al. (2008) as resulting from engagement with the legal system. Survivors becoming pregnant as a result of the rape as well as concern about contracting HIV/AIDS were reported by counsellors in this study and have been identified by researchers as some of the co-morbid sequelae of sexual assault (Campbell & Wasco, 2005; Christofides et al., 2005a).

The common underlying principle of treatment described by counsellors was that of empowerment. Of particular importance was the understanding that the client is expert in her own healing, which is a fundamental tenet of feminist therapeutic intervention in the treatment of trauma (Brown, 2004; Herman, 1992a; Wright, 2009). Counsellors' focus on building clients' strengths and resiliencies similarly reflects feminist modes of treatment, as part of the process of re-writing a narrative of survival rather than victimhood (Brown, 2004). Participants' attempts to (re)build survivors' self-esteem and reduce their self-blame as well

as reconnecting survivors to their inner-strength and previous sense of self similarly reflect feminist ways of working. More recently in the study of trauma, increasing attention has been paid to the importance of engaging with the adaptive coping mechanisms and resiliencies of trauma survivors (Harvey, 2007). Empowerment of clients involved counsellors adopting a particular therapeutic stance, which was embodied and implicitly modelled through counsellors' particular ways of listening and relating to their clients. Empowerment was also facilitated through treatment methods and techniques employed during the counselling. While the basic model of treatment was described as consisting of twelve sessions, treatment length varied depending on the needs of the client, particularly in the event of clients presenting with a history of CSA. The need to be flexible seemed to be recognised by counsellors as an inevitable reality, particularly given the multiple challenges and histories of CSA faced by clients.

The treatment offered by counsellors most closely resembled the three stage model of recovery from trauma as advocated by Courtois et al. (2009), Herman (1992a) and Lebowitz et al. (1993), as well as targeting not only intra- but also interpersonal difficulties, thus resembling the ecological or multidimensional models of trauma treatment also described in the literature (Hartman & Burgess, 1992; Harvey, 1996). For example, counsellors described taking a history and exploring her support network as forming part of the assessment process carried out with each client. This process recognises the need for consideration of a client's individual presentation within her unique context in order to develop appropriate intervention goals as described by Courtois et al. (2009) and Hartman and Burgess (1993). The counsellors' reported treatment aims also included many of the principles and objectives described by Courtois et al. (2009) and Herman (1992a) as appropriate for the treatment of survivors of complex trauma. This fits the previously described high levels of CSA and multiple traumatisation experienced by Rape Crisis clients. Counsellors used techniques from various treatment modalities as part of their counselling, which is advocated by researchers describing optimal treatments for survivors of trauma (Courtois et al., 2009; Hartman & Burgess, 1992).

The majority of counsellors' work appeared focused on the early stages of the three stage model of treatment. This involved establishing not only physical and community, but also interpersonal and emotional safety as well as the development of a trusting therapeutic relationship (Courtois et al., 2009; Herman, 1992a, Lebowitz et al., 1993). This fits with the often limited number of sessions counsellors are able to offer. Establishing physical safety

required that counsellors draw on an extensive network of NGO's and other organisations, and survivors were encouraged during this stage to practice their autonomy by initiating and taking action towards establishing their own safety, as advocated by Courtois et al. (2009) and Herman (1992a). The establishment of interpersonal and emotional safety appears to be facilitated by counsellors through their provision of psycho-education and coping skills aimed at symptom management. This approach has also been described by Hartman and Burgess (1993). The use of psycho-education to contextualise symptoms and difficult feelings as related to the trauma forms part of cognitive behavioural treatment strategies aimed at dismantling the survivor's pathological fear network (Foa & Rothbaum, 1998).

As part of establishing safety in the therapeutic relationship, counsellors emphasised the importance of building rapport and being reliable and available to their clients. This echoes an attempt to begin to repair the survivor's shattered object relationships, which psychodynamic theorists suggest occurs following traumatic experience (Garland, 2007a; Lemma & Levy, 2004). Herman (1992a) similarly notes that establishing therapeutic safety and trust forms part of the initial stages of survivors' reconnection with others. Counsellors' goals of increasing autonomy were related to empowerment and establishing safety. Autonomous functioning requires the capacity for self-awareness and decision-making based on cognitive processing strategies rather than intense emotion, and is one of the developmental achievements often disrupted by the experience of early complex trauma (Herman, 1992a; van der Kolk, 2005). Counsellors' attempts to increase survivors' autonomy through facilitating self-awareness, decision-making skills and fostering sustainable healing therefore reflects the process of "stabilization" (Ford, 2009, p. 50) in the treatment of complex trauma, where survivors' ability to cognitively process information and regulate emotion are slowly built up.

Counsellors also described the importance of survivors talking through the traumatic experience, but emphasised that this should be at the survivor's own pace. The above finding is in contrast to the majority of the treatment approaches advocated by cognitive behavioural researchers. Cognitive behavioural treatment modalities often place an emphasis on exposure techniques which, although ranging from graduated (systematic desensitisation) to flooded (prolonged exposure techniques) engagement with the traumatic memory, are designed to activate the survivor's fear network while they are still in a state of avoidance (Foa & Rothbaum, 1998; Foa et al., 1993; Sketeeke & Foa, 1987). Foa & Rothbaum (1998) report that exposure techniques have demonstrated evidence of their efficacy in the United States

and advocate their use in the treatment of rape survivors. It is possible that counsellors in South Africa pursue a different approach because of the high levels of CSA history and complicating contextual factors experienced by their clients. For example, avoidance of exposure techniques may be due to the inappropriateness of dismantling the fear network within an unsafe environment, or due to difficulty knowing which particular traumatic experience to focus on. McDonagh et al. (2005) similarly conclude that CBT may not be indicated when there is a complicated clinical picture. Thompson (2000) has also identified survivors having control over when they start to think about and process their rape experience as an adaptive coping mechanism, based on the experiences of survivors who did not seek treatment.

The importance of trauma survivors talking through the traumatic experience is also described in psychodynamic treatments of sexual assault, with the aim of transforming traumatic memory into narrative memory, which can be integrated into the survivor's life story (Garland, 2007a; Lindy, 1996). This reflects aspects of the second stage of recovery from trauma advocated by Courtois et al. (2009), Herman (1992a) and Lebowitz et al. (1993), namely remembrance of the trauma. These authors emphasise how talking about the traumatic experience should be done within the context of the survivor telling their life story (Courtois et al., 2009; Herman, 1992a; Lebowitz et al., 1993), which highlights the importance of the history taking process reported by counsellors. Counsellors commonly emphasised their role as being there to listen to their clients, thereby positioning themselves as witnesses to their clients' experiences of trauma. The role of witness has been identified as not only a position of moral solidarity with the client (Herman, 1992a), but also as part of providing them with the internal tools to be able to survive telling their story (Levy, 2004). Counsellors also described their belief in the importance of counselling to facilitate healing, which appears to be related to their belief in the link between talking about the traumatic event and the associated feelings and post-rape recovery.

As well as facilitating remembrance of the trauma, counsellors also focused on helping survivors to identify, name and express their feelings. This forms part of "affect recovery" (Lebowitz et al., 1993, p. 383), which is one of the criteria for recovery from the effects of trauma identified in the literature. Psychodynamic theoretical treatments also focus on helping clients to access and process trauma related feelings in order to facilitate meaning making and healing (Lindy, 1996). Counsellors reported using techniques such as writing exercises to assist with this process. Some counsellors also described using various cognitive

behavioural techniques to challenge some of clients' maladaptive beliefs, including reframing and re-evaluating the meanings of events, thought stopping, reality testing or positive affirmations. Helping clients to remember the trauma and engage with the associated feelings, along with challenging maladaptive coping strategies, resembles Cognitive Processing Therapy (CPT) as described by Resick & Schnicke (1993), which aims to treat depression and symptoms of PTSD. Some counsellors also reported helping survivors to face avoided situations, people or places using techniques resembling aspects of systematic desensitisation or *in vivo* exposure (Foa & Rothbaum, 1998). Counsellors' reported use of breathing and relaxation exercises for the management of anxiety and fear also form part of many behavioural approaches to the treatment of trauma, for example stress inoculation training (SIT), which combines these techniques with cognitive restructuring for the alleviation of depression and anxiety (Foa et al., 1993; Foa & Rothbaum, 1998). However Rape Crisis counsellors have employed additional physical stress and anxiety management techniques such as tai chi and Capacitar techniques. These techniques employed and taught to survivors by counsellors can be considered as helping survivors to sustain their own healing process within the context of the survivors' economic hardship and counsellors' limited resources. The process of mourning and grieving for what is lost, which usually forms part of the remembrance process, was not commonly referred to by counsellors. This is likely to be due to the limited number of sessions they are usually able to offer and their associated focus on the earlier processes of recovery such as establishing safety. These processes also require a 'post'-traumatic space, whereas many Rape Crisis clients live in situations of ongoing threat and danger.

The goal of reconnecting the survivor with others, including facilitating improvement in already existing relationships and extending their support network, was described by all counsellors. Reconnection to others forms part of the third stage of Courtois et al. (2009), Herman (1992a) and Lebowitz et al.'s (1993) three stage models of recovery from trauma. The counsellors' intervention at the level of the family, for example seeing family members and facilitating the improvement of family communication, also reflects Harvey's (1996) ecological approach to the treatment of trauma. Some counsellors reported referring clients to the Rape Crisis support group as part of facilitating their reconnection to others. Peer support has been identified by Cohen (2008) as helping to increase confidence and facilitate risk taking and the development of trust. Counsellors' additionally described attempting to engender hope for the future as well as post-traumatic growth in their clients. Linley and Joseph (2004) similarly advocate for the recognition of positive change and post-traumatic

growth demonstrated by trauma survivors and report that this therapeutic aim is associated with alleviation of survivor distress.

Counsellors commonly reported experiencing vicarious traumatisation as a result of their work with clients, including taking on their clients' difficult emotions as well as becoming increasingly fearful. These experiences are described by Herman (1992a) in her consideration of traumatic transference. However, in the South African context they are also likely to at times be due to distress regarding contextual difficulties experienced by clients or real concerns regarding clients' safety. Counsellors most frequently reported drawing on group and peer supervision to manage and work through their difficult feelings. This was followed by accessing the support of those in their personal networks as well as practicing good self-care. The most commonly reported barriers to treatment were poverty, despite Rape Crisis' attempts to reimburse clients for travel, as well as the limited amount of sessions counsellors are able to offer due to limited resources. Language and age differences were most commonly identified by counsellors as barriers to treatment. Resources may therefore be needed for more interpreters, and more importantly the recruitment and training of more multi-lingual counsellors.

All counsellors reported often seeing positive change in their clients following treatment. The most commonly reported positive changes observed in clients were improved daily functioning, improved physical appearance and retrieving dissociated traumatic memories. Although all counsellors reported usually seeing positive changes in their clients they described how at times survivors were unable to benefit from the counselling. They also described how counselling often reached the end of the allocated number of sessions before many potential positive changes could be observed. Counsellors' passion for and belief in their work was strongly felt during the research process.

5.2 LIMITATIONS OF THE RESEARCH

5.2.1 The research setting and sample

This research has particular limitations. The study was carried out at a single organisation which has a particular approach to the treatment of rape survivors based in feminist theory. The training offered by the organisation is therefore likely to have informed the way that counsellors interpret survivors' post-rape adjustment, and the treatments they offer, in particular ways. It is important that future South African research include a variety of organisations involved in the treatment of sexual assault and other trauma, in order to

describe and compare alternative treatment approaches. The data collected for the study also relied on counsellors' self-reports of both the psychological impact of rape on survivors and the treatments offered. Self-reports may be subject to bias or distortions in recall (Yin, 2003). The sample was limited to a particular geographical location and the sample size was also relatively small. Although this allowed a more in-depth exploration of counsellors' experiences, it also limits the generalisability of the findings. Counsellors' experiences are also limited to working with survivors who have sought or accessed professional support. There is a recognised need in the literature for future research to explore the post-rape experiences of sexual assault survivors who have not received therapeutic intervention.

5.2.2 The influence of the researcher

Whitehead (2004) describes how researchers bring their own "horizons" (p. 513) to the research process, which influence the way that they understand and interpret phenomena. She advocates that the researcher be cognisant of "the potential effects of their personal and social characteristics on data collection" (Whitehead, 2004, p. 516). It is likely that my being a young, white, female university student influenced the way that counsellors constructed their responses. This was evident at times when counsellors expressed concern that I may be evaluating their contribution, possibly as a result of my clinical training, and I responded by reassuring them that they are the experts in the work that they do. This is illustrated by the following interaction with one of the counsellors.

Counsellor – "...ja there's more feelings involved with that one than with this one, and you must tell me if I'm talking crap here..."

Interviewer – "No, this is coming from your experience".

My training as a clinical psychologist also meant that I approached the study of rape and CSA with more knowledge of psychopathological and medicalised understandings of responses to trauma, than for example, a feminist understanding. This is likely to have influenced the interview process as well as the manner in which the research has been presented. It also meant that it was important for me to try to suspend my training and to listen from a place of not knowing. Despite my theoretical knowledge, my limited professional experience as an intern psychologist facilitated my adoption of a curious approach to the research. However I acknowledge that it was not possible to completely suspend my preconceived prejudices and understandings (Whitehead, 2004). My clinical training is also likely to have influenced the way in which counsellors presented their accounts of working with rape survivors. For

example some counsellors emphasised the positive aspects of survivors' post-rape adjustment, possibly in response to the pilot interview's focus on the negative aspects of post-rape responses. This was taken into account and informed further development of the research questionnaire.

My position as an outsider to the organisation had an additional impact on the research. This, along with my age (I was younger than all but one of the counsellors), engendered a tentativeness in my approach, which may have prevented me from further or perhaps more critically engaging with some of the interview material. The language difference between the researcher and some of the research participants also needs to be acknowledged. Interviews were conducted in English, the researcher's first language. For participants being interviewed in either their second or third language, it is likely that much of the detail and nuanced knowledge of counsellors was lost as we struggled at times to understand each other's questions and answers. Future research should consider the use of interpreters when interviewing non first-language English speaking participants in order to maximise the documentation of their clinical knowledge.

5.2.3 The scope of the research

The research was limited in scope and length, and as a result, decisions needed to be made regarding inclusion and exclusion criteria when reporting results. For example, only themes described in at least three or more interviews were included when reporting results. It was necessary, as part of the phenomenological hermeneutic approach, to attempt to look beyond the immediate or surface expression of participants, and seek additional meanings from the data (Schmidt, 2006; Whitehead, 2004). The development of categories during the data analysis also necessarily involved making interpretations, for example, some codes could have formed part of more than one category and the counsellors' meaning had to be interpreted. The use of illustrative quotes attempts to increase the trustworthiness of the research by demonstrating that interpretations match the data closely (Whitehead, 2004). However, because of the word limited length of the dissertation, only a few quotes could be used to illustrate each reported category.

Whitehead (2004) also describes how illustrative quotations elucidate only parts of what has been described, appear out of context, and are selected by the researcher, leaving room for the exclusion of much information. I attempted to include as many illustrative quotes as possible, however it is likely that some of the nuances and complexities of counsellors' explanations

have been lost. Throughout writing up the research, I also experienced a tension between the unique or individual and the collective experience of counsellors. For example, while reporting commonalities across participants' accounts, I felt on several occasions that themes passionately described, but only by one or two out of the eleven counsellors, were lost. Finally, only counsellors' individual treatment of survivors has been focused on in this study; however it was clear from counsellors' accounts that they have many other roles within the organisation, such as group facilitators, court supporters, supervisors, administrative workers, campaigners and advocates.

5.3 RECOMMENDATIONS

Given the extent of contextual factors influencing post-rape recovery for survivors in this study, future research could investigate more closely the relationships between contextual factors and survivors' ability to adjust to and recover from rape and CSA. This would assist in further informing the focus of treatment on the individual, familial and community levels. For example, counsellors referred to wanting to start various groups such as a support group for survivors living with HIV/AIDS or an education and support group for parents of adolescent rape survivors. Further research could inform such treatment interventions. More detailed exploration of survivors' experiences of what has been most helpful during treatment may also be beneficial to guide treatment plans.

Gaps in existing support for child and adult survivors of CSA were identified by counsellors. Given the reported prevalence statistics of CSA in South Africa, which have been supported by counsellors' experiences in this study, there is a clear need for increased and specialised services for the prevention and treatment of CSA for this population.

5.4 CONCLUSION

This research has demonstrated that survivors of rape and CSA in Cape Town experience not only the extensive pathogenic effects of sexual violence reported in international literature, but also grapple with additional experiences of multiple traumatisation and chronic stressors. As a result, Rape Crisis counsellors are faced with helping clients to adjust, manage and recover from complex and multiple difficulties. Counsellors appear to have adapted internationally described treatment protocols to fit the South African context and utilise techniques based on a variety of theoretical understandings of sexual assault. It was clear from the research that much of counsellors' work is carried out through the employment of a particular, empowering therapeutic stance. Their treatment has also been necessarily

Counsellors' experiences

augmented by a large and diverse professional network of NGO's and other organisations in order to work towards ensuring survivor safety. Throughout the interviews, counsellors' passion and investment in their work with survivors of rape and CSA was evident, which is likely to provide an immeasurable contribution to survivors' journey of post-rape adjustment and recovery.

University Of Cape Town

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Contextual Factors

Table 1 Categories	
Category name and/or description	Number of Interviews
Childhood sexual abuse and other experiences of interpersonal trauma	
Experience of childhood sexual abuse	11
Other experiences of interpersonal trauma	
Domestic violence – ongoing or a history of	8
Physical or emotional abuse or neglect – ongoing or a history of	8
Multiply traumatised – experience of rape or CSA as well as another form of interpersonal trauma	11
Experience of ongoing stressors	
Poverty – including over-crowded or inadequate housing	10
Living with HIV/AIDS – including survivor or family member being sero-positive, or having lost a family member to HIV/AIDS	10
Relational difficulties at home	7
Previous history of psychopathology	5
Living in single parent families	4

Psychological Impact

Table 2 Categories	
Category name and/or description	Number of Interviews
Emotional impact	
Emotional presentation	
Fear	11
Anger	11
Tearfulness	7
Anxiety	6
Frustration	4
Unidentifiable affect	4
Feelings towards self	
Self-blame	10
Shame	9
Guilt	7
Loss of self-esteem	5
Self-criticism	5
Others' responses to disclosure	
Offering support	10
Blaming survivor	11
Not believing survivor	6
Lack of understanding about rape	7
Rejecting survivor	7
Removing survivor autonomy	6
Imposing own ideas regarding recovery	6
Interpersonal impact	
Social isolation	11

Counsellors' experiences

Loss of trust in others	10
Withdrawing from men	6
Disrupted sexual functioning	4
Negative impact on caregiver role	4
Fear of others' responses	6
Disclosed to trusted other	11
No disclosure to family/ parents	9
Cognitive impact	
Disrupted beliefs about self and the world	
Helplessness/ powerlessness	6
Belief that the world irrevocably altered	5
No belief in positive future	7
Belief that life no longer worth living	7
Impaired ability to function	
Concentration difficulties	9
Reduced functioning at school/ work	11
Fear related restriction in lifestyle	7
Avoidance behaviour related restriction in lifestyle	3
Physiological and somatic symptoms	
Sleep disturbances	11
Disturbance in eating patterns such as over- or under-eating	8
Headaches	8
Physical pain including stomach and back pain	8
Symptoms of PTSD	
Re-experiencing symptoms	
Intrusive thoughts or memories of the rape	9
Flashbacks	10
Nightmares	8
Fear or distress in response to rape reminders	5
Avoidance symptoms	
Avoiding thoughts, memories or external reminders of the rape	11
Fear or avoidance of talking about the rape	10
Amnesia for aspects of the sexual assault	9
Emotional numbing	8
No belief in positive future	7
Feeling disconnected from others and no longer human	4
Increased arousal symptoms	
Sleep disturbances	11
Concentration difficulties	9
Hypervigilance	5
Exaggerated startle response	4

Counsellors' experiences

Outbursts of anger and irritability	4
Other psychopathology and related symptoms	
Mental illness (sometimes unspecified)	5
Eating disorder	2
Suicidality	9
Depression or symptoms indicating depression	6
Behavioural changes	
Substance misuse	
Alcohol - either started using or abusing alcohol	6
Illegal substance use	6
Prescription medication abuse	3
Increased sexual activity – including risky sexual behaviour and prostitution	4
Psychological attempts at coping	
Psychological defences – including intellectualisation, suppression, denial or minimisation	5
Masking feelings from others	4
Coping and resilience	
Conscious attempts at coping	
Significant life changes – including moving home or changing school or job	6
Talking to others in their support network	4
Becoming more involved with church or religious organisation	4
Survivor resilience	
Resilient responses - including determination, courage, pro-active action	4
The extent and longevity of symptoms	
The profoundness of the impact of sexual assault – all aspects of survivors' lives affected	7
Protracted length of recovery – including resurgence of symptoms some time after the assault	8
Vulnerability to re-victimisation and re-traumatisation	5
Post-rape complicating factors	
Involvement in court case	7
Pregnancy	6
HIV/AIDS – including worry about contracting HIV/AIDS	5

Treatment

Table 3 Categories	
Category name and/or description	No. Interviews
Principles of treatment	
Empowerment	
Clients as experts in their own healing	11
The importance of clients choosing to engage in treatment	4
Encouraging decision-making	4
Counselling process	
Twelve session treatment model	11
Need for flexibility – with regard to the length and the content of counselling	9
Recognition of survivor's unique experience and presentation	7
Importance of assessing and tracking psychological impact of sexual assault	8
Collaboration with client – to prioritise treatment needs	7
Exploring client's personal history	7
Exploring extent and nature of client's support network	5
Socialising clients into counselling process – including explaining the potential benefits and the potential for counselling to be painful	9
Setting the therapeutic frame	5
Meta-thinking – monitoring and guiding the counselling process	4
Encouraging clients to seek support in the future – providing positive counselling experience	7
Aims and methods of counselling	
Ensuring safety	
Physical and community safety	10
Crisis containment and symptom management	
Crisis containment	4
Symptom management and reduction	8
Providing psycho-education to contextualise symptoms as normal responses to rape	8
Using Rape Trauma Checklist	6
Teaching coping skills and techniques	6
Safety in the counselling space	
Developing trust in the therapeutic relationship	10
<i>Building rapport</i>	9
<i>Being available and accessible to clients</i>	8
<i>Providing a positive experience of relating</i>	6
<i>Importance of being empathic</i>	4
<i>Benefit of developing trust in the therapeutic relationship – including better client engagement with counselling</i>	10
<i>Importance of counsellor reflexivity</i>	6
Creating a safe space – for clients to talk and show their true feelings	8
<i>Counsellor's role as listener</i>	9
<i>Importance of open and non-judgemental manner</i>	7
<i>Importance of confidentiality</i>	7
Increasing autonomy	
Facilitating self-awareness	6
Promoting decision-making skills	7
Fostering sustainable healing – by providing symptom management techniques	8
Identifying and building on existing talents	7
Techniques	

Counsellors' experiences

<i>Writing exercises – journaling, writing poetry</i>	9
<i>Cognitive-behavioural techniques – including reframing, re-evaluating meaning, thought stopping, reality testing and positive affirmations</i>	5
<i>Breathing and relaxation exercises</i>	4
<i>Written information</i>	5
<i>Drawing techniques</i>	3
<i>Collages</i>	3
<i>Distraction</i>	3
<i>Capacitar techniques</i>	3
<i>Tai chi</i>	3
Returning to previous levels of functioning	
<i>Helping to face avoided people, places and situations</i>	4
<i>Linking affect, cognitions or behaviour to the rape experience</i>	4
Remembering the trauma	
The importance of talking about the traumatic experience	10
The importance of following the client's own pace	5
Facilitating access to and expression of feelings	
Encouraging clients to talk about and express their feelings during counselling	9
Helping clients to identify and name feelings	10
Using techniques to facilitate engagement with negative affect	5
Improving self-concept and reconnecting to inner strength	
Reducing self-blame	8
Helping clients to rebuild self-esteem	5
Re-connecting survivor to pre-assault identity and sense of self	8
Reinforcing survivor's strengths and resilience	9
Reconnection with others – helping survivor to (re)connect with those around her	11
Fostering and improving existing relationships	10
Helping survivor to extend existing support network	6
Helping survivor to disclose the sexual assault to others	4
Providing hope and facilitating post-traumatic growth	
Helping clients to generate hope – including showing that they have a future	7
Facilitating post-traumatic growth – including setting future goals, developing talents or helping others	6
The impact on counsellor and counter-transference feelings	
Vicarious traumatisation – including taking on clients' feelings	10
Increased fearfulness or hypervigilance	9
Anger towards others	8
Helplessness	7
Feeling numb	5
Exhaustion or burnout	4
Experiencing difficult feelings towards clients – including anger and frustration	6
Self doubt	
Questioning whether managed to make a difference	4
Lacking confidence in own abilities	6
Resources drawn on – to help with counselling and manage counter-transference feelings	
Debriefing with counselling co-ordinator or administrative worker	8
Taking feelings to peer or group supervision	9
Practical or hands-on help from counselling co-ordinator	4
Private supervision or professional guidance	4
Drawing on personal support network	9
Emotional support from colleagues at Rape Crisis	6
Engaging in self-care activities – such as exercise, creativity, engaging with nature	9

Counsellors' experiences

Drawing on personal experiences to increase empathy	5
Satisfaction and personal gain	
Personal growth and development - as a result of counselling	6
Mutually beneficial nature of counselling	3
Factors impacting on treatment	
Issues of difference	
Language difference	6
Age difference	6
Directly raising issues of difference with clients	5
Discussing issues of difference with colleagues	5
Usefulness of matching clients – for language and age	4
Barriers to treatment	
Poverty – impacting on ability to travel to sessions	9
Limited number of sessions	9
Clients' avoidance symptoms – fear of talking about the sexual assault and associated feelings	6
Social stigma of rape	6
Being sent for treatment – rather than choosing to seek professional support	6
Treatment outcomes	
The link between counselling and healing – lack of treatment leads to later re-experiencing of symptoms and/or deterioration in functioning	9
Observed outcomes	
Improved physical appearance – such as smiling, improved posture, better self-care	7
Improved daily functioning – such as returning to/improving in functioning at school or place of employment	7
Stopped misusing substances	4
Reclaimed memories – enabling better engagement with the sexual assault	7
Reconnection with those in support network	4
Reconnection to motivation and hope for the future	6
Involvement in pro-social action – speaking out or helping others, generating meaning from the trauma	4
Little or no positive changes/deterioration in functioning	6
Most helpful aspects of treatment	
Experience of counsellor as genuine and trustworthy	4
Counsellor's role as listener	5
Non-judgemental stance	4
Creation of a safe space to express self	6
Writing exercises	4

Appendix A

RESEARCH QUESTIONNAIRE

1. Demographic of participants

I'd just like to get some information about you if that's okay, but first I'll tell you a bit about myself...

How long have you been a RC counsellor?

How old are you?

What is your first language?

In what language do you do your counselling?

- Can you counsel in more than one language?

How did you come into this work? / How did you get into being a RC counsellor?

Have you done any other similar work/ counselling?

Have you had any training other than the RC training?

2. Perceptions - Demographic of clients

Are you able to say something about the people that come to see you?

- Who they are?
- What context do they come from?
- What languages do they speak?
- What are their living circumstances?
 - Geographically, where do they come from?
 - What SES are they / employed/unemployed/ financially secure?
 - What sorts of work do they do?
 - What kind of housing do they live in?
- How often do you counsel men?
- What is the age range of your clients?
 - What age range is most commonly seen?
- What levels of education do they have?

What are the most pressing kinds of ongoing stressors that clients face where they live other than the rape?

- What difficulties do they face in their lives?
- What hardships do they face from day to day?

Do clients experience violence at home or in their lives?

- What kinds of violence?
- Poverty?
- HIV/Aids?

How do clients find their way to RC?

3. The kinds of rape traumas presented by clients

I'm interested to hear more about the rape experiences the clients have been through...

Can you tell me about the different kinds of rape that clients report?

- Single / repeated incidents / sexual abuse/ single or multiple perpetrators/ gang rapes

Or In what kinds of situations are the rapes perpetrated?

Or What are the kinds of circumstances/contexts in which the rapes are perpetrated?

- In the home/ parties/ social gatherings/ neighbourhood work/transport

Who are the perpetrators?

- Strangers / people known to the client / relatives/acquaintances?

If you think back over your time at RC, have you noticed any changes/trends in the kinds of circumstances / the ways in which rapes are perpetrated?

- Are there particular patterns that you've noticed?
- Do you find yourself hearing stories from different clients that are similar in some ways?

Have you noticed any changes or differences in the type of rapes that are presented since the definition of rape was extended in March 2007?

Aside from their experience of being raped, do some of the clients have other trauma histories that they tell you about during the counselling sessions?

- What kinds of history of trauma do they talk about?
- Physical violence/ childhood sexual abuse
- HIV/AIDS (ongoing)

How common is it for clients to report previous traumas?

Do you ask your clients directly about previous experience of trauma as part of your work with them or is it something that they choose to tell you?

Are there other complicating issues that come about because of the rape?

- HIV infection/ physical injuries/ court appearances

For the clients that you work with, how have people in their own network responded to their experience of being raped?

- Do clients usually tell people about the rape?
- Who do they tell?
- What have been some of the responses from their family members and friends?

4. Impact of the rape

Can you talk a bit about what kinds of difficulties the clients report needing help with?

Or In what kinds of ways do clients describe being affected by the rape?

How do they describe the rape affecting

- Their emotional state
- Their relationships with others – trust, forming new relationships
- Their ability to function at work/ doing day to day tasks
- Changes in the way they view the world

Do they describe having

- Nightmares
- Having flashbacks of the rape
- Feeling numb/ not being able to feel emotions
- Being jumpy or very aware of things around them all of the time
- Changes in their sleeping patterns
- Somatic symptoms
- Eating patterns
- Eating disorders
- And anything else?

Are there parts of the rape that clients don't remember?

Do they express wanting to avoid thinking or talking about the rape?

Do clients report avoiding the place where the rape happened, or avoiding other places or situations?

Do they report avoiding people/ places that remind them of the rape?

Or Can you tell me about some of the clients you have worked with / or give me some examples of what effects clients have reported to you...

How have your clients tried to manage their feelings after the rape?

- What positive coping mechanisms/ strategies/resiliencies do they use?
- Do they ever use more harmful strategies such as alcohol / other substances / medication?

Or Is there anything else that they try to use to make themselves feel better?

- E.g. religious beliefs

What in your experience do clients seem to need the most when they come to you? What do they ask for and expect from the counselling?

Does this differ from what you think they need?

5. Treatment model

Can you tell me about the counselling model that RC uses?

Or, In your training, how do they teach you to work with clients?

What are your goals / aims during the counselling?

- Explore in depth if necessary
- What is it that you want to help your clients to be able to do differently?

How is the RC model put into practice?

Or What steps do you take to put the model into practice?

- What strategies do you use?
- What do you try to do with clients during the counselling sessions?

Or What are the steps you take to help the clients in:

- Building on their positive coping strategies or resiliencies?
- Validating clients' experiences?
- Helping clients to name feelings?
- Providing education / teaching/ psychoeducation?
- Helping them to start facing situations they have been avoiding since the rape?
 - i.e. situational exposure to avoided places, people etc.
- Preparing clients for court?
- Identifying and building on coping strategies / resiliencies / or coping resources?
- Helping them to manage their reported symptoms?
- Working with issues of safety / safety management?
- Anything else?

Or What would an actual counselling session look like?

Do you make your own changes or adaptations to the model during your work?

- Do you need to be flexible and creative in terms of how you apply the model in practice / what you actually do during sessions?
- Do you prepare your session beforehand / or do you decide how to proceed depending on what the client presents with, in that session?

Do clients actually talk through the experience of rape in detail?

Counsellors' experiences

- Do you ask the client to revisit the rape in a lot of detail?
 - If so, what is the purpose of this?
- Do you try to help clients to tell the story about the rape?

Do you ever work with anyone other than the client?

- Family members / partners / friends?

If so, when would you do that?

If the client has a history of other traumas besides the rape, does this influence the model of counselling you use / the way you counsel clients?

How many sessions are you allowed to offer?

- Is there a limit?

How many sessions do clients actually attend?

What is your sense of why this is?

- Is it because they've been offered enough that's useful during this time?
- Are there things that make it difficult for clients to come back/ continue counselling?
 - External / practical difficulties such as time / money / stigma / lack of support
 - Internal difficulties such as avoidance / psychological pain
 - What stops the client from progressing during counselling?

Can you tell me what you find works well for you in the counselling that you do?

Are there parts that you feel particularly confident in doing?

- If so what are these?

Are there parts / aspects of the model that you find hard to put into practice?

- If so what are these?

What have clients said has been most helpful for them?

What is your sense of what is most helpful for your clients?

Do you see any changes / improvements in your clients' functioning and psychological wellbeing as a result of counselling at RC?

Do you sometimes feel there isn't any change?

How to you deal with / manage issues of difference with your clients?

- Clients from different cultures / with different beliefs?
- Clients of different races?
- Clients who speak different languages?

Do you bring this up in your sessions?

- How/ what do you say?

Have you experienced difficulties in the counselling work because of these differences?

Is difference something you think about or talk about in your work?

Do you discuss this with colleagues/ other counsellors?

What other resources, apart from the counselling sessions do you draw on in your work with rape survivors?

- Community resources / legal system / other areas of the health system / government agencies / Social Workers / other NGO's / community health workers/ referrals etc.

6. Counsellors' own responses and resources

I would now like to ask you some questions about your own experiences as a RC counsellor...
Could you tell me what the hardest part of this work is for you?

Or What have you struggled with most when doing this work?

Or What have been the biggest challenges for you?
What kinds of feelings have come up for you when working with clients and hearing their stories?

Many people who work with rape or other trauma survivors have said that it is sometimes hard to be with their clients, I wonder whether you have ever experienced this.

Or Can you talk about whether there are any difficult feelings you experience while you do work with your clients

- I wonder whether you've ever felt sad/ angry/ down/ numb?
- Do you ever feel like you want to avoid the work/ don't want to come in?
- I wonder whether you've ever felt helpless / like you want to do more than you can as a counsellor?
- Do your clients ever make you feel irritated / cross?

Are you able to give me an example of when you've felt this way?

Or Can you think of a time recently when you've been working with a client and you felt irritated or cross?

- How did you manage these feelings?
- Did you think about these feelings/ discuss them with anyone else?

What about positive feelings?

Is there anyone that you talk to about your positive or difficult feelings?

- In your personal network?
- At RC / supervision / peer supervision?

How do you try to manage the feelings that come up during your work?

- What resources do you draw on to help you with the work?
- How do you look after yourself?

How has this work affected you, has it changed the way you think about things/ see the world?

What makes you stay doing this work?

Or Do you find the work rewarding / does it have benefits for you?

If there was further training available would this be something you would be interested in doing?

Thank you so much for participating in the interview, your responses have been very helpful

Do you have any questions / Or anything else you want to share about your experience of being a RC counsellor?

Appendix B

UNIVERSITY OF CAPE TOWN

CONSENT FORM

Rape Crisis Counsellors' Experiences of Working with Rape Survivors in Cape Town

1. **Purpose of the study**

South Africa is reported to have one of the highest incidences of rape worldwide and South Africans are exposed to ongoing violence and traumatisation within a context where resources are sorely lacking. This necessitates the development of a shared knowledge base of skills, successful interventions and mechanisms for managing the particular struggles faced by South African practitioners working with rape survivors. This study aims to document the clinical knowledge that has been gained by Rape Crisis counsellors in Cape Town regarding the demographic profile of their clients, the rape experiences that their clients report, the psychological difficulties that clients present with, the methods of treatment being offered by Rape Crisis counsellors, and counsellors' experiences regarding the effectiveness and/or limitations of these interventions.

2. **Procedures**

You will be interviewed at a time and place convenient to you. Interviews will last between 1 and 2 hours and will be recorded for the purposes of transcription. You are free to refuse to answer particular questions if you so wish.

3. **Risks**

We do not anticipate any risks to you from partaking in this study; however you are free to withdraw from the study at any point.

4. **Confidentiality**

In order to maintain confidentiality, your name and identifying details, as well as those of your clients, will remain anonymous. However, the research will be made available to the Rape Crisis organization on completion and, although your details will be anonymous, due to the small sample size complete confidentiality cannot be guaranteed.

5. **Benefits**

The study aims to be of benefit to you and other Rape Crisis counsellors as information from the study may help to inform the development of a questionnaire for the collection of demographic and other relevant information about rape survivors seeking treatment at Rape Crisis centres. The data from the study will also be utilised in the development of a survey instrument which can explore on a much larger scale the experiences of practitioners and counsellors involved in the treatment of rape and other trauma throughout South Africa.

6. **Signatures**

Participant Date

Researcher Date